U.S. DEPARTMENT OF COMMERCE
National Technical Information Service
PB-278 448

Evaluation of Child Abuse and Neglect Demonstration Projects 1974-1977 Volume XI. Child Client Impact

Berkeley Planning Associates, Calif

Prepared for

National Center for Health Services Research, Hyattsville, Md

Dec 77

PREFACE

In May of 1974, the Office of Child Development and Social and Rehabilitation Services of the Department of Health, Education and Welfare jointly funded eleven three-year child abuse and neglect service projects to develop strategies for treating abusive and neglectful parents and their children and for coordination of community-wide child abuse and neglect systems. In order to document the content of the different service interventions tested and to determine their relative effectiveness and cost-effectiveness, the Division of Health Services Evaluation of the National Center for Health Services Research, Health Resources Administration of the Department of Health, Education and Welfare awarded a contract to Berkeley Planning Associates to conduct a three-year evaluation of the projects. This report is one of a series presenting the findings from that evaluation effort.

This evaluation effort was the first such national study in the child abuse and neglect field. As such, the work must be regarded as exploratory and suggestive, not conclusive. Many aspects of the design were pioneered for this study. Healthy debate exists about whether or not the methods used were the most appropriate. The evaluation focused on a demonstration program of eleven projects selected prior to the funding of the evaluation. The projects were established because of the range of treatment approaches they proposed to demonstrate, not because they were representative of child abuse programs in general. The evaluation was limited to these eleven projects; no control groups were utilized. It was felt that the ethics of providing, denying or randomly assigning services was not an issue for the evaluation to be burdened with. All findings must be interpreted with these factors in mind.

Given the number of different federal agencies and local projects involved in the evaluation, coordination and cooperation was critical. We wish to thank the many people who helped us: the federal personnel responsible for the demonstration projects, the project directors, the staff members of the projects, representatives from various agencies in the projects' communities. Ron Starr, Shirley Langlois, Helen Davis and Don Perlgut are all to be commended for their excellence in processing the data collected. And in particular we wish to thank our own project officers from the National Center for Health Services Research--Arne Anderson, Feather Hair Davis and Gerald Sparer--for their support and input, and we wish to acknowledge that they very much helped to ensure that this was a cooperative venture.

Given the magnitude of the study effort, and the number and length of final reports, typographical and other such errors are inevitable. Berkeley Planning Associates and the National Center for Health Services Research would appreciate notification of such errors, if detected.

i-b

LIST OF CONTENTS

LIST OF TABLES

LIST OF TABLES, continued

SUMMARY

Introduction

In May of 1974, prior to expenditure of funds appropriate to the Child Abuse and Neglect Prevention and Treatment Act, Public Law 93-247, the Office of Child Development and Social and Rehabilitation Services, of DHEW, jointly funded eleven three-year child abuse and neglect service projects in order to develop and test alternative strategies for treating abusive and neglectful parents and their children and alternative models for coordination of community-wide child abuse and neglect systems. The projects, spread throughout the country and in Puerto Rico, differed by size, the types of agencies in which they were housed, the kinds of staff they employed, and the variety of services they offered. In order to document the content of the different service interventions tested and to determine their relative effectiveness and cost-effectiveness, Health Resources Administration awarded a contract to Berkeley Planning Associates to conduct a three-year evaluation of the projects. This report presents the final analyses of the impact of services for children. The purpose of this report is to describe the types of problems which abused and neglected children have at the time they enter treatment, and their progress toward overcoming these problems during treatment.

I. Methodology

Three projects among the eleven in the overall Evaluation, the Family Center in Adams County, the Family Care Center in Los Angeles, and the Family Resource Center in St. Louis provided direct therapeutic services to abused/neglected children. In order to document the characteristics of the children served at these projects, the problems which they exhibited while in treatment, and the effectiveness of these services, a system for recording, processing and analyzing information for all children entering the projects between January, 1976 and March, 1977 was developed. The information required was recorded by the project clinician(s) working most closely with the children on forms developed by the evaluator. Complete data sets, which included information on the children's characteristics, the services received, problems at intake, and progress during treatment, were collected for 70 children during the course of the study. The data were coded and analyzed by the evaluators both by project and for the sample of children as a whole, to address the study questions. Interpretation of the findings from this study must be made keeping in mind limitations--the small number of children studied and the selective nature of those studied.

