

Treatment of Child Victims of Abuse and Neglect

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Child abuse and neglect are an unfortunate reality for many children in our community. The past thirty years have witnessed a growth in our awareness of and attention to the problems faced by children exposed to violence in their homes. This publication reviews the effects of and treatment for various types of child victimization experiences. It will be helpful to child protection workers, guardians ad litem, attorneys, family court judges, and others involved with children who have been abused or neglected. This information will enhance the ability of child protection professionals to recognize a need for mental health treatment and to seek appropriate treatment services. This publication will also enable other professionals to better communicate with therapists about a child's needs and progress.

Effects of child abuse and neglect

Child Sexual Abuse

Child sexual abuse is a social problem of significant magnitude. Estimates suggest that more than 1000 new cases of CSA are reported in South Carolina each year.¹ Prevalence rates, obtained from studies of adults indicate that as many as one in three women and one in six men have experienced sexual abuse in childhood.^{2,3}

Child sexual abuse has been found to be associated with the development of a wide variety of mental health and social problems in childhood and adulthood⁴⁻⁶:

Short-Term Problems

Anger/acting out
Difficulty regulating emotional responses
Effects on self-perception
Fear and anxiety
Interpersonal problems
Nightmares
Posttraumatic stress disorder (PTSD)
School difficulties
Sense of betrayal, powerlessness, stigmatization
Sexualized behaviors
Sleep problems

Long-Term Problems

Anxiety disorders
Depression
Interpersonal difficulties
Posttraumatic stress disorder (PTSD)
Sexual dysfunctions
Substance-related disorders
Suicidal thoughts/behaviors

Social withdrawal or isolation
Somatic difficulties

The experience of child sexual abuse varies from individual to individual. Severity, intensity, and frequency, age of the child, relationship between the child and perpetrator, degree of support from non-offending parents, level of acknowledgment by the perpetrator, quality of family functioning, extent of violence, and specific nature of the abuse all affect the type and severity of effects seen in the child victim. Thus, it is important to note that no one symptom profile is unique to children who have been sexually abused, nor do all (or even the majority of) children who have been sexually abused display any one symptom.⁶⁻⁸ Logically, therefore, each child victim should be assessed carefully and a treatment plan should be developed that is specific to that child's response to the abuse and living context.

It is interesting to note that research suggests that a minority of children (roughly 20 - 40%) who have been sexually abused appear to suffer few dramatic psychological or social symptoms of distress.⁶⁻⁸ It may be difficult to determine whether a child who is not displaying symptoms is coping adequately with his/her experience or is denying, suppressing, or avoiding difficulties.⁷ Some children may display what are thought of as "sleeper effects" or the development of serious symptoms some time after termination of the abuse.⁹ It is not clear whether these individuals would benefit from some type of treatment immediately after disclosure of the abuse, even though there may be an absence of symptoms at that time. Many practitioners believe that it is important to provide support and education to children who have been sexually abused but who show few overt symptoms in order to prevent the development of difficulties in the future.⁷

Risk factors for mental health problems

Research findings suggest that there are a number of characteristics of sexually abusive experiences that are predictive of greater mental health and social problems:^{3,4,8,10,11, 12}

- More intrusive sexual behavior, particularly sexual penetration
- Concomitant physical injury
- Concomitant physical violence
- Cognitive appraisal of life threat or serious injury
- Psychological abuse
- Closer relationship to the offender
- Longer duration of abuse incidents
- Higher frequency of abuse incidents
- Less maternal support
- Less sibling support
- Less community support

Gender (male victims seem to have greater difficulties)
Multiple perpetrators
Disturbed family relationships and family conflict

Child Physical Maltreatment

In some ways, child physical maltreatment is more difficult to define than child sexual abuse, because the use of physical punishment occurs in the vast majority of families. Thus, individual and cultural factors often affect where the line is drawn between “normal” physical punishment, such as spanking, and physical force that is seen as excessive or abusive. Reported cases of child physical maltreatment in South Carolina number approximately 4000.¹

Children who have been physically abused demonstrate a variety of problematic reactions and behaviors including:¹³⁻¹⁸

