

TREATMENT ISSUES FOR ABUSED AND NEGLECTED CHILDREN AND SPECIALIZED INTERVENTIONS

There are a number of concerns or issues common to children who have been abused and/or neglected. This section presents some of the most common treatment issues for maltreated children and identifies some related interventions.

PHYSICAL HEALTH CONCERNS

Children often have a number of health or health related concerns that are generated by abuse or neglect. A child who has been physically abused may complain of difficulties opening and closing his/her mouth, noting that he/she was slapped or hit on the side of the head. The child may also complain of earaches or stomachaches, fearing that these areas of the body were damaged when the child was beaten. The child may have lost teeth or hair. He/she may have broken bones or internal injuries that require a hospital stay. A child who has been sexually abused is often concerned that any invasive sexual contact, especially vaginal or anal penetration, may have caused internal damage. The child may also fear having contracted an “invisible” sexually transmitted disease.

The issues of body integrity, sexual or physical adequacy, injury or scarring, and concerns about any changes in the body that might have resulted from abuse and neglect need to be explored with the child. Symptomatic behavior such as encopresis, enuresis, or psychosomatic aches and pains are also important to identify and explore during therapy.

Sexually Transmitted Diseases and Fear of Acquired Immunodeficiency Syndrome (AIDS)

Sexually transmitted diseases are not uncommon occurrences in child sexual abuse. Generally, diseases are determined at the time of the medical exam and treated with appropriate medication. Currently, few cases have been documented of human immunodeficiency virus (HIV) infection through sexual abuse. However, the increasing incidence of both HIV infection and sexual abuse suggests the need to follow guidelines for HIV-antibody testing of pediatric victims of sexual abuse.¹⁶⁰ A child who is known not to have experienced rectal, vaginal, or oral exposure to semen or HIV-positive body fluids can be assumed to be safe.¹⁶¹

Interventions related to this health concern include the following:

- ✍ testing the child for HIV antibodies if the child remains anxious or concerned,
- ✍ addressing the child’s fear and anxiety regarding test results, and
- ✍ using information and services for the child if the tests results are positive.

Sexual and Physical Adequacy

Some children worry that their bodies have been damaged by the sexual or physical abuse and that they are somehow inadequate compared to nonabused children. Issues of strength, body and muscle development, and size are especially important to children who have been physically abused.

A sexually abused boy may also compare his genitalia to the adult perpetrator's and worry that he is somehow inadequate because of the difference in size. A boy who has been molested by a female also worries that he is sexually inadequate or unable to satisfy a partner both emotionally and sexually. Many boys who have been victimized by males often worry about their sexual identity and fear that they are homosexual.

A sexually abused girl often worries about "virginity" and that partners in future relationships will be able to tell that she has been sexually assaulted. Some girls fear they will not be able to have children. For adolescent girls, fears about pregnancy from sexual abuse can motivate them to begin sexual relationships with boys their own age to "cover" for the possibility.

Sexually abused boys and girls are often confused about their sexuality and their desirability to members of the opposite sex. Often, victims report initiating sexual relationships to "prove" that they are adequate and capable of having sex. These relationships may be described as voluntary but are often initiated under duress and continue the process of victimization.

To intervene with these health concerns, the therapist can:

- ✍ address concerns about the body by having the child undergo a thorough medical exam;
- ✍ clarify anatomy, purpose, and function of the genitalia and sex organs;
- ✍ explain theories of sexuality and sexual orientation to the children his/her parents;
- ✍ offer support and encouragement to change relationships that are not reciprocal or satisfying;
- ✍ clarify age-appropriate interactions and intervene to protect the child if he/she is being exploited or abused;
- ✍ offer support and encouragement to support the child decision to refrain from engaging in sexual activity until he/she is physically and emotionally ready for the experience; and
- ✍ provide information on safe sex, sexual health care, and birth control to sexually active teenagers.

Pregnancy

Although pregnancy is a very rare occurrence among sexually abused children, the fear of pregnancy, the desire for an abortion, or the reality of carrying a fetus to term and undergoing delivery of the baby all provide a concrete focus for victims' fear of the body being affected or damaged by the experience.¹⁶²

In helping a child deal with the issues regarding pregnancy, the therapist should:

- ✍ provide support and reassurance to help the child integrate the experience of sexual abuse and pregnancy;

- ✍ address any changes in the body's functioning or appearance;
- ✍ address issues of guilt, blame, and responsibility; and
- ✍ address decisions made regarding care of the baby.

Scarring and Permanent Damage

Some children have scars or disfigurement from the abuse or neglect. Damage may serve as a continual stimulus, reminding the child of the maltreatment. These reminders need to be acknowledged and discussed in therapy.

To address these issues, the therapist can:

- ✍ have the child receive a thorough medical exam;
- ✍ examine experiences and feelings related to any time spent in the hospital;
- ✍ help the child who is disfigured by the abuse express his/her anger and sense of loss of a healthy and normal body;
- ✍ explore the child's embarrassment about injuries, possible envy of children who are not disfigured, and fear of rejection because of appearance;
- ✍ use role play and anticipatory planning to practice replies to questions people ask about injuries or scars;
- ✍ help the child develop responses to questions about their injuries that do not elicit fear, rejection, or pity; and
- ✍ help the child develop an identity that is based on behavior and accomplishments, rather than on body image.

Encopresis and Enuresis

Encopresis and enuresis may be behavioral indicators of abuse. Some victims have never managed to control elimination or their bladders, but other children, who were toilet-trained, become enuretic or encopretic with the onset of abuse. The former situations often are ones of chronic family dysfunction and chronic sexual abuse. In the latter, the incontinence is a regression to an earlier developmental stage.¹⁶³

The encopretic or enuretic behavior may be related to regression, anxiety, and misperceptions about the abuse and how the body functions. This behavior may also be an attempt to make the victim unappealing to protect against future assault.

When addressing these health related issues, the therapist can:

- ✍ Determine if there are any organic problems by having the child undergo a thorough medical exam with a pediatrician. For example, if there was anal tearing from sexual abuse, the child may initiate a cycle of constipation out of fear of having a painful bowel movement.
- ✍ Explain to parents the possible etiology of the behavior. Help the parents/caretakers understand that this behavior is related to the child's difficulties recovering from abuse.

- ✍ Identify and explore any unresolved safety and protection issues. A child who has mastered control of urination and bowel movements and then regresses and loses this mastery, often benefits from some extra attention, nurturing, and discussion about precautions the parents/caretakers have taken to protect and care for the child.
- ✍ Help the parents reestablish a toilet-training program, which is responsive to the age and developmental abilities of the child. Parents/caretakers may need to patiently implement a toilet-training program that was successful at a younger age and remind the child to use the toilet. Gradually, most children resume age-appropriate behavior.
- ✍ Explain to parents and caregivers that shame and punitive measures usually create more problems. Changing encopretic or enuretic behavior requires a strong parental alliance with the child and cooperation with medical and therapeutic professionals. Dysfunctional families may have a difficult time addressing a consistent, supportive program of toilet training with their child.

Psychosomatic Complaints

In the absence of any medical evidence, persistent fears and concerns that the child or the child's body is somehow "damaged" or less desirable than before the abuse require interventions suitable to psychosomatic complaints or stigmatization. Psychosomatic complaints can include headaches, stomachaches, feelings of tiredness or exhaustion, and vague aches and pains.

A child who has difficulty articulating his/her anger, fear, relief, loss, or sadness may develop aches and pains that express his/her discomfort. Psychosomatic complaints can often be identified as the child recounts the details of the assault(s). The child will state that he/she doesn't "feel good" or that he/she has a headache or stomachache. The child may state that he/she feels pain in his/her genitals or squirm in the chair or reposition him/herself to protect a vulnerable part of his/her body.

To address psychosomatic complaints, the therapist can:

- ✍ arrange for the child to have a thorough medical exam;
- ✍ help the child recognize the connection between his/her experience of abuse and his/her body sensations;
- ✍ facilitate the expression of emotions about abusive or neglectful experiences, including loss and depression; and
- ✍ support the child's need for nurturance and attention.

Sometimes, psychosomatic complaints are symbolic requests for nurturing and attention. When a child states that he/she needs to see the school nurse because he/she has a stomachache (after thinking about how much he/she misses his/her mother), the therapist can make the connection between what the child was thinking about and how he/she felt by asking the child what he/she was hoping for from the nurse. The therapist can validate the importance of having someone pay attention to the child's pain and the special need that the child has to be nurtured. Hopefully, the child will be able to recognize that his/her needs for attention and nurturing are legitimate and learn to negotiate to have those needs met without having to become physically ill or being vulnerable to abuse or exploitation.

In addition, the therapist can:

- ✍ Help the child learn to interact and socialize in a manner that facilitates receiving appropriate attention and nurturing. When a child's dependency needs and needs for acceptance and appreciation are met, the child may not need these symptoms. It is also helpful to ask the child to try to identify the area of the body that is the source of the pain or discomfort. Sometimes, a child will have misconceptions about the abuse, perhaps thinking that his/her stomach was injured from penetration. The child may also worry about disease or damage.
- ✍ Explain to the child how the body operates and what kinds of stress the body can accommodate. Some of the child's fears may be alleviated when he/she understands how the body functions.

DEVELOPMENTAL ISSUES

As stated previously, child abuse and neglect does not appear to affect each victim in a predictable or consistent fashion.¹⁶⁴ From the perspective of the child's psychological development, child abuse is more than an assault. The physical consequences are typically overshadowed by the associated disruption in the child's critical areas of attachment and development.^{165 166}

Attachment

Some argue that it is the disruption in attachment that is the main source of symptom formation and future problems. Many of the fundamental aspects of a person's emotional well-being, including trust, esteem, worth, efficacy, identity, relationships, and intimacy rest on a foundation of attachment to a responsive caretaker.

To deal with attachment issues, the therapist can:

- ✍ Ensure that the child experiences a consistent figure to whom he/she can relate. An ongoing relationship that is built over time is most useful in developing the trust that facilitates attachment. A child who establishes a connection and relationship with a responsive adult may be able to recover some of his/her ability to accomplish developmental tasks. This responsive adult can be the therapist, caretaker, teacher, or other appropriate adult available to the child on a regular basis.
- ✍ Model protective parenting and soothing responses to distressful experiences. The child can learn to nurture and respond to his/her feelings by practicing on dolls in the therapy room. As an example, the therapist can "play" with the doll and nurture the doll after the doll "experiences pain" from a doctor's shot. At first, the child may be the doctor and be impervious to the doll's pain. However, with the therapist modeling protective parenting and enacting soothing responses to the doll's tears and cries, the child learns how adults respond when a child is hurt.
- ✍ Reinforce the child's right to appropriate nurturing, attention, and protection. The therapist can ask, "Who took care of you when you were crying or hurt?" Often, the child will withdraw, become angry, or say he/she never needed any help. Then, the therapist can respond that all children need help sometimes and say, "I'm sorry no one was there to help you when you were crying or hurt. It is really hard to take care of yourself when you are small."
- ✍ Help the child explore the therapeutic relationship as a model for quality interaction.