II. Characteristics of the Children and Their Families

Most children in the sample were male (61%), Caucasian (67%) and between three and seven years old (65%); the age range of children served was 0-12 years. Typically, the children were the victims of emotional abuse or neglect, or were high risk cases, although 23% of the 70 children had mild or moderate physical injuries. Few of the children had any special characteristics such as prematurity, mental retardation or an emotional or learning disability which would separate them from their non-abused/neglected counterparts. The children were in treatment an average of 9 months. Data available on the families of 34 of the 70 children in treatment indicated them to be similar to other abusive/neglectful families; half the parents were abused themselves as a child, and the same proportion had an adolescent parent in the household. In 38% of the families no one was employed, and over half the families were socially isolated. Over 70% of the families had preschool children, but few had more than 4 children. The parents were in treatment an average of 16 months, during which time some legal intervention took place in the case.

III. Problems of Children at Intake

Children who entered the projects for treatment displayed a wide variety of problems; there was not one area in which all children were deficient, nor were there specific types of problems or behaviors which clustered together. The greatest number of children had problems in the following areas: (1) physical problems--hyperactivity, erratic eating patterns, excessive crying behavior, and the presence of tics and twitches; (2) socialization problems--poor interaction with peers and adults, over-reaction to frustration and very short attention spans; (3) family interaction problems--inappropriate perception of child's needs and response to these needs, child's differences from parent's expectations and child's provocative behavior; (4) cognitive/language/motor skill problems--the majority of children tested lower than one standard deviation below the mean on several standardized tests, placing them in the clinical "dull normal" range.

IV. Progress While in Treatment

Many children made some progress on their problems while in treatment; the problems of 50% of the children were reported to be completely ameliorated in areas of malnutrition, delayed height and head circumference, eating patterns, ability to gain and receive affection, hypermonitoring, and ability to protect themselves; apathetic behavior, general interaction with peers and the parent's use of harsh discipline on the child. At the time of termination, most children had significantly higher scores on the standardized tests administered (assessing cognitive, language and motor skill development) although they were still at the low end of the "normal" range. Many children's problems, however, remained unchanged, and a small proportion were reported to have regressed during treatment.

V. Factors Associated with Progress in Treatment

The seriousness of the case at intake, the presence of abuse or neglect reincidence while in treatment, and the length of treatment were not shown to be good predictors of how a child will progress in treatment. Children appeared to have scattered success in overcoming their problems in much the same way that they exhibited a wide variety of problems, and intensity of problems, at the time they entered treatment.

VI. Conclusions

Based on the analysis of the children's problems, it is clear that abused and neglected children have numerous delays and deficits in both developmental areas such as cognition, language and motor skill acquisition, and in more behaviorally-related areas such as their ability to develop adequate socialization process and behaviors with adults and peers and their ability to interact positively within the family setting. These problems require direct interventions at an early age to forestall more permanent damage and to ameliorate the already existing deficits. Specific programs to provide a variety of therapeutic services for children need to become a component of all communities' child abuse and neglect service delivery systems.

INTRODUCTION

History of the Demonstration Effort

During the fall of 1974, prior to the passage of the Child Abuse Prevention and Treatment Act, Public Law 93-247, the secretary's office of the federal Department of Health, Education and Welfare (DHEW) decided to allocate four million dollars to child abuse and neglect demonstration projects. A substantial portion of that allotment, approximately three million dollars, was to be spent jointly by the Office of Child Development's (OCD) Children's Bureau, and Social and Rehabilitation Services (SRS) on a set of demonstration treatment programs. On May 1, 1974, after review of over 100 applications, OCD and SRS jointly selected and funded eleven three-year projects.[1] The projects, spread throughout the country, differ by size, the types of agencies in which they are housed, the kinds of staff they employ, and the variety of services they offer their clients and their local communities. However, as a group the projects embrace the federal goals for this demonstration effort, which include:

(1) to develop and test alternative strategies for treating abusive and neglectful parents and their children;

(2) to develop and test alternative models for coordination of community-wide systems providing preventive, detection and treatment services to deal with child abuse and neglect;

---

[1] The projects include: The Family Center: Adams County, Colorado; Pro-Child: Arlington, Virginia; The Child Protection Center: Baton Rouge, Louisiana; The Child Abuse and Neglect Demonstration Unit: Bayamon, Puerto Rico; The Arkansas Child Abuse and Neglect Program (SCAN): Little Rock, Arkansas; The Family Care Center: Los Angeles, California; The Child Development Center: Neah Bay, Washington; The Family Resource Center: St. Louis, Missouri; The Parent and Child Effective Relations Project (PACER): St. Petersburg, Florida; The Panel for Family Living: Tacoma, Washington; and the Union County Protective Services Demonstration Project: Union County, New Jersey.

