John E. B. Myers, EDITOR

Child Maltreatment

A COLLECTION OF READINGS

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John E. B. Myers

University of the Pacific

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FOR INFORMATION:

SAGE Publications, Inc.
2455 Teller Road
Thousand Oaks, California 91320
E-mail: order@sagepub.com

SAGE Publications Ltd.
1 Oliver's Yard
55 City Road
London EC1Y 1SP
United Kingdom

SAGE Publications India Pvt. Ltd.
B 1/I 1 Mohan Cooperative Industrial Area
Mathura Road, New Delhi 110 044
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Contents

Introduction

This Reader contains 20 articles and is designed to supplement the third edition of the *APSAC Handbook on Child Maltreatment*. The articles are arranged to correspond with the contents of the *Handbook*, although not all chapters of the *APSAC Handbook* have corresponding articles in the Reader.

Part I: The Child Protection System in the United States

Part I of the *APSAC Handbook* describes America's child protection system. The articles selected for the Reader deepen our understanding of important aspects of the system.

Chapter 2 of the *APSAC Handbook* provides in-depth analysis of prevention. The Reader article by Leventhal (Chapter 1 in this volume) supplements Chapter 2. Leventhal asks the critical questions: Why is it important to focus on prevention? Do clinicians think preventively? If not, why not, and what can be done to change people's thinking so prevention becomes an issue of greater concern to professionals working with abused and neglected children? Leventhal describes in helpful terms the three types of prevention: primary, secondary, and tertiary. From there he launches into an analysis of various prevention efforts, especially home-based services to families.

Chapter 3 of the *APSAC Handbook* describes the child protection system (CPS). Because many readers of the *APSAC Handbook* are keenly interested in CPS, the Reader includes five articles on various aspects of CPS. The article by Maiter, Palmer, and Manji (Chapter 2) explores the CPS worker-parent relationship. How do parents feel about the CPS workers they encounter? What is it like to work with a professional who "takes your child away from you"? Maiter and colleagues conducted in-depth interviews of 61 parents involved with CPS. The insights gleaned from these interviews will help CPS workers interact positively with parents under extremely stressful circumstances.

African American children are overrepresented in foster care. Chapter 3, by Harris and Skyles, discusses the problem of overrepresentation and the use of kinship care. They describe the evolution of kinship care policies and argue that kinship care is overused for African American children. Harris and Skyles conclude that current child welfare policies conflict with the overriding goal of reunifying African American children with their parents.

Chapter 4, by Berger, Paxson, and Waldfogel, describes research on the relationship between CPS involvement in families and the mother's relationship status with men (e.g., married, dating, live-in boyfriend). Not surprisingly, the authors found that CPS involvement is higher when a mother is living with a man who is not the child's biological father. The article offers useful insights into risk assessment.

Professionals working in child welfare understand the pervasive impact of substance abuse. Two articles in the Reader grapple with this issue. Chapter 5, by Rockhill, Green, and Furrer, asks

whether the Adoption and Safe Families Act (ASFA) is influencing decision making for families with substance abuse issues. This article provides an opportunity to discuss the extent to which large-scale policy-level changes in child welfare such as ASFA impact practice in the trenches of child protection.

Are child welfare professionals and substance abuse treatment providers like ships passing in the night—out of touch with each other and working at cross purposes? In Chapter 6, Drabble discusses the divergent perspectives of professionals in CPS and substance abuse treatment. After describing the sometimes differing perspectives of CPS workers and substance abuse clinicians, Drabble highlights ways to build bridges among professionals.

Chapter 5 of the *APSAC Handbook* discusses foster care and adoption. The Reader contains two articles related to foster care and one focused on adoption.

Many children in foster care experience mental health issues, including depression. The article by White, O'Brien, Pecora, English, Williams, and Phillips (Chapter 7) analyzes depression among alumni of foster care and offers strategies to ameliorate the problem.

Children living in foster care have increased rates of behavioral and psychological problems. Nilsen (Chapter 8) reviews the literature on social and emotional problems experienced by children in foster care and then describes an intervention designed to help foster caregivers respond to foster children's special needs.