- ✍ Educate the child about social behavior, including reciprocal relationships and prosocial responses to others. This kind of education facilitates a child's acceptance by peers and adults in the community and gradually decreases the child's dependence on the therapist as an attachment figure.

Mastery and Control

Abused and neglected children attempt to understand and manage fear, anxiety, and overwhelming feelings generated from the abuse. A children can feel shame and rage over his/her vulnerability. The inability to prevent abuse and the overwhelming feelings that are part of an abusive experience are often identified by the child as weakness and loss of control.

The therapist has two simultaneous tasks related to mastery and control issues ? clarifying the limitations regarding the child's ability to care for and protect him/herself and identifying the strengths and acknowledging the child's attempts to care for and protect him/herself.

The therapist can:

- ✍ Help the child acknowledge and accept his/her limitations by offering information about developmentally realistic behavior.
- ✍ Identify and acknowledge the child's attempts to protect or take care of him/herself during and after the abuse. This may include describing the child's symptoms and behavior as his/her attempt to call attention to the abuse or the child's attempt to manage his/her feelings about the abuse.
- ✍ Identify and support the child's abilities to accomplish developmentally appropriate tasks. Sometimes, a child will fantasize that he/she used extraordinary measures such as kicking, hitting, or knocking out the perpetrator to ward off the abuse or retaliate. The child may fantasize or repeatedly act out elements of the abuse in an attempt to gain some understanding and control over the experience. Talking about what a child his/her age is capable of doing, compared to what he/she wanted to do during the abusive experience, is one way of helping the child be realistic about his/her abilities. Acknowledging and describing his/her fantasies as a wish for power and a need for help can enable a child to accept his/her limitations and express his/her feelings about his/her powerlessness.
- ✍ Use interventions that help the child learn and master new skills. Support the child's willingness and attempts to learn new skills. Children need to know that everyone must learn how to do certain tasks. A child often benefits from hearing that the need to practice is a part of being human and that people are not born perfect. The therapist can connect making mistakes with being human and help the child learn to laugh and learn from his/her behavior.
- ✍ Use interventions that allow the child to practice decision making and experience a sense of control. The choices need to be constructed so that the child is not left with repercussions of shame or doubt about his/her abilities to handle situations.
- ✍ Help the child recognize dangerous situations and teach the child whom to ask for help. Helping a child connect with and use strong, appropriate, and protective adults can diminish his/her sense of vulnerability and powerlessness.

Impulse Control

A child with overwhelming fear and anxiety, as well as feelings of vulnerability and powerlessness, has difficulty managing his/her thoughts, feelings, and behavior. Thoughts may include suicidal ideation, destructive wishes, and fantasies with themes of retaliation and revenge. Feelings can include envy, hatred, fear, and anger. Often, a child who has been abused or neglected cannot manage his/her behavior and has difficulty delaying gratification of wishes. Sometimes, the child's behavioral reactions to situations seem to be out of his/her control. The child's behavior and communication may appear impulsive and unrelated to what is happening at the time.

Impulsive behavior includes exhibiting temper tantrums, being argumentative, and challenging authority or rules. Some children may verbally or physically attack their parent or caretaker, siblings, or peers. A child can feel angry with other children who have not been abused, whether family members or strangers. The abused or neglected child may damage property or hurt pets or younger children.

The therapist can:

- ✍ Help the child express the anger and rage associated with victimization. A child needs to learn how to express strong emotions. Discharging his/her feelings can reduce some of the intensity and overwhelming effects on behavior. Pounding on pillows, using action figures to fight out anger, tearing up paper, or smashing cans to demonstrate his/her feelings can sometimes free the rage and help the child identify his/her fears.
- ✍ Help the child develop vocabulary and language skills so that he/she can express his/her feelings. When a child can use words to express his/her feelings, he/she will not need to act out and dramatize his/her anger to the same degree. Once the child is more comfortable talking about his/her feelings, he/she can begin to think about how to express those feelings appropriately.
- ✍ Help the child identify the thoughts and feelings that precipitated his/her actions. Making the connection between the experience of abuse and subsequent behaviors can help the child begin to monitor his/her impulses.
- ✍ Address the issues of loss and powerlessness and, particularly with adolescents, probe for suicidal thoughts and plans.
- ✍ Support and educate caregivers to respond appropriately to acting-out behavior. The concept of regression can help the caretaker understand change in the child's behavior. The child will often revert to an earlier stage of behavior when he/she is feeling overwhelmed and unable to cope. This regression allows the child to depend on his/her caregiver and relearn that adults can be there to help him/her with problems or difficulties. Modifying behavior, teaching natural and logical consequences, and structuring the child's interactions and environment so he/she can better manage his/her behavior are important.^{167 168}

Identity

A child develops a sense of who he/she is and how to behave from the experiences that occur in his/her life. These experiences form a sense of self that affects how the child feels about him/herself and how he/she behaves toward others. The necessary components in establishing a positive identity include love, attention, nurturing, affection, intimacy, autonomy, power, and control. The experience of abuse or neglect impacts each of these areas. An abusive experience affects the child's identity, how the child behaves in order to have his/her needs met, and how the child responds and interacts with other people.

INTERPERSONAL ISSUES

A range of interpersonal issues must be dealt with in therapy. In this section the issues of identification with the aggressor, victimizing behaviors, intimacy, and betrayal are discussed.

Identification With the Aggressor

Theorists note that one way of dealing with and combating the experience of being a helpless victim is to become the powerful victimizer.^{169 170 171 172} A child often imitates another person who the child feels is strong and powerful; for many abused children this “someone” is the abuser. Unfortunately, the abusive adult did not teach the child appropriate problem-solving skills or methods for negotiating to fulfill needs and desires. In cases of sexual abuse, the child has learned inappropriate ways to satisfy the need for intimacy, control, and power. A child learns that intrusive and controlling behaviors are the norm and uses these behaviors for management of stress and anxiety, problem solving, and social and intimate interactions. The therapist must address loss, responsibility for the abuse, affiliation, and power and control in therapy sessions with the child.

The therapist can:

- ✍ Help the child identify the positive and negative behaviors that the child experienced with the perpetrator. The positive experience may generate a feeling of loss in the child. The child may need to mourn for what is missing in his/her life once the abuse has been disclosed. The therapist can express this loss for the child, and thus, give the child permission to acknowledge the experience. It is important for the therapist to identify the positive behaviors, attributes, or skills that the child has learned from the perpetrator.
- ✍ Focus on the abusive behavior rather than on the perpetrator. This helps the child feel more comfortable talking about what happened. Telling the child that the perpetrator’s *behavior* is wrong is far more effective than telling the child that the perpetrator is “bad.” When a child hears that a parent or someone they cared about is “bad,” the child often thinks that he/she needs to protect or justify his/her relationship and may protest and minimize the abuse. Expressing anger at the perpetrator often elicits the child’s loyalty and generates defensiveness from the child.
- ✍ Connect the child with appropriate adult role models in the community. This helps the child learn that he/she can benefit from a relationship without suffering abuse. This also facilitates and supports a shift in loyalty from the perpetrator to more available and appropriate role models.
- ✍ Help the child’s caregivers address issues of role reversal, boundaries, and setting limits. If the perpetrator was the disciplinarian in the family, and the nonabusive parent turns to the child to assume this role, the parent needs to know that the child is neither an appropriate role model nor has the skills for disciplining siblings. In these cases, the parent needs support and skills assume a disciplinary role and relieve the child of these responsibilities. Clearly defined limits on interacting with siblings and other children need to be stipulated.
- ✍ Educate parents about warning signals that indicate that the child is having difficulties managing anxiety, powerlessness, or anger. These warning signals include displaying intrusive and controlling behavior toward siblings, peers, and younger children; hurting or victimizing peers or younger children; and demonstrating aggressive or sexual acting out.

Victimizing Behaviors

A child who uses secrets, threats, intimidation, force, or weapons to secure access to a vulnerable child needs to be evaluated for unresolved issues related to physical or sexual abuse and protected from acting out his/her inappropriate behavior. Numerous articles have been written addressing the “abuse-reactive” child, adolescent, or juvenile perpetrator as well as aggressive or antisocial behavior.^{173 174 175 176} Developing empathy, a perspective on his/her own victimization, behavior management, and relapse prevention techniques, facilitate managing this behavior. Family therapy can provide a structure in which to develop and implement these skills.

In dealing with victimizing behaviors, therapists should address issues related to mastery and control, impulse control, and aggressive behavior.

Intimacy

Intimacy, the need and ability to feel close to a responsive and willing (age-appropriate) partner and be able to share one’s most personal thoughts, feelings, and behaviors, can be affected by abuse and neglect. An abused child is shaped, in part, by his/her age-inappropriate knowledge of sexual behavior and violent interaction, his/her experience of the perpetrator’s abuse of power and trust in a relationship, and his/her awareness of the impact and effects of emotional and physical manipulation. These experiences have an effect on the child’s ability to interact in an appropriate and responsible manner and can interfere with the establishment of positive, supportive relationships.¹⁷⁷

To help the child with issues related to intimacy, the therapist can:

- ✍ Work to increase the child’s investment in age-appropriate activities and relationships.
- ✍ Help the child increase his/her comfort with interactions such as talking, listening, and sharing.
- ✍ Support and encourage the child for interacting with others and developing close, reciprocal, personal relationships. Initially, the therapeutic relationship is a model for responsive, appropriate, and caring interaction. Help the child identify the qualities in the therapeutic relationship that can be expected or transferred to other relationships.
- ✍ Help the child manage his/her anxiety about connecting with others.
- ✍ Clarify and interpret positive and negative behaviors that support or interfere with developing meaningful relationships.
- ✍ Offer nurturance and support as the child invests his/her time and energy into meaningful relationships.
- ✍ Offer hope and guidance if the child feels rejected or loses an important friendship.
- ✍ Acknowledge the adolescent’s excitement and fascination with intimate relations. This is a natural part of the adolescent experience, and willingness to talk with the therapist about these feelings can indicate the establishment of trust in the therapeutic relationship.
- ✍ Discuss sexual concerns, questions, behaviors, health protection, and birth control.
- ✍ Interpret the adolescent’s sexual behavior in light of his/her history of maltreatment as well as in terms of normative issues (e.g., universal adolescent concerns about sexuality).