(3) to document the content of the different service interventions tested and to determine their relative effectiveness and cost-effectiveness.

Overview of the Demonstration Evaluation

In order to accomplish the third goal, as part of DHEW's strategy to make this demonstration program an interagency effort, the Division of Health Services Evaluation, National Center for Health Services Research of the Health Resources Administration (HRA) awarded an evaluation contract to Berkeley Planning Associates (BPA) in June 1974, to monitor the demonstration projects over their three years of federal funding, documenting what they did and how effective it was. The overall purpose of this evaluation was to provide guidance to the federal government and local communities on how to develop community-wide programs to deal with problems of child abuse and neglect in a systematic and coordinated fashion. The study, which combined both formative (or descriptive) and summative (or outcome/impact-related) evaluation concerns, documented the content of the different service interventions tested by the projects and determined the relative effectiveness and cost-effectiveness of these strategies. Specific questions, addressed with quantitative and qualitative data gathered through a variety of collecting techniques, notably quarterly five-day site visits, special topic site visits and information systems maintained by the projects for the evaluators, include:

- What are the problems inherent in and the possibilities for establishing and operating child abuse and neglect programs?
- What were the goals of each of the projects and how successful were they in accomplishing them?
- What are the costs of different child abuse and neglect services and the costs of different mixes of services, particularly in relation to effectiveness?
- What are the elements and standards for quality case management and what are their relationships with client outcome?

- How do project management processes and organizational structures influence project performance and, most importantly, worker burnout?

- What are the essential elements of a well-functioning child abuse and neglect system and what kinds of project activities are most effective in influencing the development of these essential elements?

- What kinds of problems do abused and neglected children possess and how amenable are such problems to resolution through treatment?

- And finally, what are the effectiveness and cost-effectiveness of alternative service strategies for different types of abusers and neglectors?

During the summer of 1974, the projects began the lengthy process of hiring staff, finding space and generally implementing their planned programs. Concomitantly, BPA collected baseline data on each of the projects' community child abuse and neglect systems and completed design plans for the study. By January 1975, all but one of the projects was fully operational and all major data collection systems for the evaluation were in place. Through quarterly site visits to the projects and other data collection techniques, BPA monitored all of the projects' activities through April 1977, at which time the projects were in the process of shifting from demonstrations to ongoing service programs. Throughout this period, numerous documents describing project activities and preliminary findings were prepared by the evaluators. This report presents part of the final knowledge gained from the projects' joint experiences.[1]

---

[1]See Appendix A for a listing of other major evaluation reports and papers.

Project Profiles

As a group, the projects demonstrated a variety of strategies for community-wide responses to the problems of abuse and neglect. The projects each provided a wide variety of treatment services for abusive and neglectful parents; they each used mixes of professionals and paraprofessionals in the provision of these services; they each utilized different coordinative and educational strategies for working with their communities; and they were housed in different kinds of agencies and communities. While not an exhaustive set of alternatives, the rich variety among the projects has provided the field with an opportunity to systematically study the relative merits of different methods for attacking the child abuse and neglect problem.

Each project was also demonstrating one or two specific and unique strategies for working with abuse and neglect, as described below:

The Family Center: Adams County, Colorado

The Family Center, a protective services-based project housed in a separate dwelling, is noted for its demonstration of how to conduct intensive, thorough multidisciplinary intake and preliminary treatment of cases, which were then referred on to the central child protective services staff for ongoing treatment. In addition, the Center created a treatment program for children, including a crisis nursery and play therapy.

Pro-Child: Arlington, Virginia

Pro-Child demonstrated methods for enhancing the capacity and effectiveness of a county protective services agency by expanding the number of social workers on the staff and adding certain ancillary workers such as a homemaker. A team of consultants, notably including a psychiatrist and a lawyer, were hired by the project to serve on a multidisciplinary diagnostic review team, as well as to provide consultation to individual workers.

The Child Protection Center: Baton Rouge, Louisiana

The Child Protection Center, a protective services-based agency, tested out a strategy for redefining protective services as a multidisciplinary concern by housing the project on hospital grounds and establishing closer formal linkages with the hospital including the half-time services of a pediatrician and immediate access of all Center cases to the medical facilities.