Focusing on adoption, Goldberg, Downing, and Richardson (Chapter 9) explore how lesbian and heterosexual couples deal psychologically with the transition from infertility to adoption. Goldberg and colleagues review the literature on infertility and psychological well-being and discuss the psychological transition from infertility toward adoption. What does it mean to be "childless"? The authors found interesting similarities and differences between lesbian and heterosexual couples making the transition to adoption.

Part II: Neglect

Part II of the *APSAC Handbook* delves into the most common form of child maltreatment: neglect. The Reader gives neglect the attention it deserves, with eight articles.

Chapter 4 of the *APSAC Handbook* provides detailed discussion of neglect, including definitions, prevalence, and effects. The Reader supports Chapter 4 with seven articles analyzing various issues related to neglect.

Dubowitz, Pitts, and Black (Chapter 10) discuss three subtypes of neglect: physical, psychological, and environmental. Dubowitz and colleagues address the difficulty of defining neglect, which is an inclusive concept, and conclude that while physical, psychological, and environmental neglect overlap, they are not identical. The three types of neglect should be responded to with their differences in mind.

Neglect is associated with poverty. In Chapter 11, Slack, Holl, McDaniel, Yoo, and Bolger explore the complex relationship between neglect and poverty. They note that although a strong association has been established between poverty and neglect, the causal mechanisms explaining this association are poorly understood. The authors explore possible explanatory factors, including level of poverty, employment history, and various parenting characteristics.

Lounds, Borkowski, and Whitman (Chapter 12) extend the analysis of neglect and poverty, focusing on teen mothers. The authors followed 100 low-income adolescent mother-child dyads

from the third trimester of pregnancy until the children were 10 years old. Not surprisingly, neglected children displayed numerous problems. The article provides convincing evidence of the developmental harm inflicted by neglect.

Osborne and Berger (Chapter 13) delve into the relationship between substance abuse and neglect. They confirm what is generally known in child welfare circles: that living with a parent who abuses substances is related to a range of poor behavioral and health outcomes. The harm is compounded when both parents are substance abusers.

Jones, Finkelhor, and Halter (Chapter 14) describe the downward trend in recent years in cases of physical and sexual abuse. Neglect, by contrast, did not decrease substantially. The authors discuss why neglect differs from sexual and physical abuse and why neglect is not declining.

Parent training programs—often called *parenting programs*—play an important role in child protection. The skills and insights imparted in parent training help parents improve parenting so that parents who have maltreated their children can retain or regain custody. In Chapter 15, Lundahl, Nimer, and Parsons provide a meta-analysis of research on parent training programs. The authors conclude that parent training can help reduce physical abuse, verbal abuse, and neglect. The article affords an opportunity for students to read and discuss a meta-analysis.

The article by Haugaard and Hazan (Chapter 16) offers a useful summary of attachment theory. The authors apply attachment theory to reactive attachment disorder, which results from extreme neglect, and discuss treatment strategies for this disorder.

Chapter 10 of the *APSAC Handbook* provides in-depth analysis of the impact of intimate partner violence on children. Every year, many thousands of children witness intimate partner violence in which their mother is the victim. Chapter 10 discusses the relationship between intimate partner violence and child maltreatment. The Reader supplements the text with an article: Hartley (Chapter 17 in this volume) examines the characteristics of families that experience both intimate partner violence and child maltreatment.

Part III: Physical Abuse

Part III of the *APSAC Handbook* addresses physical abuse. The Reader contains an interesting article by Maker, Shah, and Agha (Chapter 18) that dissects the relationship between culture and physical abuse. Maker and colleagues administered a self-report survey to 251 South Asian, Middle Eastern, East Asian, and Latina college-educated women in the United States. The authors found a high rate of physical abuse among the women who responded to the survey. Maker and colleagues explore the relationship between experiencing harsh physical discipline as a child and beliefs in adulthood about the propriety of corporal punishment.