- ✍ Clarify the possible intentions, meanings, and consequences of the adolescent's behavior. Many adolescents welcome hearing that they can wait to have sexual relations until they are married or until they are absolutely certain that they are choosing to do so because they want to rather than to prove that they are unaffected by the abuse.

Betrayal

Betrayal occurs when a child realizes that what he/she understood to be real and acceptable turns out to be painful and emotionally damaging. When a trusted adult acts out his/her anger in a physically assaultive manner or uses the child for sexual and emotional needs, the child's expectation that adults will provide for his/her care and protection is violated.¹⁷⁸ A child who recognizes that he/she has been hurt or abused by an adult often has feelings of confusion and vulnerability. This can be profoundly negative and disruptive to the child's world view.¹⁷⁹ Betrayal by a physically or sexually assaultive parent may lead to disillusionment, distrust of others, hostility, and anger.¹⁸⁰

To help the child deal with feelings of betrayal, the therapist can:

- ✍ Help the child express his/her feelings about the abuse or neglect.
- ✍ Identify and talk about the adults who should have protected the child. Address issues of abandonment and feelings of rejection. Often, children are more negatively affected by abuse when they believe other people knew and took no action to protect them.
- ✍ Increase the child's ability to recognize hurtful and abusive situations. Instill the idea that children need help and have a right to protection. Help the child feel comfortable asking for and eliciting help from adults.
- ✍ Help the child identify similarities between the abusive experiences and his/her expectations regarding how adults will respond to children. This awareness can be related to the child's interaction with and expectations for the therapist, peers, and other adults in his/her life.

INTRAPERSONAL ISSUES

The effects of child sexual abuse and physical abuse can be understood as a combination of classically conditioned responses to traumatic stress and socially learned behavioral and cognitive responses to the abuse experiences.¹⁸¹¹⁸² Two main themes dominate the generation of symptoms— affective responses characterized by anxiety and behavior patterns that are the result of social learning processes. Treatment that is directed at altering the conditioned and the socially acquired responses to victimization will alleviate initial symptoms and reduce the likelihood of long-term or more serious disruptions in development.

Fear

Fear is generated when an external event threatens a child's safety or well-being. A child who expresses fear of the perpetrator, fear of retaliation, fear for his/her own safety, or fear of reoccurrence needs to be protected to the best of the professional's ability. Mandated reporting laws and emergency response and placement out-of-home (if the child's safety cannot be ensured in the home) can provide some protection for the child. Any current safety or protection issues that may be frightening the child warrant immediate assessment.

Trauma

Trauma occurs when the child is unable to manage the overwhelming affective reactions generated by the abuse.^{183 184 185 186} When a child becomes overwhelmed by his/her sensations, thoughts, or feelings about the abuse, the child is unable to make sense of this experience. The child continues to feel as if he/she is still in danger and repeatedly reenacts the abusive experience and continues to relive the event as if it were still occurring. The child's ability to feel safe and secure is impaired. He/she needs to develop strategies that enable him/her to feel that he/she can survive the experience. Sometimes, a child will behave in such a way that elicits reactions from others that resemble the abusive event. The child creates situations that replicate the abuse in an attempt to master overwhelming feelings and gain the sense that he/she has some control over the experience.

A child also offers symbolic representation of abusive experiences through his/her play, art work, dreams, and fantasy reconstruction. The child's art work may include actual information about the assault or representations of his/her sense of powerlessness. Play and fantasy reconstructions often include wishful or magical thinking, themes of anger, violence, and rescue fantasies.

In many ways, trauma is an open-ended experience that the child needs to address in order to gain understanding and closure. Trauma resolution comes about when there is sufficient processing for the information to be stored. That is, the event is remembered, the attendant feelings are neutralized, and control of the anxiety generated by the event is achieved. When a traumatic event is not resolved and remains either in active memory or defended by a cognitive mechanism, the diagnosis of PTSD is generally used.

To help the child work through the trauma, the therapist can:

- ✍ Help the child recall the details of the traumatic event.
- ✍ Help the child identify the sensations, thoughts, feelings, and beliefs generated by the experience.
- ✍ Help the child make the connection between what occurred during the abuse and how the child is feeling currently.
- ✍ Use interventions that provide a sense of completion and closure to the experience.
- ✍ Use techniques such as relaxation exercises and cognitive completion to help the child manage overwhelming experiences.^{187 188 189}

Anxiety

Anxiety is created when a child anticipates that a frightening or dangerous experience will reoccur. Sometimes, a child will remain in a state of anticipation, hyperalertness, or fearfulness when no immediate danger is present. In these cases, the child has often moved from the specific abuse experience to more generalized anxieties of circumstances or situations reminiscent of the abuse. Because anxiety is experienced as an intensely unpleasant state, the anxious individual is motivated to engage in responses to reduce or eliminate the anxiety. These coping responses may be behavioral; for example, avoidance of situations or persons associated with the anxious feelings. These responses may be cognitive; for example, compulsive or ritualized behavior that are attempts to render the anxiety-producing cues inert.¹⁹⁰

To help children work through the anxiety they experience, the therapist can:

- ✍ Provide support and encouragement for addressing a difficult task.

- ✍ Help the child relate the details of the abuse in a relaxed and matter-of-fact way.
- ✍ Encourage discussion about various aspects of the abuse experience. With a young child, play therapy can incorporate elements of desensitization, graduated exposure, modeling, and assertiveness training. The play interaction can be structured in a number of different ways, such as using puppets, dolls, art work, or story telling. The process is facilitated by gently encouraging and directing reenactment and discussion about various aspects of the abuse experience. This kind of desensitization is characterized by the gradual, imaginal presentation of a hierarchy of feared situations paired with relaxation and safety.¹⁹¹

A more direct approach is often useful with an older child.¹⁹² Graduated exposure and alleviation of emotional distress can be encouraged by helping the child talk about the abuse in therapeutic situations that are safe and supportive. Through a process of talking about abuse-related material in a regular and matter-of-fact way, the memories eventually lose the capacity to elicit arousal.

- ✍ Monitor the child's ability to talk about anxiety-inducing experiences. Berliner and Wheeler note that sensitivity and clinical judgment are required in determining at what rate to proceed in eliciting this material.¹⁹³ The child should not be forced prematurely to recall or talk about the abuse because the therapist and the therapeutic environment may become simply an aversive reminder of the abuse.
- ✍ Identify the source of the child's anxiety. This usually requires eliciting specific information from the child about the content of his/her intrusive memories, dreams, or nightmares or identifying cues that evoke anxiety responses.¹⁹⁴
- ✍ Initiate and model methods of managing difficult experience. Appropriate methods of managing anxiety, such as asking for help, talking about feelings, and expressing strong emotions need to be modeled by the therapist.
- ✍ Reinforce the child's attempts at effective coping responses.

Depression

Many of the methods developed to alleviate depression in children and adolescents are also useful for abused and neglected children.¹⁹⁵ In depression, one of the most important areas that needs to be addressed is repressed or pent-up feelings. Therefore, the therapist can:

- ✍ Identify the child's capacity and willingness to experience and express his/her feelings. For example, does the child have an adequate vocabulary? How did the parents/caregivers react when the child expressed his/her feelings or opinions? Does the child feel secure in expressing his/her feelings about the abusive experience?
- ✍ Facilitate awareness and identification of feelings.
- ✍ Acknowledge and encourage the expression of feelings. Support the child's utilization of various media including poetry, song, dramatic play, art, and written expression to express his/her feelings.

Lack of Expression of Feelings

The lack of verbal expression is a characteristic of an abused and neglected child. There are several reasons why the child says little about how he/she feels including the following:

- ✍ The child may not know how to express his/her feelings.
- ✍ The child may not have the language or verbal skills to express his/her feelings. For example, one 6-year-old girl who was both physically abused and neglected referred to her home as a “crying place.”
- ✍ The child may be unsure of his/her own ability (or others’ abilities) to tolerate and manage a display of feelings. The child may be unwilling to acknowledge or display his/her pain, fear, or sadness.
- ✍ The child may have a limited range of feelings or limited awareness of his/her feelings.
- ✍ The child may not feel or think that his/his feelings are “safe.”

To help the child express his/her feelings, the therapist can:

- ✍ Educate the child about feelings. Teach the four groups of feelings—mad, sad, scared, and happy.
- ✍ Model and demonstrate appropriate expression of a wide range of feelings. For example, the therapist can model anger or sadness about the child’s statement that no one responded when he/she was hurt. The therapist can reaffirm to the child the message, “I am here to help you now. I want to make sure you are safe and you get help when you need it.” The therapist can model pleasure as the child demonstrates new skills and abilities.
- ✍ Support the child’s attempts to manage his/her feelings about the abuse. Some children will not allow themselves to remember or reexperience the pain involved in the assault. This ability to ignore, dissociate, or not have feelings about the experience has been a useful survival technique. The child will not surrender this survival technique until he/she feels that he/she is absolutely safe from abuse.
- ✍ Routinely explore safety issues with the child.
- ✍ Make the distinction between how the child felt when the abuse occurred and how the child feels currently. Remind the child that he/she is able to manage better now that he/she is bigger, older, or in a safe place. This assurance helps the child recall the experience of being hurt and still remain connected to the present where he/she is more capable of asking for help and receiving protection.

Guilt, Blame, and Responsibility

An abused or neglected child has a very difficult time placing responsibility for the abuse where it belongs—with the perpetrator. It is often a constant struggle for the abused child to determine who is responsible for the abuse and to understand who is the victim and who is the aggressor.¹⁹⁶ It is more likely that the child will internalize responsibility and blame him/herself for the perpetrator’s abusive behavior. The following are some of the reasons why a child might blame him/herself for the abuse:

- ✍ The perpetrator may have said things to make the child feel responsible for the abusive behavior.
- ✍ The perpetrator may have cultivated a special relationship with the child and offered special rewards or privileges for the child’s cooperation or silence (particularly in cases of sexual abuse). The child may feel guilty and blame him/herself for enjoying the special treatment, especially if it interfered with seeking help quickly.

- ✍ The abused child may have experienced some covert power and feel guilty about using the secret to manipulate the perpetrator or other family members.
- ✍ The child may think his/her behavior provoked the abusive behavior. The behavior of a physically abused child is often provocative. The child may interact with parents in ways that elicit the parents' attention, even if that attention is negative and hurtful.
- ✍ The child may feel guilty about what happened after the abuse was disclosed, especially if the family has financial problems or is experiencing shame, sadness, anger, or loss from the removal of the perpetrator.^{197 198}
- ✍ The child may feel guilty if he/she experienced any physical pleasure from the abuse or acted out similar behaviors with peers or younger siblings. Assuring the child that he/she is "not to blame" for the abuse is not enough to convince the child that the abuse was not his/her fault.