- ADHD
- Aggression
- Anxiety
- Cognitive/Intellectual impairments
- Conduct Disorder
- Depression
- Negative parent-child interactions
- Neurological impairment
- Poor interpersonal relationships/social skills
- Self-injurious behavior
- Social/Interpersonal difficulties
- Substance-related disorders
- Suicidal thoughts/behaviors
- Trauma-related problems/PTSD
- Violent/criminal behavior

As was noted in the case of child sexual abuse, children’s experiences of and responses to child physical maltreatment are quite varied. Thus, a thorough assessment is warranted before the initiation of treatment.

Neglect

Child neglect is the most commonly reported form of child maltreatment with estimates of nearly 8000 reported cases each year in South Carolina¹. Based upon national reports, about 80% of reported cases and 1/2 of substantiated cases involve neglect.¹⁹ Neglect is defined differently by different people. However, the most commonly-cited forms include physical, emotional, medical, mental health, and emotional neglect.²⁰

Although neglect is the most commonly reported form of maltreatment, it has received less attention in the clinical and research literatures than other types of child abuse. Neglect has been found to have a negative impact on children's physical, intellectual, social/behavioral, and emotional development as listed below.²⁰ One life-threatening outcome of neglect is nonorganic failure to thrive.²¹

<p>Long-term Problems</p> <p>Poor intellectual and academic functioning</p> <p>Aggression</p> <p>Delinquency</p> <p>Poor interpersonal relationships</p>
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Theories regarding the etiology and treatment of neglect emphasize the importance of the relationships between the individual, family, and community. Thus, there are virtually no descriptions of individual treatment directed specifically toward child victims of neglect. Rather, interventions that have been described involve the parents²² or the entire family²³⁻²⁵. Neglected children may be involved in treatments including therapeutic day care, emotional/cognitive stimulation programs, peer mediation, and after school/recreational programs. These treatments tend to address the socioeconomic needs, familial dysfunction, and disconnection between the family and community that are seen as important factors in neglect.²³⁻²⁵

Multiple victimization

Much of the research on child victimization and exposure to violence has focused on a single type of event. Interestingly, recent findings underscore the fact that there is extensive overlap in exposure to victimization experiences.²⁶ Thus, it is essential that assessment and treatment be comprehensive, with an eye towards uncovering and addressing each type of victimization the child has experienced or witnessed.

Assessment

It is difficult to make a general statement regarding the treatment needs of child

victims of abuse or neglect, since, as noted above, the effects of such experiences, the contexts in which these experiences occur, and the nature of the family's response to disclosure are so varied. The timing of the assessment in relation to when the disclosure occurred may also affect the child's immediate treatment needs. In addition, children may have difficulty expressing their concerns, fears, or questions directly to a professional.²⁷ Young children may lack the ability to communicate clearly about their emotional responses. Older children may be mistrusting of professionals. Finally, parents may be poor reporters of their children's reactions. That is, an abuse offender may have a motivation to minimize the child's emotional reactions. A neglectful mother may have a psychiatric impairment which would also distort her perception of her child. It is important to assess the situation from multiple perspectives, including both the child and the parent in the assessment process.^{16, 27, 28}

Having said all of this, it is recommended that a child be seen by a qualified mental health professional for a clinical assessment following disclosure or discovery of abuse/neglect.^{16, 28-36} Note that a clinical assessment differs from a forensic assessment. The goal of the clinical assessment is to identify treatment needs, strengths, and deficits as opposed to determining whether or not abuse occurred.^{16, 34}

A thorough clinical assessment addresses multiple areas of child functioning as well as the child's family situation prior to and following disclosure. The results of the assessment provide information regarding the child's need for treatment. While some children's need for treatment will be painfully obvious, even to a layperson (e.g., excessive aggression towards peers), many children's reactions will be more subtle (e.g., depression, post-traumatic stress disorder) and identifiable only via a professional evaluation. Given that the effects of child maltreatment can vary widely, it is essential that the treatment process begin with a thorough assessment of the child's current level of the target areas listed below.^{16, 28-38}