Part IV: Child Sexual Abuse

Part IV of the *APSAC Handbook* offers detailed coverage of child sexual abuse. The Reader adds an article by Leclerc, Wortley, and Smallbone (Chapter 19) that discusses victim resistance to sexual abuse. The authors note that the extent to which children resist sexual victimization has not been studied in detail. Ninety-four adults who sexually abused children completed a confidential self-report survey describing their offending behaviors, reporting on several types of resistance by victims as well as the impact of resistance on perpetrators and their offenses.

Part V: Investigation and Substantiation of Neglect and Abuse

Part V of the *APSAC Handbook* discusses a broad range of issues relevant to investigation and prosecution of child abuse and neglect. In Chapter 20, Hershkowitz discusses research on the role of rapport building in helping children describe traumatic events such as abuse.

PART I

The Child Protection System in the United States

The Prevention of Child Abuse and Neglect

Pipe Dreams or Possibilities?

John Leventhal

In 1962, C. Henry Kempe and colleagues brought to the attention of physicians and other clinicians the shocking problem of physical abuse of children (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). What followed was a remarkable effort to define the problem, improve the recognition and reporting of abused children and subsequently those who had been neglected or sexually abused, develop a legally mandated reporting and investigative system (in the USA), develop treatment programs for children and adult victims, and understand how maltreatment occurred and its consequence to children and families. Although there was some early attention to the issue of prevention, only in the last 10 to 15 years has there been increasing attention among clinicians and researchers and even governmental agencies and foundations about the need to focus on the prevention of abuse and neglect. In this article, I review some of these recent efforts and the evidence suggesting that prevention of abuse and neglect is more a possibility than a pipedream.

Author's note: Adapted from a talk presented at the conference "Children in Distress: Reducing the Risk, Reducing the Harm," sponsored by *Clinical Child Psychology and Psychiatry,* 30 January 1997. This article is supported in part by a Behavioral Pediatrics Training Grant from the Maternal and Child Bureau (MCJ 9087).

Source: Leventhal, J. (1997). The prevention of child abuse and neglect: Pipe dreams or possibilities? *Clinical Child Psychology and Psychiatry, 2,* 489–500.

Why Focus on Prevention?

There are a number of reasons why it is worthwhile focusing on prevention. First, there is the magnitude of the problem. The abuse and neglect of children have come to be recognized as substantial problems in our society. For example, in 1995 in the USA, approximately three million children were reported to protective service agencies, and one million of these reports were substantiated, resulting in 46 reports and 14 substantiated reports per 1000 children less than 19 years of age (Lung & Daro, 1996). Of these cases, about 25% were due to physical abuse, and 50% due to neglect. In the UK in 1995, 48,000 children were referred for child-protection conferences (a rate of 4.4 per 1000 children), and 63% of the children were placed on the registry (Department of Health, England, 1996).

Second is the enormous costs in terms of the affected lives of children and families and the financial expense to society. Although some studies have examined the consequences of maltreatment, much less information is available about the financial costs. The National Committee to Prevent Child Abuse (NCPCA) (1994) has estimated that the minimal annual cost of child maltreatment in the USA is $9 billion, which includes the costs of health care, out-of-home placements, child-protective services and family-preservation services. Not included in these estimates are costs due to special educational services, mental health counseling, juvenile court services, or the criminal justice system. Clearly, the costs to society of maltreatment are substantial and cannot be ignored.

Third, once abuse or neglect has occurred, it is difficult to change the human behaviors that resulted in the child or children in the family getting hurt. Resources in the community often are inadequate in scope and number to treat maltreating parents, and families often have other important problems that directly or indirectly influence how the children are cared for, including substance abuse, domestic violence, mental health problems and the like.

Fourth, preventive efforts can focus on families before they develop fixed and negative ways of behaving towards their children and before substantial dysfunctions develop in the children related to the abuse or neglect. An ounce of prevention may, in fact, be worth a pound of cure.

Thinking Preventively

Most clinicians are not accustomed to thinking preventively. They are used to seeing a child or family after a problem occurs, help is sought, and the family or child takes on the role of a patient. Although the clinician who provides preventive services takes on a helping role, there are at least three differences about preventive efforts compared to the traditional clinical role. First, clinicians need to recognize that they will be working with families before they become 'patients'. Thus, families may not believe that they have a problem and may not necessarily seek out preventive services. In fact, preventive services usually find families as opposed to families finding the services. Second, when preventive services are offered, families need to be interested. Since most preventive programs are voluntary, families can refuse. An important aspect of the provision of preventive services is to make them attractive to families by offering something special. Third, since it is difficult and expensive to offer services to everyone, an important task for those providing preventive services is to identify who is at risk of the outcome, in this case abusing or neglecting a child.