To help the child work through guilt, blame, and feeling responsible, the therapist can:

- ✍ Discuss the child's relationship with the offender.
- ✍ Increase the child's understanding of why this kind of behavior is so hurtful to children.
- ✍ Educate the child about adult responsibilities (i.e., caring for and protecting children, knowing right from wrong, and using the child's body and mind appropriately—that is, to not hurt or trick the child) and why adults are assumed more responsible (e.g., they know more, they are more mature, they have more options, they are bigger, they control resources).¹⁹⁹ The child needs to know that the perpetrator is an adult and knows the difference between right and wrong. Often, the child understands the concept of right and wrong when he/she is reminded that the perpetrator asked him/her to keep a secret or hide the injuries from physical abuse.
- ✍ Explain the concept of consent to the child (i.e., when a person is afraid or doesn't understand what he/she is agreeing to or how to say "no," then the agreement is unfair).
- ✍ Help the child explore the reasons why he/she kept the abuse a secret, and why the child finally decided to disclose the abuse. The child needs to recognize that there were reasons why he/she was unable or unwilling to disclose the abuse and that these reasons do not make the child responsible for the abusive behavior.

Secrecy itself is a choice.²⁰⁰ The child may choose to keep the abuse a secret for a number of reasons. Perhaps the child did not think anyone would understand. Perhaps he/she made the decision not to tell because he/she thought that his/her family would be angry with the child, or perhaps the child did not tell because he/she believed that the abuse was his/her fault. The perpetrator may have threatened to harm the child or his/her family members or pets. Some children attempt to avoid the abuse rather than tell someone.

Whatever reasons the child had for keeping the secret, they imply that the child made a decision based on information that was available, whether that information was accurate or inaccurate. This means the child was capable of discriminating between options and deciding what to do. It is this decision-making capacity that needs to be maximized. Implicit in this experience is that the child needs to learn that he/she has choices and feels that he/she can make decisions to care for him/herself.²⁰¹ Therefore, the therapist should enforce this behavior as follows:

- ✍ Help the child understand that certain kinds of behavior contribute to his/her vulnerability. Be sure that the child understands that his/her behavior does not make him/her responsible for the perpetrator's decision to abuse. However, the child's behavior can result in a situation that leaves him/her vulnerable to exploitation or abuse. Berliner and Wheeler note two examples.²⁰² The child who believes she caused her molestation by asking her father where babies come from requires reassurance that her father's literal demonstration was a result of his disturbed thinking and behavior and that her conduct was completely normal. On the other hand, the child who has repeatedly returned to the neighbor's home, knowing of the possibility of molestation, or who has sought extra privileges in exchange for compliance with abuse can be gently helped to acknowledge that a choice was made. This child needs to understand why, at the time, it seemed the better or only alternative, and how this decision put the child in a vulnerable position.
- ✍ Educate the child about the prevalence of abuse in our society. A child who realizes that abuse does happen to other children seems to experience less self-blame than a child who feels that abuse is extremely rare.²⁰³
- ✍ Affirm the child's sense of power, rather than his/her status as victim.
- ✍ Educate the child in an age-appropriate manner about the physical nature of sexual response to explain the presence of physical pleasure (if applicable) and address feelings of guilt.

Loss and Grief

Loss and grief are major issues for an abused and neglected child. Grief can result from the loss of an important relationship (e.g., older brother, baby-sitter), from a legally mandated separation from the abuser (e.g., grandparent) or from an irrevocable change in the view of the person or role (e.g., "It's like I don't really have a dad").²⁰⁴ The child may need to mourn the abuse and the subsequent loss of personal integrity.²⁰⁵

A very young child who is separated from his/her primary caregiver for a period of time may respond in three progressive stages described by Bowlby:²⁰⁶

- ✍ protest,
- ✍ despair, and
- ✍ detachment.

The abused and neglected children often experiences grief and mourning and moves through stages similar to those identified by Kubler-Ross.²⁰⁷

- ✍ denial,
- ✍ anger,
- ✍ bargaining or ambivalence,
- ✍ depression,
- ✍ acceptance, and
- ✍ hope for the future.

A child who has experienced a disruption in his/her usual living arrangements or needs to adjust to a major change in his/her environment, needs to focus his/her energy on adapting and figuring out what is expected of him/her and what he/she can expect of others. Major changes in the child's immediate family or circumstances interfere with the necessary mourning process.²⁰⁸ The child needs to adjust to new conditions and become familiar with his/her surroundings, new relationships, and behavioral expectations before he/she will have the energy to address the deeper work of mourning the loss of an important relative or membership in the family.²⁰⁹

To help the older child work through loss, the therapist can:

- ✍ Talk with the child about any changes, including his/her adjustment to a new home or life without the perpetrator. Often, the child does not realize that he/she is in the middle of a major upheaval. The child benefits from hearing that change is a major challenge for most people.
- ✍ Explain that everyone needs some time to adjust to major changes. This gives the child permission to be accepted and understand him/herself and to express his/her difficulties adapting to the specific changes in his/her life.
- ✍ Prepare the child for the possibility that he/she may feel some powerful, perhaps confusing, feelings. It may confuse the child to miss the perpetrator and long to see or meet with the perpetrator. The child may report that he/she thinks about the perpetrator or an unavailable family member all the time. He/she may frequent places where he/she might “accidentally” run into the perpetrator or unavailable family member. This puts the child in a vulnerable position. He/she may be at risk for further abuse or could be emotionally hurt by the adult's inappropriate response to the attempted contact. This type of behavior needs to be monitored and restricted when possible.
- ✍ Help the child express powerful feelings of sadness, loss, and anger. These feelings need to be expressed and dealt with repeatedly throughout the course of therapy.
- ✍ Give the child permission to acknowledge his/her sadness and loss. Sometimes, a child may feel uncomfortable expressing sadness for someone who hurt or molested him/her. This is a natural ambivalence; the child needs permission to care about and long for connection or membership in a family.
- ✍ Help the child recognize the positive qualities or interactions with the perpetrator. Help the child express love, disappointment, hurt, and hope that the perpetrator will be able to change his/her behavior. Help the child express anger about the behavior or fear of the reoccurrence of abuse.
- ✍ Explain to the child the changes the perpetrator or other family members need to make in order for visitation or reunification to occur. The child needs to be informed of family expectations and aware of possible decisions regarding placement and reunification.
- ✍ Let the child come to his/her own realizations about his/her relationship with the perpetrator or other family members. It is usually better to let the child conclude at his/her own pace and ability that contact or reunification may not take place. If the perpetrator or other family members demonstrate that they are unable or unwilling to meet the child's needs appropriately, the therapist can then support and commiserate with the child.

Self-Worth, Self-Esteem, Self-Efficacy

Self-worth, self-esteem, and self-efficacy are all affected by abuse and neglect. Many abused or neglected children feel that they are unworthy of attention, protection, or nurturing. They have a limited understanding of their value as human beings and often feel inadequate and ineffective in their interaction with people. Low self-worth and low self-esteem often contribute to a pattern of interaction with peers and in relationships that increases the possibility of revictimization.

To help the child improve his/her self worth, the therapist can:

- ✍ Address issues related to mastery and control.
- ✍ Help the child develop self-image based on competence and realistic expectations of performance. This helps the child feel effective and hopeful about attempting new behaviors. Some children may see themselves as capable and adequate to the tasks of protecting and caring for themselves. Younger maltreated children can have an inflated self-image.²¹⁰ Though inaccurate, this inflated self-image may represent active defense mechanisms and a need for physical competence and control.
- ✍ Give the child permission to acknowledge his/her wishful thinking or difficulties without losing esteem.
- ✍ Teach the child that he/she has the right to be protected and cared for appropriately and that he/she does not need to be victimized to be loved.²¹¹
- ✍ Educate the child about the intricacies of social skills and educational tasks. The child may need support and information about appropriate behaviors. The child may need tutoring or may have to make up a grade in school because his/her fear, stress, or anxiety interfered with his/her ability to learn new educational skills.

Stigmatization/Damaged Goods

Children often experience intense concern about physical and emotional impairment resulting from abuse. The child may feel physically damaged, dirty, ruined, or no longer whole or perfect.²¹² The child may feel that others can tell that there is something wrong with the child or that he/she is somehow different from other children.

Victims may behave in ways that result in their bodies becoming damaged or dirty. The child may fail to bathe; have poor hygiene; or dress in sloppy, dirty, or unattractive clothes. The child may develop eating disorders such as overeating or undereating in an attempt to make him/herself less attractive to abuse and to feel that he/she has some control over his/her body.

To help the child deal with this concern, the therapist can:

- ✍ Talk to the child about what it is like to feel vulnerable or powerless.
- ✍ Help the child figure out what it would take to feel safe and strong. Sometimes, the child can identify activities (e.g., karate or self-defense classes) that can counteract the feelings of being damaged by the abuse. The therapist may need to suggest activities that help the child feel empowered and protected. Team sports and activities that build on current skills and interests are helpful.
- ✍ Develop therapeutic interactions that help the child to feel good about his/her participation in therapy. The goal is to develop a series of tasks that helps the child feel competent. The therapist can speak positively about the child's ability to explore issues in therapy, noting how difficult that can be and how strong someone needs to be to remember and talk about the abuse.

- ✍ Emphasize the positive aspects of the child's abilities and behavior. The therapist can identify the child's interests and strengths and build on these factors so that satisfying interactions and esteem-enhancing activities are developed and expanded.
- ✍ Support and encourage new interests and strengths so that they become a progressively larger part of the child's life while the memories of the abuse diminish in importance. This is a change in the child's identity from an abused child to a child who is capable and involved in positive activities.

Learned Helplessness

All children need to feel that they have some control over their behavior and what happens to them. When this sense of control is diminished from repeated abusive experiences, the child may lose the interest, energy, and drive to protect him/herself. A child who feels powerless may believe that there is nothing that he/she can do to counteract the abuse. The child may learn to submerge his/her true feelings, distrust his/her own perceptions, and deny his/her own reality. An abused and neglected child will often demonstrate fear, confusion, passivity, pessimism, hopelessness, and an inability to protect him/herself.