Abuse-related information

- Characteristics of the abuse
- Type of response to the child's disclosure
- Type of legal involvement expected
- Current living situation
- Cognitions/attributions about abuse

Behavioral functioning

- Sexualized behavior
- Aggression
- Withdrawal
- Self-destructive behavior
- Substance abuse

Suicidal thoughts/behaviors

Emotional functioning

Depression

Anxiety

Fear

Anger

Trauma-specific symptoms

Social functioning

Peer involvement

Social skills

School achievement and behavior

Current functioning of supportive caregiver(s) also is assessed in order to determine specific treatment needs which may impact the child's functioning.^{16,29, , 36, 38}

Caregiver functioning

Level of support

Level of supervision

Trauma history

Cognitions/attributions regarding child's abuse experiences

Substance abuse

Emotional functioning

Cognitive functioning

Future abuse/neglect potential

Parenting and social skills

Level of familial and community support

Treatment

Descriptions of treatment for child sexual abuse, physical abuse, and neglect have been reported separately within the literature, with much more attention paid to treatment of child sexual abuse. In fact, there are relatively few studies or reports of individual treatment of the physically abused or neglected child. In practice, however, treatment programs often address individual needs of children. This section draws largely from reports of treatment of the sexually abused child,^{7, 27, 29, 30, 32-34, 37-41} but has been written in order to encompass treatment strategies for physically abused^{16, 28, 31, 35, 36, 42} or neglected children as well. The emphasis here is cognitive behavioral treatments, as these have shown the greatest effects in controlled studies.^{32, 31 - 41, 43, 44}

General Issues for Treatment

First and foremost, it is important that the child be safe from potential harm from the offender as well as from nonbelieving or unsupportive family members. In addition to ethical issues of treating a child within an unsafe environment, treatment of abuse-related problems is not likely to be effective if the child is living in such conditions.

The targets for treatment are determined to a large degree by the child's presenting symptomatology and are defined following the initial assessment. There are, however, certain overriding goals that should guide the treatment process. Treatment should be directive and focused on the abuse or trauma itself.^{7, 43, 44} Treatment approaches^{7, 16, 30-34, 36-41}

- 1) help and encourage the child to talk and think about the abuse/neglect without embarrassment or significant anxiety;
- 2) help the child to modulate and express feelings about the abuse;
- 3) reduce the intensity and frequency of behavioral and emotional symptoms;
- 4) clarify and change distorted, inaccurate, or unhealthy thinking patterns that might negatively affect the child's view of self and others;
- 5) help the child develop healthier attachments;
- 6) strengthen the child's coping skills
- 7) enhance social skills, and
- 8) educate the child regarding self-protective strategies.

An additional goal, accomplished specifically through group therapy is to reduce the child's sense of isolation or stigma through exposure to other victims of abuse.⁷ Group treatment for victims of child physical abuse can have positive effects⁴⁵ but may also be associated with increased behavior problems. Therefore the therapist should be cautious and monitor group participants' behavior closely.¹⁶

Treatment strategies

Strategies for treating the abused child are varied⁷ and are used as appropriate to the child's presenting problems. Recommended treatment approaches include^{7, 23-42}

- cognitive-behavioral strategies
- graduated exposure to aspects of the abusive experience
- relaxation training
- education regarding abuse process and effects of abuse
- skills training
- supportive strategies
- teaching self-protective strategies
- behavioral strategies/parent training

clarification of responsibility/blame and offender's behavior

Strategies for treating abuse victims which have received some scientific support, have been those derived from a cognitive behavioral perspective and which focus on the abuse itself.^{7, 16, 28, 32-34, 36-45} Cognitive behavioral strategies typically address the child's thinking patterns, affective response, and behavioral reactions to the abuse. In particular, the child's attributions of blame and responsibility for the abuse should be addressed. That is, the child should be helped to recognize that it is adults rather than children who are responsible for healthy parent-child interactions. Gradual exposure, or discussion of abuse experiences helps to reduce the child's anxiety and embarrassment and provides opportunities to modify inaccurate or self-defeating thinking processes. Relaxation training further addresses the child's fear or anxiety reaction to abuse-related cues and can facilitate more effective affect regulation. Educational approaches facilitate clarification of misperceptions developed in response to the abuse. Skills training is used to teach the child coping strategies to manage negative emotions and to improve social/interpersonal functioning. Supportive techniques also are required, as the child may be coping with nonsupportive family members, upcoming court proceedings, and/or negative reactions from peers.