In addition to a shift in conceptual thinking about the provision of services, it is helpful to have a framework, which, as demonstrated in Figure 1.1, includes the levels of prevention and the targets of services. The three levels of prevention that usually are considered include

1. Primary, in which preventive services are offered to the entire population
2. Secondary, in which services are offered to a selected, high-risk population, and
3. Tertiary, in which services are offered after the outcome has occurred, but usually a mild version of the outcome.

Figure 1.1 Framework for Preventive Services

Levels of prevention	*Targets of service*
Primary	Community
Secondary	Parents
Tertiary	Children

Services might be directed at the following targets: the community, parents or children. In the examples of preventive services that follow, I focus mainly on services directed toward parents.

Two Approaches to Preventing Abuse and Neglect

Two basic approaches are available to prevent the abuse and neglect of children. The first includes programs that generally are supportive of parents and families. Thus, affordable, quality child care, parenting programs, decent housing, Head Start programs, mental-health services for parents and children, medical insurance either through employment or the government and the like are all examples of services that support families and therefore directly or indirectly support parenting. Although no studies have examined the effects of quality child care or Head Start on the occurrence of abuse or neglect, it seems reasonable to believe that if such programs are available in communities, parents are likely to be supported and less likely to maltreat their children. A major concern in the USA is that federal and state governments have been less likely to support these types of service, particularly for impoverished families. Without such services, not only will it be difficult to support families but even programs that specifically focus on preventing abuse and neglect will likely be less successful. A caring community truly is necessary to raise a child.

The second approach includes programs that specifically target the prevention of child abuse and neglect. One such approach that has gained considerable interest over the last several years has been home visiting by nurses, paraprofessionals or even trained volunteers (Center for the Future of Children, 1993; U.S. Advisory Board on Child Abuse and Neglect, 1993; U.S. General Accounting Office, 1990). Home visitors are able to work on relationships, parenting behaviors and concrete needs in the family's own environment. Fraiberg, Adelson, and Shapiro (1975) called this kind of intervention 'psychotherapy in the kitchen'.

Child abuse occurs when an adult's (usually a parent's) hand strikes, hits, slaps, punches, twists or, in some other way, directly harms a child. Neglect occurs when the parent's hand fails to provide adequate nurturing including food, shelter, clothing, supervision or medical care. In both abuse and neglect, parental behaviors are influenced by a rejecting relationship with the child and feelings of anger and hatred toward and disappointment with the child. Parental behaviors also are influenced by a parent's own degree of impulsiveness and by other stresses in the parent's current or past life, such as substance abuse, domestic violence or having been abused as a child. Consequently, programs that target the prevention of abuse and neglect need to focus on four aspects of parenting: the parents' behaviors towards the child; their feelings towards the child; their own impulsiveness; and the internal and external stresses that can influence their behaviors. Thus, it is not surprising that prevention is not a simple task.

Nine Ingredients of Home-Based Services

There are at least nine ingredients necessary for home-based services to be successful (Leventhal, 1996).

1. Services should begin early either prenatally or shortly after a child's birth. The pregnancy, the child's birth and bringing the new baby into the family's life are emotionally critical periods. Helfer has called the perinatal period 'a window of opportunity for enhancing parent-infant communication' (Helfer, Bristor, Cullen, & Wilson, 1987). At this time, parents may be particularly open to emotional and physical support.

2. Home visiting needs to occur frequently and over an extended period of time so that relationships can develop between the home visitor and the parents. Most programs begin with weekly visits, which are then spaced out to visits every 4 to 8 weeks. In the most widely cited study of home visiting conducted by Olds and colleagues in Elmira, New York, nurses averaged 8 visits prenatally and 23 visits during the child's first two years of life (Olds, Henderson, Chamberlin, & Tatelbaum, 1986). In Hawaii's Healthy Start program, which is funded by the state's Health Department, the goal is to provide home visiting through the child's fifth birthday (Department of Health, Hawaii, 1992).