To help the child work through learned helplessness, the therapist can:

- ✍ Demonstrate care and concern for the child's welfare. In therapy, children need to experience adults who are willing to pay attention to their behavior and help them communicate their needs and wishes. The therapist needs to take special notice of the child. He/she needs to see and comment on how the child looks as well as how the child is behaving in the therapeutic relationship. The therapist should note the child's changes and accomplishments within and between sessions. Paying attention gives the child a model and permission to also pay attention.
- ✍ Screen for any victimization that the child is unaware of or unable to report. Ask the child about his/her day and activities, including the child's interactions with friends and other people in the neighborhood. The child may indicate that he/she is being rejected, bullied, or victimized.
- ✍ Teach the child the kinds of behaviors that are considered hurtful or inappropriate and help the child identify these behaviors and talk about them. The child also learns that the therapist is there to help and will respond with respect, concern, and take action on the information. As the child gradually learns that he/she is important, valuable, and worthy of protection, he/she may be more willing to seek help or, when needed, protect him/herself.
- ✍ Take steps to ensure the child's safety. This may include asking the parents or caretakers to implement more supervision, contacting teachers or school officials if the child is being teased or bullied on school grounds, and reporting any inappropriate or abusive touching to proper authorities.
- ✍ Emphasize that the child deserves to be safe and protected. The therapist can thread this theme throughout the session and remind the child when the session is over to tell someone if he/she needs help.
- ✍ Teach the child assertiveness, communication, and problem-solving skills. Generally, these skills have minimal use until the child has a frame of reference that allows him/her to understand the importance of standing up for one's safety and well-being. This positive frame of reference is based on increased self-esteem and self-worth.

By asking the child if he/she has any questions and reinforcing those questions with positive experiences, the therapist teaches the child to think about and ask for information. It takes courage to ask questions, especially if the child fears retaliation or humiliation. Permission to make mistakes also helps the child feel comfortable as he/she learns to make productive decisions. The therapist can set up role-playing situations and help the child practice asking for what he/she needs.²¹³ The therapist can model problem-solving skills and teach the child how to think about situations and problems. When the child asks questions, the therapist can state, “Let’s figure it out,” and take the child through the steps for problem solving and decision making. Learning how to determine adequate and appropriate responses when requests are denied and developing alternative ways to achieve goals are also helpful. For example, an adolescent who feels she is not dressed adequately compared to her peers may benefit from wardrobe planning, learning to sew, or the joys of thrift store shopping.

BEHAVIORAL ISSUES

There are a number of behavioral issues that require attention in the treatment of abused and neglected children. In this section, avoidant behavior, dependent behavior, aggressive behavior, and hypersexual behavior are discussed.

Avoidant Behavior

Some children will avoid contact or interaction with adults or other children in an attempt to try to protect themselves from abuse. This behavior may be the child’s attempt to manage his/her anxiety about revictimization. However, this kind of behavior pattern often leads to isolation and alienation from peers and adults and can leave the child vulnerable.

Oftentimes, the child is undersocialized and feels stigmatized by the abuse or neglect. The child generally has low self-esteem, poor communication skills, and difficulties managing his/her feelings or behavior when in social situations. This child often appears quiet, watchful, and anxious in social settings. Although the child may be actively engaged in avoiding physical and social contact with peers and adults, he/she is often very lonely and longs for connection to other people.

A child who demonstrates avoidant behaviors is reticent in social situations and is fearful that he/she will say something silly or inappropriate or not be able to respond adequately. This child can benefit from participating in a supportive social and therapeutic group with children of the same age.

It is important to remember that the avoidant child is probably anxious about the interaction with the therapist. In working with a child who demonstrates avoidant behaviors, the therapist can:

- ✍ Begin establishing a relationship with the child in a slow and deliberate manner. This allows the child to feel comfortable and safe. The avoidant child may need a much longer beginning phase of therapy in which to develop rapport, trust, and realistic expectations. The clinician can offer reassurance that the child is not in trouble or not going to be penalized for anything that he/she might say.
- ✍ Monitor body language, vocal quality, and reactions to the child’s statements. A calm tone of voice and willingness to slow the pace of the conversation can help the child attend to the information and process the experience.
- ✍ Give information about the format of the sessions and the therapist’s availability, such as what will happen if an appointment is cancelled. It is important for the professional to remember that simply because the child avoids contact and interaction does not mean that the therapeutic relationship is

- unimportant. Many avoidant children come to depend on the therapeutic interaction and are quite bereft when the therapist cancels or needs to terminate the relationship.
- ☞ Choose activities that support the child's skills and abilities and enhance his/her self-esteem and competency. When a therapist asks the child for help arranging the playroom or deciding where to put the toys, these requests engage the child in an activity in which he/she feels productive and learns the way about the playroom.
 - ☞ Help the child retain a sense of control and decision making. Provide choices.
 - ☞ Use anticipatory planning, which not only tells the child what will happen but offers him/her options about how to respond or react. This increases the child's repertoire of behaviors and gives him/her choices.
 - ☞ Help the child develop coping skills that will allow him/her to manage his/her feelings and thoughts, memories, and disclosure about the abuse or neglect.
 - ☞ Remember that the child may only be able to give small amounts of information at a time. Therefore, the professional should allow periods of nondirected play between statements about abuse. This provides the child with the opportunity to manage his/her anxiety and allows the child to note and monitor the therapist's response to the disclosure. Davies and Montegna note that respecting the child's pace may seem time-consuming and tedious, but can result in a more effective therapeutic relationship.²¹⁴

Dependent Behavior

Children are dependent on adults for their care and well-being. Often, a child who has been abused or neglected by an adult upon whom the child relied to care and protect him/her will regress to a previous developmental stage that feels safer and more comforting. This normal coping behavior enables the child to regain emotional energy for his/her passage into a new phase or stage of development.

However, a dependent pattern of behavior is more pervasive than regressed behavior. A child who exhibits this dependent pattern of behavior often allows other people to make important decisions, such as whether or not the child is hungry or needs help. Dependent children who fear rejection may agree with people even when the child knows that these people are wrong. The child may volunteer to do things that are unpleasant or demeaning in order to get other people to like him/her. A dependent child is vulnerable to exploitation and revictimization because he/she has a tendency to attach to anyone who he/she feels attends to their physical or emotional needs. This pattern of behavior can create major long-term developmental and relationship problems.

Initially, a dependent child is "easy" to engage in therapy. The child is compliant, offers little resistance to developing a therapeutic relationship, and welcomes the chance to participate in therapy. However, upon observation, the dependent child is often indiscriminate in his/her attachment to adults, has few opinions or issues to discuss in therapy, and can appear to the therapist as a "good" child who is a pleasure to have in therapy. The challenge in working with a dependent child is to generate separation and individuation, to elicit a strong and determined response from the child, and help the child integrate a sense of self that is based on worth, abilities, and individuality.

In working with dependent children, the therapist can:

- ✍ Be nurturing while expecting and teaching the child to behave in an age- and/or developmentally appropriate manner. In this way, the therapist is “pulling” the child into maturity while protecting the child from his/her fears of rejection or abandonment.
- ✍ Be consistent and continuously provide support and encouragement. Usually, this child did not bond with his/her parent/caretaker or have the opportunity to attach to a stable and consistent caregiver.
- ✍ Practice problem-solving skills and help the child determine what it is he/she needs and wants.
- ✍ Reinforce questions, requests for information, and the development of interest and curiosity in outside activities and support systems.

Aggressive Behavior

A high percentage of severely aggressive children have histories of suspected child maltreatment. These children may be identifying with the aggressor, have pent-up anger and rage, or problems with impulse control that make it difficult for them to control their behavior. The child who acts out his/her aggression must learn to take responsibility for the consequences or outcomes of the behavior. The potential recipients of the child’s aggression need to be protected from this kind of victimization.

A child who exhibits aggression often has been raised in families that are characterized by harsh and inconsistent discipline, little positive parental involvement with the child, and poor supervision of the child’s activities.²¹⁵ Structure, planning, continuity, consistency, and a nurturing environment are all factors important in working with aggressive children.²¹⁶

Some parents may not be able or willing to deal with their child’s behavior. They may be resistant to interventions that feel as if they are being “told what to do” or “how to raise their children.” At these times, CPS involvement is crucial in engaging resistant parents and protecting any vulnerable children in the household. The aggressive child also needs to be protected. Regardless of his/her behavior, the child deserves protection from dangerous or inappropriate adult-child behavior.

Ongoing family problems or disruption contribute to an adolescent’s vulnerability to peer pressure. Peers supply the adolescent with the attitudes, motivation, and rationalizations to support antisocial behavior; peers also provide opportunities to engage in specific delinquent acts.²¹⁷ Many antisocial and aggressive adolescents already have a deviant peer group that reinforces their behavior.

In working with an aggressive child, the therapist can:

- ✍ Determine whether the child is currently being abused.
- ✍ Provide opportunities for the child to anticipate and plan for the resurgence of past feelings and experiences. This can help the aggressive child become aware of underlying feelings and pain and develop a plan for managing his/her reactions. In extreme cases, medication as well as higher levels of care, including hospitalization, day treatment, or residential care may be useful to the aggressive child.
- ✍ Ensure that the treatment of young males addresses the issue of body image and its relationship to the victim’s self image. Sebald notes that the child may require more physical space during casual conversations.²¹⁸ He also notes that touching can elicit a rigid and uncomfortable physical response. He raises two important questions about sexually abused males ? Do sexually abused males become

touch deprived? How can therapists develop treatment approaches that recondition sexually abused males to appropriate touch experiences?

- ✍ Teach a child to delay gratification, manage his/her impulsive behavior, and become aware of how his/her behavior affects others. This will help the child relate in more appropriate and acceptable ways to peers and adults.
- ✍ Assess if the child is a danger to him/herself or to others. The clinician must identify the problematic behavior as dangerous. Consequences to the recipient of the violence or to the aggressive child must be clarified. Risk taking, seeking out violent altercations, or assaulting others needs to be restricted. The therapist can portray these behaviors to the child as an indication of his/her need for protection. The therapist must connect the child's experience of abuse with the anger, rage, or rebellious behavior.
- ✍ Explore the benefits and liabilities of participating in a peer group that reinforces aggressive and destructive behavior.

In addition, the clinician must address sexually aggressive behavior immediately. The therapist must report this behavior to the appropriate authorities and use law enforcement and CPS interventions to guarantee that other children are not victimized. Interventions useful to address sexually aggressive behavior can be found in the sections on identity and victimizing behavior.

Hypersexual Behavior

Browne and Finkelhor describe premature sexualization as a process in which a child's sexuality (including sexual feelings, attitudes, and behaviors) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse.²¹⁹ In the same way that a physically abused child often demonstrates physically aggressive behavior as a coping and interaction style, the sexually abused child may also demonstrate sexualized behavior to express anxiety or socialization problems.

A children who has been sexually abused has been prematurely introduced to sexual behavior and often has been taught, reinforced, or rewarded for behaving in a sexual manner. The child may not be aware of how his/her behavior appears to other people. Most victims have little awareness that their behavior is seductive and may feel hurt or confused when people are put off by their behavior or are distraught and bewildered when adults accost them sexually.²²⁰ Suggestions for dealing with sexualized behaviors are provided in the following discussions.