Education in the use of self-protective strategies is important for minimizing the likelihood that the child will be abused/neglected again.^{7, 32} It is important to establish a safety plan within the home, delineate danger cues, and identify support persons in the child's environment to decrease the secrecy within previously abusive/neglectful families.^{16, 46} This, in turn, is expected to minimize the risk of repeated abuse.

Age-related issues

The treatment approach should be appropriate to the age of the child.⁴⁷ For example, a four year old child should not be expected to come into a therapist or counselor's office, sit on a couch, and recount the details of her abuse. The therapist can utilize a variety of play techniques to encourage the young child to communicate about his or her abuse. Many cognitive behavioral strategies which are used with adolescents and adults can be modified or simplified for use with young children. For example, there are numerous scripts for relaxation training which are humorous and which engage the child in the therapeutic process. Puppets and drawings are useful as well for helping children to tell of their experiences, learn strategies for coping with negative emotions, and behaving in a more organized and directed manner.

In contrast, older children and adolescents are more able to directly communicate their thoughts and feelings about their abuse experiences. It is recommended, however, that the therapist be flexible in method of approach. Drawings, therapeutic

stories, and therapeutic games can be very helpful for engaging children of all ages.

Treatment duration

There are no clear guidelines regarding the length of treatment for the abused or neglected child, although most studies of treatment effectiveness have examined short-term interventions.⁷ Clinical experience suggests that while some children can resolve their negative reactions to the abuse in a relatively brief period (i.e., 12 - 16 sessions), many will require more extended treatment.⁴³ Typically, treatment length will be determined by the nature of the child's social, behavioral, or emotional difficulties. That is, the child who is experiencing a wide array of problems of a serious nature is likely to require more intensive treatment over a long period of time. In addition, the quality of support that the child is receiving from the nonoffending caregiver or other family members will affect treatment length. That is, child problems are typically more significant if there is no support coming from the nonoffending caregiver⁴⁸, and, therefore, treatment of the child whose nonoffending parent is disbelieving or nonsupportive is likely to be more extensive than that of a child who has the support of a nonoffending parent.

Additional treatment approaches

Family involvement in treatment

Children should not be treated in isolation of intervention with their family and/or current living situation.³⁰ Thus, many in the field recognize the importance of incorporating family members, particularly parents or primary caregivers, into treatment addressing abuse and neglect.^{16, 25, 30, 32, 42, 49-51} The goal of family work is to reduce the risk of recurring abuse, increase safety, and promote healthy growth and development of all family members. Family approaches address the needs of all family members while also targeting the interactions between them. However, it is difficult to specify the precise structure of therapeutic work addressing family issues. The specific approach with the family will vary, depending upon the child's living context and the level of acknowledgement of abuse by offender(s) and non-offending caregiver(s).^{46, 51} For example, a child who has been placed in foster care due to parent-child abuse and lack of a supportive non-offending caregiver will be addressing different issues than the child who is receiving support from a non-offending caregiver and/or whose abusive parent is acknowledging abuse and is committed to treatment. Family work is not indicated if the child is in out-of-home placement and there are no plans for reunification.¹⁶

Treatment involving the entire family and that has as a goal family reunification is generally of a much longer duration than individual treatment of the child.⁵¹ Initial stages involve the child, offender, and non-offending caregiver in individual treatment,

allowing members to first address individual issues related to the development and outcomes of the abuse. In addition, marital work is recommended to address relational issues between the child's caregivers prior to any reunification efforts. If early work with caregivers is successful, family therapy may ensue. The clarification session (as described below) can serve as the bridge between each family member's individual treatment and treatment addressing the entire family's needs.⁴⁶

Therapeutic interventions with caregivers typically begin with individual sessions addressing the abuse itself, as well as the specific needs of family members. These stages of treatment encourage assumption of responsibility by the offender and non-offending caregiver(s).⁵¹ An alleged perpetrator who is denying having abused the child or a non-offending parent who does not believe that abuse has occurred cannot fully benefit from abuse-specific treatment. Therefore, initial treatment efforts focus on reducing denial.⁵² If such efforts fail, family treatment is contraindicated.