3. The primary goal of the home visitor is to develop a therapeutic relationship with the family. For a home visitor to develop a trusting, honest relationship may be especially difficult with families that are vulnerable or feel disenfranchised (Kennel, 1996). Ongoing mental-health supervision can help the home visitor understand the dynamics and practical issues concerning such relationships. Through the relationship, the home visitor helps the parent feel better about himself or herself, and the parent, in turn, feels better about the relationship with the child.

4. The home visitor needs to be a watchful eye in the home. By making frequent visits to the home, the worker can be aware of early signs of trouble—small bruises on the child, inappropriate discipline, early signs of domestic violence—and can help the family recognize these problems and get appropriate help. Grandparents or other supportive relatives who may be involved with the child's care often have difficulty recognizing these early signs of trouble, or, if such signs are recognized, have difficulty believing that the mother or father is actually hurting the child.

5. The home visitor needs to focus on parenting. This can be accomplished by modeling effective parenting, providing alternative approaches to care, and reflecting with parents about the child's development and needs. In Olds's studies, a curriculum for the home visitor was provided so that important issues were discussed at specific times (Olds et al., 1986). In the evaluations reported to date, there have been differences in parenting behaviors between the intervention and control

groups, but there have been no differences in the child's intellectual development. Some have suggested that an additional center-based developmental program might be necessary to enhance the child's development (Daro & McCurdy, 1996).

6. The child's needs should be the primary focus of the intervention. Although the home visitor must form an alliance with parents and help them get appropriate services, such as treatment for substance abuse or enrollment in an educational program, the child and his or her needs cannot be ignored. Balancing the needs of the child and parents can become particularly difficult when the parents' needs are substantial and even overwhelming. In such circumstances, it may be very difficult to remember that the focus of the services is on the child's needs for appropriate nurturance.
7. The home visitor should be able to provide concrete services, such as helping to find appropriate housing, providing transportation to the child's health-care provider and the like. The provision of such services can help establish a relationship between the worker and the family and help the family overcome real barriers to adequate parenting.
8. Fathers need to be included in the preventive efforts. Although programs generally have focused on mothers and some have successfully reduced the occurrence of maltreatment, serious abuse of young children is often caused by males in the home (Starling, Holden, & Jenny, 1995).
9. The frequency and intensity of services need to be titrated according to the family's needs. Providers should examine on a periodic basis whether the services being provided are helpful to the child and family and what kinds of changes, if any, are necessary in the service plan.

Evaluating Prevention Programs

The evaluation of prevention programs can be a difficult scientific endeavor. The most methodologically rigorous approach is a randomized-controlled trial, which can be very costly and take many years to conduct. In addition, large sample sizes are needed because abuse and neglect are relatively rare outcomes.

Ascertainment of Abuse and Neglect

A particular problem related to the prevention of maltreatment is the measurement of the occurrence of the outcome, namely abuse or neglect. Most studies have relied on counting reports to protective service agencies. An inherent problem with this approach is the possibility of detection bias, which can occur when one of the two groups under study is observed or followed more carefully and therefore the outcome is more likely to be detected in this group (Leventhal, 1982). In the randomized trials of home visiting, frequent home visits occur in the intervention group; thus less severe injuries due to abuse or neglect are likely to be recognized and reported to protective services. In contrast, these types of injury would be unlikely to be detected or reported in the control group, which is not receiving home visits.

My colleagues and I have proposed an alternative strategy, which is less likely to result in detection bias, to ascertain injuries due to abuse or neglect (Leventhal, Garber, & Brady, 1989; Stier, Leventhal, Berg, Johnson, & Mezger, 1993). In this approach, all injuries resulting in a visit to a health-care provider are reviewed and classified using predefined criteria, which include the following categories: definite, probable, and possible physical abuse; four categories of neglect; unintentional (or accidental) injuries; unintentional injury-neglect (for injuries such as those due to falls off the bed that could