Suggestive Sexual Behavior

Suggestive sexual behavior is learned behavior that is often reinforced by the perpetrator. It is disconcerting and sometimes frightening to parents. Many parents can become very punitive in their attempts to end this kind of behavior, but this approach can exacerbate the problem and alienate the child.

The therapist working with this type of behavior can:

- ✍ Help parents/caregivers intervene with inappropriate sexualized behavior, set limits on this type of interaction, and support and reinforce new behaviors.
- ✍ Help parents/caregivers understand that this type of behavior is not an uncommon response to sexual abuse and does not mean that the child is permanently damaged or going to become homosexual, a prostitute, or a child molester.

- ✍ Help the child address all the issues related to sexual abuse. This offers the child insight and an ability to manage his/her behavior in an appropriate manner.
- ✍ Bring provocative clothing, suggestive body language, and inappropriate sexual statements or innuendos to the child's awareness. This awareness is important to protect the child from inappropriate adults and from peers who can tease, ostracize, or make inaccurate assumptions about the child's motives or desires. By using examples of movie stars or rock stars to help explain how behavior and dress create an image, the therapist can help the adolescent understand the impact of his/her behavior without instilling a sense of shame or guilt.
- ✍ Provide sex education to the child by discussing the correct terminology for sexual body parts, functioning of genitalia, and normal sexual behaviors. Sex education can assist in correcting distortions in the child's knowledge or belief system regarding sexuality.

Once the child becomes aware of these sexualized behaviors and has been exposed to alternative behaviors that are more appropriate, then he/she can begin to choose how he/she wants to present him/herself to others.

Masturbation

Masturbation is a fairly common occurrence among children and adolescents. However, the sexually abused child may be more likely to demonstrate this behavior in inappropriate places and at inappropriate times. Masturbation is often an attempt to soothe stress and anxiety generated by the abuse.

A five-part plan for working with families/caregivers whose child exhibits compulsive masturbation includes.²²¹

- ✍ Assessing parental/caretakers' attitudes and behaviors related to the masturbation. Friedrich suggests that the parents/caretakers be educated regarding the possible relationship between sexual abuse and masturbatory behavior.
- ✍ Helping the parents/caretakers positively shape and reinforce the child's non-masturbatory time.
- ✍ Creating a time and place for the child to masturbate. Isolating the child with the masturbatory behavior may reinforce that method of soothing his/her anxiety. Replacing the masturbatory behavior with pleasant, socially acceptable and engaging behaviors may be more productive.
- ✍ Normalizing values and attitudes about masturbation.
- ✍ Dealing with the child's abuse experience because this, in part, is driving the masturbation.

SUMMARY

This section has identified many of the symptoms or issues common to abused and/or neglected children. Modifying these symptoms until the abused or neglected child is able to manage his/her thoughts, feelings, and behavior in a positive and productive or prosocial manner is the major goal of therapy. However, this major goal is reached by the accumulated mastery of more specific goals and objectives or interventions. The interventions noted in this section are only some of a wide variety of possible interventions that are useful to children. It is the therapist's responsibility and challenge to choose the most appropriate interventions for each individual child and to evaluate and modify the interventions when appropriate.

The child's ability to benefit from a specific intervention(s) is based, for the most part, on a willingness to utilize the new experience and information. This willingness, of course, is facilitated by a strong and helpful therapeutic relationship or alliance as well as by support from parents/caregivers, family members, and friends.

As is true when learning any new task, the beginning is always difficult; no one is perfect; and practice, practice, and more practice establishes confidence.

CASE MANAGEMENT

Successful intervention in the lives of abused and neglected children and their families requires the concurrent involvement of many different systems. Interventions aimed exclusively at the individual victim often ignore or underutilize the family and the environmental resources available to the child. This approach can perpetuate the child's experience of isolation and exacerbate his/her victimization.

A time-limited, hourly therapeutic session with a child will not guarantee his/her safety nor will it guarantee successful interactions in his/her home, school, or community. Careful assessment and utilization of family members and caregivers as well as liaison with school personnel, law enforcement and court-related personnel, and child welfare agencies increases the likelihood that the child will benefit from treatment, remain safe, and promote healthy relationships with others.

FAMILY MEMBERS

Inherent in good case management is the principle that the therapist must have a parent or guardian consent and sign a release of information form that gives the therapist permission to contact the appropriate parties whether they be friends, relatives, acquaintances, or professionals. The parent has the right to be informed of the purpose of each contact and the information received from the contact. The child has the right to be informed about how information is obtained and shared.

Parents

Parents of abused and neglected children can be their child's strongest ally or most serious detractor in the process of therapy. In order for the child to benefit from therapy, his/her parents need to support the use of therapy and be willing to provide the time and effort necessary to help the child maintain the therapeutic relationship.

For most children, the ability to use therapy depends on their parents' understanding of the therapeutic process and their parents' willingness to support and follow through with established goals and objectives. The therapist needs to engage the parents' cooperation, use the parents' strengths, and when necessary, advocate for appropriate resources to meet the parents' physical and emotional needs.

Parents often need information about the effects of abuse and neglect and the signs and symptoms that indicate that their child may need therapy. Parents need encouragement for facilitating their child's participation in therapy and ongoing support when the child's progress is slow or difficult. Many parents who have unresolved feelings related to their own history of child abuse, neglect, or abandonment need additional attention to help resolve some of their feelings before they can fully address the needs of their child. Parents who understand the therapeutic process and have reasonable expectations regarding the outcome of therapy are more supportive and practical about their child's feelings and behaviors. Parents who have a fairly objective perspective and a sense of hopefulness about recovery are more helpful to their children.

Siblings

Case management includes advocating for siblings in the family. Often, siblings benefit from services to help them understand the ramifications of abuse and neglect. It is also important to rule out any chance that they have also been victimized. Siblings often need help addressing the following issues:

- ✍ fear and heightened sense of vulnerability;
- ✍ confusion, guilt, or envy (“why not me?”), or self-blame for failing to protect the victim;
- ✍ embarrassment or shame; and
- ✍ misunderstandings regarding the abuse of children, including blaming the victim, scapegoating the victim, sexualizing the sexual abuse victim.

When the perpetrator is a family member, especially a parent, the siblings, as well as the primary victim, will need services to address the following:

- ✍ changes that may have occurred in the family;
- ✍ divided loyalty;
- ✍ anger at the victim for disclosing abuse; and
- ✍ learned behavior, including victimization of younger siblings, inappropriate problem-solving skills, and issues related to gender and the use of power.

Relatives

Relatives can be very helpful or harmful to a child or family that is attempting to resolve issues related to abuse or neglect. Relatives can be an important resource for overburdened and exhausted parents. They can offer comfort, support, and child care for parents who need a respite from the tasks of parenting.

However, relatives need to be screened for their ability to respond appropriately to the child and parent; they should be carefully evaluated for any history of inappropriate behavior that could suggest a propensity to abusive or neglectful behavior. Parents who were abused as children by a family member, including a mother or father, should be strongly advised against seeking care for their child from that family member. Sometimes, a parent will need to explore his/her own history of victimization before being able to understand the ramifications of continuing to socialize or depend on a family member with a history of victimizing children.

If a relative is to be considered as a possible placement for a child who has been removed from parental care, it is important that relative’s motives for caring for the child be evaluated. The relative’s desire to take care of the child may emanate from a sense of obligation or guilt rather than from a real interest in protecting and parenting the child. This can contribute to confusion and perhaps feelings of rejection in the child. The relative must be evaluated to determine his/her understanding of the abuse or neglect. The relative must be able to clearly understand the responsibility for the abuse and place this responsibility with the perpetrator. Any anger or confusion regarding the child’s disclosure needs to be clarified and corrected. Blaming the child for disrupting the family or generating a criminal prosecution will be damaging to the child and increase the child’s fear and anxiety and possibly symptom formation.

On the other hand, relatives need to understand the importance of the child's relationship with a parent or parent figure and refrain from denigrating the parent to the child. The relative should be evaluated to determine his/her willingness to utilize outside resources including social service caseworkers and therapists. The relative's willingness and ability to be more alert to family problems and make any changes necessary to address the problems needs to be explored. Most importantly, the relative's style of discipline needs to be explored and evaluated because family members often learn and use similar childrearing and disciplinary techniques.

A child who is placed with a relative needs to recognize and acknowledge the family connection and have some relationship with the intended caregiver. When a child is placed with an unfamiliar relative, conditions similar to foster placement may apply. The child who will reside with a relative needs to feel that he/she can discuss his/her feelings about the abuse or neglect, the absent parent(s), or changes in the family situation, including the placement with the relative without fearing repercussions or that he/she is jeopardizing his/her place in the family.

SCHOOL

Good case management includes liaison with school personnel, including the child's teacher, principal, school counselor, and school psychologist. School personnel have the daily responsibility of educating the child; they are a primary source of information about the child's social and educational skills. The school can be a "safe haven" and is often referred to by abused and neglected children as the one constant and predictable environment in which they felt competent and safe. School can also be "torture" when a child is teased and ostracized because his/her behavior is inappropriate or different from that of other children. Working together with school personnel can add important information to the overall assessment of the child's behavior and allows the therapist to utilize a support system that is already in place.

Teacher

The teacher is an important source of information about the child's social abilities and relationships. Many abused or neglected children have conflict-ridden or difficult interpersonal relationships. The teacher can provide selective and unique information about a child's behavior and can be engaged as a support person for changing problematic behaviors.

The therapist can address social skills and behavior management techniques in therapy and reinforce successful mastery only with accurate information from reliable sources. Explaining to a teacher that the child is receiving therapy for issues related to abuse or neglect can help the teacher understand any problematic behavior the child may be demonstrating in class. Consistent discipline techniques and responses to the child establish a familiar pattern of interaction with adults that helps the child learn to manage problematic behavior.

School Counselor

The school counselor can offer onsite support for emotional or behavioral problems. Coordination with school counseling services can assure that the child receives appropriate and consistent intervention. It can eliminate duplication of services while generating a "team" approach to intervention with children.

School counselors are often available on an emergency basis and can intervene in problematic behavior as it occurs. This timely response and ability to modify behavior problems before they escalate can decrease some of the stigma often generated by abuse or neglect. A child who complains of being teased or bullied on the school grounds can seek protection, and a child who behaves in a threatening or intimidating manner can be monitored and limited in his/her acting out behavior. An accurate report from the school counselor about the child's

academic and behavioral performance can enhance the therapist's awareness of the child's strengths and needs and help him/her plan useful interventions.