If the offender is acknowledging having abused and/or neglected the child, then he or she can engage in abuse-specific treatment that addresses faulty thinking patterns, behavioral actions, emotional responses, and physiologic reactions.⁵³ Sexual abuse offenders will be targeting their sexual arousal to children, thought patterns which allow them to justify perpetrating sexual abuse, and examining the behavioral repertoire that lead up to abuse.⁵³ Physical abuse offenders will learn strategies for managing anger, parenting skills, and non-physical means of discipline.^{16, 35} Caregivers who are neglectful will receive assistance in securing basic goods and resources, will learn parenting strategies and be taught skills which facilitate independent management of the children and family's needs.⁵⁴

In the treatment of all forms of abuse it is important to address attributions of blame. Invariably child abuse/neglect offenders minimize their own responsibility for the abuse/neglect and project blame on other family members, most often the victim. The **abuse clarification process**,⁴⁶ which addresses such attributions, should be included in treatment if at all possible. The abuse clarification involves an acknowledging offender who has proceeded through treatment to a sufficient degree to be able to clarify the nature of the abuse, assume responsibility for the abuse, demonstrate empathy for the child's responses to the abuse, and begin to participate in the development of a family safety plan. The abuse clarification process is addressed in the offender's individual or group treatment and is ongoing, often for many months before an abuse clarification session is possible. The abuse clarification session provides the opportunity for the offender to read a letter written to the child victim that focuses on the offender's assumption of responsibility, empathy for the child, and commitment to developing the family safety plan. This session is likely to occur some months after the abuse is disclosed, allowing the offender sufficient opportunity to engage in and

progress in his/her own treatment.

Ideally, at least one supportive adult should be included in the treatment process. Several programs around the country have targeted non-caregivers parents in their approach to treating child sexual abuse and have found success with such an approach.^{16, 32, 50} Treatment with non-offending caregivers also must also be built upon a foundation of acknowledgement that abuse has occurred. In most cases, where non-offending caregivers believe and support their child, family work addresses the caregiver's individual needs. Early treatment strategies must address denial if it is present.

Treatment of the non-offending caregiver(s) addresses his/her emotional responses to the abuse and individual mental health needs. In addition, treatment includes focus on the caregiver's responses to the child's abuse, education regarding the child's symptoms and provides assistance for developing strategies for reducing these symptoms.

It is recommended that the non-offending parent be involved in an **abuse protection clarification**.⁵⁵ This process is similar to the abuse clarification conducted with the offender. The protection clarification involves clarification of the abuse, commitment to protection of the child, and participation in the development of a family safety plan. The protection clarification may be initiated relatively early in treatment, especially if the non-offending parent believes and supports the child from the time of disclosure.

Long-term family resolution of parent-child abuse is a life-long process and involves changing many aspects of family functioning.⁵¹ Some type of resolution must occur in all cases, regardless of whether the child or offender has been removed from the home. Resolution may take the form of helping a child adjust to permanent foster care and cope with a nonsupportive family or may involve reunification of the family following the successful completion of individual/group treatment, the clarification process, and family therapy which addresses a safety plan, alteration of family member's rigid patterns of thinking and behaving.

If reunification becomes a therapeutic goal, certain preconditions must exist:

- Offender acknowledgment of abuse
- Offender assumption of responsibility for the abuse
- Offender awareness of offending pattern and commitment to change
- Offender demonstration of willingness to participate in safety plan
- Nonoffending caregiver acknowledgment of abuse

Nonoffending caregiver assumption of responsibility of safety for the child
Nonoffending caregiver demonstration of willingness to participate in safety plan

Psychopharmacologic treatment for child victims

Medications may be used with child victims of abuse and neglect who are experiencing post-traumatic stress disorder (PTSD).⁵⁶ A number of medications may be of use, though the state of our knowledge about which are most appropriate for use in children is limited. Some have recommended that the use of medication may be reserved for those children who do not show improvement with cognitive-behavioral treatments for PTSD.^{56, 57} Children experiencing other types of behavioral or emotional difficulties, including depression, anxiety, or attentional problems also can benefit from pharmacologic treatment. In all cases, the choice of medications is determined by a psychiatrist through a careful assessment.

Obstacles to treatment

Treatment of child victims of abuse and neglect can often be frustrating and difficult. There are a number of obstacles which regularly present themselves to the treating professional:

Family obstacles

- Lack of acknowledgment by offender/non-offending caregiver
- Lack of resources
- Lack of motivation to participate in treatment
- Mistrust of the "system" (including counselor/therapist)

Child obstacles

- Fear and anxiety related to thinking or talking about the abuse
- Mistrust of others as a consequence of the abuse
- Lack of understanding about the therapeutic process
- Developmental limitations (e.g., language development, understanding of emotions)

System obstacles

- Lengthy investigation/prosecution process
- Delays for the court process
- Lack of coordination between criminal justice, child welfare, and treatment systems
- Poor communication between therapist/counselor and social services/legal personnel
- Lack of appropriate treatment resources within the system

Disregard of therapist/counselor recommendations

Communication between therapists and other professionals

A variety of professionals may be qualified to treat the child victim of abuse/neglect. Mental health professionals involved in treatment delivery include psychologists, psychiatrists, counselors, and social workers. It is important that the treatment provider have training and experience working with victimized children. That is, not all mental health professionals are qualified to treat abused/neglected children solely as a result of their generic training. The professional should have specific knowledge of the abuse/neglect process, factors associated with the development of problems in children, typical outcomes of abuse/neglect, and social services/legal responses to abuse/neglect.

Most mental health professionals are required by law and their code of ethics to maintain confidentiality of their clients' disclosures in treatment. Although mental health professionals are required to report suspected abuse and neglect and situations in which the client is perceived to be a danger to self or others, they are constrained from revealing other confidences discussed in the treatment process unless the client (or legal guardian) has signed a consent form. It is recommended that there be an open line of communication between the treating professional and **relevant** professionals dealing with the needs of the child and his/her family. However, only information relevant to the protection of the child, placement issues, and to factors affecting the child's ability to participate in legal proceedings should be shared from the therapist to caseworkers and legal professionals.

Caseworkers also can (and should) obtain information regarding goals for treatment, the treatment plan, and progress towards treatment goals. Competent mental health professionals should be able to articulate a clear treatment plan which has well-defined treatment goals and proposed approaches towards attaining those goals.

Caseworkers can be very helpful to the therapist by providing information that might affect the intensity of a child's symptoms and the course of treatment. In particular, information regarding changes in the offender's or nonoffending parent's stance towards the abuse and towards his/her treatment, and changes in the child's placement can alert the therapist to potential sources of stress. In addition, the expression of the child's difficulties in neighborhood or school settings, particularly changes in the child's functioning, can help a therapist to direct his or her clinical focus toward appropriate clinical targets.

Conclusions

In general, treatment of child abuse and neglect is complex and involves coordination of many different services (e.g., medical, legal, child protection, mental health). While a great deal of treatment is delivered to abused and neglected children, there is a relative paucity of published work that has evaluated the effectiveness of various treatment approaches.⁷ Cognitive-behavioral approaches have received the most scientific support.^{38, 43, 44} Parent-child interaction training (PCIT) also has been found to be an effective treatment.⁴⁴ Both empirical and clinical findings suggest a few clear conclusions about treatment of child abuse and neglect:

- treatment should be abuse-focused (i.e., help the child adjust to the experience of having been abused)
- treatment should include an educational component
- treatment should address the child's relationships with other family members and the community
- treatment should be directed to both offending and non-offending caregivers as well as toward the child

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