School Psychologist

A school psychologist can be particularly useful in developing an educational plan that addresses the abused or neglected child's academic performance. Academic testing and individualized educational plans can help assure that the child does not lose the benefits of a positive educational experience. It is helpful and important to explain to school personnel that the experience of child abuse or neglect can impair a child's cognitive functioning. This kind of information can help the school teacher, counselor, and psychologist consider learning plans that take into account the stress and anxiety the child may be experiencing from addressing emotional issues related to abuse or neglect.

CHILD WELFARE AGENCIES

It is incumbent on the therapist to work as part of a team with the child welfare caseworkers in order to ensure the safety and protection of the child. A positive and cooperative effort on the part of the therapist enables him/her to better advocate for the needs of the child, including the implementation of optimal, permanent plans.

Child welfare caseworkers typically coordinate all of the services provided to abused and neglected children and their families and are responsible for ensuring that effective and timely decisions are made in a case. This decision making can be influenced by the knowledge and opinion of the therapist, but only if the therapist has a good working relationship with the agency. To this end, it is important that the therapist maintains clear and accurate notes describing therapy sessions. The therapist is often called on to provide written opinions about issues (e.g., placement, custody, or need for ongoing therapy) involving his/her clients. Consistent documentation, that is, the keeping of progress notes or client session notes, facilitates the decision-making process and offers objective information to support recommendations made to the child welfare agency.

JUVENILE COURT

The therapist needs to be familiar with the juvenile court system that makes decisions about the safety and protection of children. Placement decisions, visitation policies, and criteria for termination of parental rights are all important concepts that may need to be explained to the child. The therapist may be asked to make reports (i.e., recommendations for placement or visitation) to the juvenile court. These reports often help the child welfare caseworker make decisions that are in the child's best interest. It is often useful to inform the child that the therapist does not get to "tell" the child welfare caseworker or juvenile court what to do. It is important that the child realize that the judge has the ultimate responsibility for any decisions about the child's living arrangement.

Substitute Care Placement

When a child is removed from his/her family and is placed in substitute care, he/she has many needs that must be met. The therapist can advocate for the child's experience to continue to be as safe, familiar, and as "normal" as possible in order to decrease the stress and anxiety generated by the move. The therapist needs to be aware of the child's social, emotional, and educational needs in order to advocate for a setting that will be suitable for the child. The therapist advocates for the child's social needs by sharing information about the child's style of interacting and skill at joining with adults and peers. The therapist can offer suggestions for helping the child feel comfortable negotiating for attention and resources. Finally, the therapist can help the child's caregivers interpret and respond to the child's behavior in a consistent and productive manner. Information about the child's educational abilities and extracurricular activities need to be available to the child's welfare caseworker and caregivers in order to ensure some feeling of continuity, predictability, and access to esteem-building activities.

At times, the therapist may need to advocate for a more intensive level of care for the child. The therapist may need to negotiate with the child welfare caseworker to have a psychiatric evaluation conducted if the child's emotional state or behavior warrants medication or hospitalization, a psychological evaluation if additional diagnostic information is necessary, or a medical evaluation if any physical problems seem to interfere with the child's stability and well-being.

The child welfare caseworker should always be notified if the child is a danger to self or others. Any suicidal or homicidal ideation or plans need to be passed on to the child welfare caseworker who has responsibility for the child. However, in such instances, the therapist has responsibility for facilitating hospitalization of the child (when appropriate) and for continuing involvement in the case.

Visitation

The therapist is often asked to make recommendations regarding visitation with noncustodial parents or caretakers. The child's needs and wishes must be considered as primary information. The child's concerns regarding safety and protection, feelings about the parent and the visits, and the child's interest and willingness to interact with the parent seeking visitation need to be considered. Again, a multidisciplinary approach that elicits information from the parents, the parents' attorneys, the parents' advocate or therapist if possible, and the child welfare agency is important.

Reunification

When reunification with the parents is a consideration, the therapist needs to be in close contact with the child welfare caseworker in order to relay information about the child's progress in treatment and to gain information to help prepare the child for changes in visitation or living arrangements. Recommendations regarding reunification, including information about the child's ability to trust the parent and feel safe and protected, need to be relayed to the child welfare caseworker. The therapist should advocate for appropriate departure from the foster home and a reasonable transition to termination of child welfare services.

Conjoint sessions with parents and child are useful at this time. During these sessions, the course of events can be reviewed, changes discussed, and parental responsibility verbalized and processed. The sessions also offer a forum for the child to share his/her concerns and for the parents to make a commitment to protect the child from further harm.

It is often useful to continue the child's therapy through the reunification process in order for the child to have a place to discuss adjustment to living with his/her family again and explore solutions to any problems that may arise.

Law Enforcement

When the child is involved in a criminal investigation, it is often helpful to advocate for timely and sensitive intervention with law enforcement personnel. The therapist can help the child feel comfortable about the interview by providing some pertinent details about the experience. Providing the officer's name and time of visit can help the child feel the officer is a somewhat familiar figure. Identifying the officer as a friend and a person who helps children can also ease some of the child's discomfort.

Educating officers regarding developmental considerations, including the use of language, skills that facilitate memory and recall, as well as personal skills that help the child feel comfortable and safe are important.

Encouraging the officer to explain to the child the process of investigating a case can help the child feel that he/she has not been forgotten or that his/her case was not important. For more information on the law enforcement officer's role, the interested reader is referred to *The Role of Law Enforcement in the Response to Child Abuse and Neglect*, another manual in this series.

Prosecution

Testifying in criminal court can be such a stressful experience that it keeps the child focused on the outcome of the criminal proceeding and deters resolution of the issues related to the abuse or neglect. Schetky and Green note that the fears expressed by child witnesses include:²²²

- ✍ the fear of retaliation by the defendant, particularly if the defendant has made threats to the child in the past;
- ✍ the fear that he/she will not be believed;
- ✍ feeling as if he/she (the child) is on trial, often reinforced by aggressive cross-examination, or guilt if the child blames him/herself for what happened; and
- ✍ humiliation and embarrassment from the nature of questions asked and the presence of the jury and press.

The child and family need to develop coping responses that ameliorate these fears. The therapist can help the family remain realistic about the criminal proceedings and can prepare them for the possible outcomes. Praising the child's effort, without emphasizing the content or outcome of the criminal court proceedings, can enhance the child's self-esteem and positive feelings about the experience. The therapist may need to advocate with the attorney prosecuting the case for the child who is expected to participate in a criminal proceeding. For a description of preparing a child for testifying in court, the reader is referred to another manual in this series entitled *Working With the Courts in Child Protection*.

CONCLUSION

Therapy alone will not eradicate child abuse and neglect. Clinicians must develop, organize, and use all the resources available to help children. Parents and family members, school, law enforcement, and child welfare personnel are all striving to protect children from trauma generated by abuse and neglect. A comprehensive and cooperative effort that builds on the skills and services in the community will improve the condition of abused and neglected children.

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GLOSSARY OF TERMS

Abreaction - the verbal expression of unconscious thoughts or feelings, usually in the presence of a therapist.

Affiliation - the ability and willingness to feel a part of or connected to other people or groups of people.

Anatomical Dolls - specially made dolls that have genitalia specific to sex and age, that is, those dolls that represent adults have larger genitalia with pubic hair; the female adult doll also has developed breasts. In a clinical setting, these dolls are useful tools to help the child demonstrate sexual acts or help the clinician understand the child's curiosity and relationship to various body parts. Because these dolls are often used to represent the perpetrator and victim, special attention to the child's feelings and behavior is important when the dolls are utilized.

Anxiety - the persistent feeling that danger or harm is imminent.

Assessment - the beginning stage of therapy in which information is gathered that helps the professional understand the possible origins of the symptoms and decide the best methods in which to address and modify those symptoms.

Attachment Theory - a developmental theory that emphasizes the relationship between an infant and its caretaker(s). Typically, attachment theory states that the preliminary framework for relationship patterns is established through early childhood relationships (i.e., through interactions with parents and siblings), but this framework is malleable and subject to change throughout an individual's lifetime.

Attributions - beliefs or perceptions about the self, others, and the world that are derived from training, learning, or experience.

Behavioral Theory - initially established by John B. Watson, the theory that overt behavior is the sole basis for scientific psychology. Founded on operant conditioning principles, behavioral theory attempts to explain the cause-effect relationship between the class of stimulus variables and response variables, with reinforcement stimuli increasing behaviors and punishment stimuli decreasing behaviors.

Case Plan - the professional document that outline the outcomes, goals, and strategies to be used to change the conditions resulting in child abuse and neglect.

Case Planning - the stage of the child protection process whereby the caseworker and other treatment providers develop a case plan with family members.

Child Protective Services (CPS) - the designated social service agency (in most States) to receive reports, investigate, and provide rehabilitation services to children and families with problems of child maltreatment. Frequently, this agency is located within larger public social service agencies, such as the Department of Social Services of the Department of Human Services.

Clinical Supervision - allows the therapist to seek information and share his/her clinical experience with another professional who can offer guidance, knowledge, and support. Generally, the clinical supervisor is more experienced and can share insight gained from working with the client population. Supervision helps professionals become more realistic in their expectations for themselves and their clients. It also allows therapists to share the burden of hearing and responding to numerous disclosures of child maltreatment and know that some other professional is aware of the work being done.

Cognitive Functioning - awareness of objects, thoughts, or perceptions.

Cognitive Theory - as a development of behavioral theory, cognitive or cognitive-behavioral approaches aim to change behavior by changing an individual's cognition.

Confidentiality - a provision in all State child abuse and neglect reporting laws that protects the privacy of children and families by not permitting information about the findings of the child maltreatment report to be released to other agencies without permission of the family. In some States, members of multidisciplinary teams may receive information without a release from the family.

Conjoint Therapy - therapeutic approach whereby the therapist works with a pair of clients, generally parent/caregiver/victim, sibling/victim, perpetrator/victim (when appropriate), to facilitate communication and appropriate interaction and improve the relationship of the two individuals.

Content and Process - two forms of information that are useful in gauging a client's participation in therapy. Content includes the specific topics or information that are discussed in the session whereas process includes information about the client's behavior and interaction.

Countertransference - the conscious and unconscious emotional reactions of the professional to the client.

Developmental Milestones - important tasks and accomplishments that occur during the child's normal development including, but not limited to, walking, talking, toilet-training, school attendance, puberty, sexual interest and contact, marriage, and birth of children.

Developmental Psychopathology - the perspective of understanding problems and abnormal interpersonal processes within an individual within the context of that individual's developmental abilities and skills.

Documentation - information related to provision of therapeutic services. Generally, this information includes date of service, persons present during the session, brief description of topics covered, the client's responses to the subject matter, and the date of the next scheduled appointment. Suicide or homicide ideation, threat, or intent must be documented with appropriate responses, including all attempts to protect the client as well as intended victims. Any child abuse and neglect disclosures must be documented and reported to the appropriate authorities.

Ego Defenses - unconscious attempts such as denial, projection, rationalization, regression, intellectualization, and sublimation which are used to manage overwhelming emotions or experiences.

Encopresis - the incontinence of feces, which is not due to any organic defect or illness.

Enuresis - the involuntary discharge of urine, often occurring at night (often referred to as bedwetting or nocturnal enuresis).

Family Assessment - the stage of the child protection process when the CPS caseworker, community treatment provider, and the family reach a mutual understanding regarding the most critical treatment needs that must be addressed and the strengths on which to build.

Family Systems Theory - a view of how family members interact with one another in relationship patterns that promote and/or accommodate the functioning of the family as a unit (or system).

Family Therapy - the therapist and cotherapist, when possible, work with family members, including parents, siblings, and extended family members (e.g., grandparents) in a group setting to address the changes necessary to ensure the safety and protection of the children in the family, especially the identified victim. Any problems or confusion generated by the abuse or neglect are also dealt with.

Genogram - a diagram of family members and their relationship to each other. This chart is useful to help the client understand the intergenerational aspects of child abuse and neglect and helps the client acknowledge helpful or problematic familial relationships.

Good Faith - the standard used to determine if a reporter has reason to suspect that child abuse or neglect has occurred.

Group Therapy - treatment approach in which the therapist and cotherapist work with a group of clients similar in age and experiences (e.g., sexual abuse, physical abuse, parents of victims) to help them share their thoughts and feelings related to their situation. This approach is particularly useful with clients who feel alienated or different from their peers or who have isolated their feelings as well as clients who would benefit from learning more positive and productive ways for interacting with others.

Honeymoon Phase - As used in child welfare, this period, which may vary in length of time, reflects a child's attempt to exert control over his/her behavior (i.e., behaving appropriately) when placed in a new environment.

Ideation - the formation of images and objects in the mind.

Immunity - established in all child abuse laws to protect reporters from civil lawsuits and criminal prosecution resulting from filing a report of child abuse and neglect. Immunity is provided as long as the report is made in good faith.

Individual Therapy - treatment approach in which the therapist and client work together in a one-to-one relationship to address thoughts, feelings, and behavior generated by the experience of abuse or neglect.

Initial Assessment - the stage of the child protection case process when the CPS caseworker and other treatment providers determine the validity of the child maltreatment report, assess the risk of maltreatment, and determine the safety of the child and the need for further intervention. Frequently, medical, mental health, and other community providers are involved in assisting in the initial assessment.

Integration - therapeutic process wherein the client is able to utilize the new information gained during therapy and feels willing and comfortable in relying on this new information.

Interpersonal Development - developmental processes between the child and other persons in his/her life (e.g., parents, siblings, extended family members, or peers).

Interpretation - a hypothesis about seemingly random symptoms or behavior that is connected to meaningful experience. During interpretation, the client connects his/her symptoms with a reasonable explanation that helps him/her make sense of the experience.

Intimacy - the need and/or ability to feel close to other persons, especially an age-appropriate responsive and willing partner. The ability to feel intimate usually involves sharing one's most personal thoughts, feelings, and/or behaviors.

Intrapersonal Development - developmental processes that occur within the child (e.g., development of affects, empathy, or intelligence).

Learning Theory - in clinical work and therapy, learning theory is typically referred to as social learning theory, which assesses the synergistic effects of behavior, personal factors, and the environment. This may involve observational learning, modeling, and/or cognitions.

Mandated to Report - each State has listed professionals who must report child abuse and neglect to the proper authorities, usually law enforcement or CPS agencies. There are penalties for failing to report suspected abuse and neglect. Most professionals are protected from liability if they make a report that is unfounded after investigation as long as the report was made in the best interest of the child.

Metaphor - a phrase or story that represents themes and offers the client insight into his/her feelings, thoughts, and behavior.

Modalities - approaches to psychotherapy that include individual, group, or family therapy.

Multidisciplinary Team - established among agencies and professionals to mutually discuss cases of child abuse and neglect and aid decisions at various stages of the CPS case process. These teams may also be designated by different names, including child protection teams, interdisciplinary teams, or case consultation teams.

Out-of-Home Care - child care, foster care, residential care provided by persons, organizations, and institutions to children who are placed outside their families, usually under the jurisdiction of Juvenile/Family Courts.

Parent/Caretaker - person responsible for the care of the child.

Personality Disorders - the implication of inflexible and maladaptive patterns of behavior, of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress.

Play Therapy - a treatment approach in which the child utilizes play as a method to express feelings and understand the experience of abuse and/or neglect. Some tools useful for play therapy include dolls, dishes and imaginary food, baby bottles, blankets, trucks and cars, action figures, and doctor's kits. Other types of therapy that may be useful to a child who has experienced abuse and/or neglect include art therapy, dance and movement therapy, drama therapy, and sandtray therapy.

Prognosis - anticipated outcome for the client participating in therapy. Outcome is often affected by factors such as the client's developmental and cognitive capacity and ability, parent/primary caretakers' availability and response to therapy, and client's willingness to participate in and utilize the therapeutic relationship.

Psychoeducational Group - experience that both educates members of the group and allows them to explore their thoughts and feelings related to the information. Useful topics for parents of abused and/or neglected

children include protection, communication, discipline, childhood experiences and how they affect current parenting, child development, and realistic expectations for the child.

Psychopathology - the branch of medicine that deals with the causes and nature of mental disease.

Psychotherapy - a method of treatment designed to produce a response by mental rather than physical stimuli; it includes the use of suggestion, persuasion, reeducation, reassurance, and support as well as hypnosis and psychoanalysis.

Regression - behavioral state in which the client reverts to an earlier or younger developmental stage and demonstrates behavior such as increased dependency, soiling or wetting problems, or temper tantrums.

Risk Assessment - an assessment and measurement of the likelihood that a child will be maltreated in the future, usually through the checklists, matrices, scales, and/or other methods of measurement.

Role Play - therapeutic approach which presents the opportunity to “try out” various roles or positions that are unfamiliar or confusing to the client. Role play is also an opportunity for the client to practice skills (e.g., a teenager practicing “no” to a sexual activity for which he/she is not ready).

Social Desirability - the tendency for an individual to alter his/her response to a question in a manner that is consistent with his/her perception of the interviewer.

Social Skills Group - therapeutic experience that focuses on teaching types of social interaction that facilitate appropriate relationships with peers and responsible adults. Communication skills such as listening, asking questions, sharing information, learning assertiveness, resolving conflict, and learning behaviors that appropriately express nurturing and affection are often practiced within this type of group.

Stigma - negative meaning associated with experience or behaviors.

Strange Situation Paradigm - research protocol that assesses the strength of the emotional relationship (i.e., attachment) between a parent and infant by observing behaviors associated with parent departures and reunions.

Support Systems - individuals or groups of people who are helpful and responsive to the client. These individuals or groups may include family, friends, and professionals such as therapist, social worker/caseworker, or group member.

Symptoms - emotional or behavioral reactions to the experience of abuse and/or neglect.

Therapeutic Alliance/Therapeutic Relationship - the understanding that the client gains that the purpose of the interaction between therapist and client is intended to benefit the client and is organized to help the client explore and learn from painful and/or overwhelming experiences. The client’s willingness to accept and acknowledge the value of the therapeutic relationship is based on the therapist’s ability to be trustworthy, responsible, and useful to the client.

Transference - the unconscious transfer of feelings of hostility or affection from the client to the professional.

Traumagenic Dynamics - a model developed by Finkelhor that describes the short-and long-term sequelae of child sexual abuse (i.e., betrayal, traumatic sexualization, stigmatization, and powerlessness).

Treatment - the stage of the child protection process whereby specific treatment services geared to the reduction of risk of maltreatment are provided by mental health and other social services professionals.

Treatment Plan - prepared by the clinician to outline the goals and objectives of therapy. Goals are broad treatment issues, whereas objectives are more specific activities or tasks that will help the client achieve his/her goals.

Validation - acknowledgment that the client's thoughts and feelings are worthy of attention.

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OTHER RESOURCES

ACTION for Child Protection

4724 Park Road
Unit C
Charlotte, NC 28203
(704) 529-1080

American Professional Society on the Abuse of Children (APSAC)

University of Chicago
School of Social Service
Administration
969 East 60th Street
Chicago, IL 60637
(312) 702-9419

Association for Sexual Abuse Prevention (ASAP)

P.O. Box 421
Kalamazoo, MI 49005
(616) 349-9072
(216) 221-6818

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect

University of Colorado Health Services Center
Department of Pediatrics
1205 Oneida Street
Denver, CO 80220
(303) 321-3963

Child Welfare League of America (CWLA)

440 First Street, N.E.
Suite 310
Washington, DC 20001
(202) 638-2952

Childhelp USA

6463 Independence Avenue
Woodland Hills, CA 91367
(800)4-A-CHILD or (800)422-4453

Clearinghouse on Child Abuse and Neglect

Information

P.O. Box 1182
Washington, DC 20013
(703) 385-7565

Community Leadership to End Abuse of Children (CLEAC)

2211 Riverside Drive
Suite 14
Ottawa, Ontario, Canada
K1H 7X5
(613) 738-0200

Military Family Resource Center (MFRC)

Ballston Centre Tower Three
4015 Wilson Boulevard
Ninth Floor
Arlington, VA 22203
(703) 385-7567

National Center for the Prosecution of Child Abuse

1033 North Fairfax Street
Suite 200
Alexandria, VA 22314
(703) 739-0321

National Center on Child Abuse and Neglect (NCCAN)

Administration on Children, Youth and Families
Administration for Children and Families
Department of Health and Human Services
P.O. Box 1182
Washington, DC 20013
(703) 385-7565

National Child Abuse Coalition

733 15th Street, N.W.
Suite 938
Washington, DC 20005
(202) 347-3666

National Children's Advocacy Center
106 Lincoln Street
Huntsville, AL 35801
(205) 532-3460

**National Committee for Prevention of
Child Abuse and Family Violence**
332 South Michigan Avenue
Suite 1600
Chicago, IL 60604
(312) 663-3520

**National Council on Child Abuse and
Family Violence**
6033 West Century Boulevard
Suite 400
Los Angeles, CA 90045
(818) 505-3422
(800) 222-2000

**National Resource Center on Child Abuse
and Neglect**
American Humane Association
63 Inverness Drive, East
Englewood, CO 80122
(800) 227-5242
(303) 695-0811