The Child Abuse and Neglect Demonstration Unit: Bayamon, Puerto Rico

In a region where graduate level workers are rarely employed by protective services, this project demonstrated the benefits of establishing an ongoing treatment program, under the auspices of protective services, staffed by highly trained social workers with the back-up of professional consultants to provide intensive services to the most difficult abuse and neglect cases.

The Arkansas Child Abuse and Neglect Program: Little Rock, Arkansas

In Arkansas, the state social services agency contracted to SCAN, Inc., a private organization, to provide services to all identified abuse cases in select counties. SCAN, in turn, demonstrated methods by which a resource poor state, like Arkansas, could expand its protective services capability by using lay therapists, supervised by SCAN staff, to provide services to those abuse cases.

The Family Care Center: Los Angeles, California

The concept behind the Family Care Center, a hospital-based program, was a demonstration of a residential therapeutic program for abused and neglected children with intensive day-time services for their parents.

The Child Development Center: Neah Bay, Washington

This Center, housed within the Tribal Council on the Makah Indian Reservation, demonstrated a strategy for developing a community-wide culturally-based preventive program, working with all those on the reservation with parenting or family-related problems.

The Family Resource Center: St. Louis, Missouri

A free-standing agency with hospital affiliations, the Family Resource Center implemented a family-oriented treatment model which included therapeutic and support services to parents and children under the same roof. The services to children, in particular, were carefully tailored to match the specific needs of different aged children.

Parent and Child Effective Relations Project (PACER): St. Petersburg, Florida

Housed within the Pinellas County Juvenile Welfare Board, PACER sought to develop community services for abuse and neglect using a community organization model. PACER acted as a catalyst in the development of needed community services, such as parent education classes, which others could then adopt.

The Panel for Family Living: Tacoma, Washington

The Panel, a volunteer-based private organization, demonstrated the ability of a broadly-based multidisciplinary, and largely volunteer, program to become the central provider of those training, education and coordinative activities needed in Pierce County.

The Union County Protective Services Demonstration Project: Union County, New Jersey

This project demonstrated methods to expand the resources available to protective services clients by contracting for a wide variety of purchased services from other public and, notably, private social service agencies in the county.

The Child Client Analysis

One aspect of the Evaluation of Joint OCD-SRS National Demonstration Projects in Child Abuse and Neglect has been an assessment of the services provided specifically to children by these projects. Several of the eleven demonstration projects are providing direct, therapeutic services to the children of adults in their caseloads, or children whose parents are receiving services from local Protective Service Agencies.

There were several purposes in undertaking this child client evaluation. These included:

(1) to describe the characteristics and developmental problems of children accepted by the demonstration projects;

(2) to determine the type and quantities of services provided to children by the projects and the associated costs of those services;

(3) to assess the changes children undergo while receiving services.

The specific questions we were interested in exploring included: Are there any specific characteristics or developmental problems of abused and neglected children which differentiate them from other children? Are these characteristics related to the type or severity of the abuse and neglect suffered by the child or his/her familial background? What services (and with what intensity and duration) are most often provided to children with specific developmental problems? Do these services appear to reduce or ameliorate the problems? What are the total costs and unit costs of services provided to children by the demonstration projects?

The overall purpose, then, was not to compare the projects against each other or to compare different types of services provided in terms of which were more "effective", but rather, to describe the types of children seen, their backgrounds, the problems with which they entered the projects, and the overall progress they appeared to make while in treatment. This report presents the finding from this Child Client Analysis.

SECTION I: METHODOLOGY

Instrument Development

Although many of the projects in the demonstration effort provided some services to children (e.g., day care, psychological testing, family therapy, crisis nursery, or referral for medical and other treatments), only three of the projects, the Family Center in Adams County, the Family Care Center in Los Angeles, and the Family Resource Center in St. Louis, provided what could be called therapeutic services of sufficient duration and intensity that any measurement of change in the children's deficits or problems would be feasible. At these projects, the clinicians working with the children saw them frequently enough (often every day) over a sufficiently long period, to become thoroughly familiar with their problems and to be able to assess variation in behavior and functioning. Therefore, although some basic information relative to children was collected at all eleven projects, data collection as it relates to more specific concerns about the characteristics of abused and neglected children and their progress while in treatment was carried out only at the above mentioned sites.

Early in the course of this evaluation study, a thorough review of the literature related specifically to abused and neglected children, including all previous studies of these groups of children, a focused review of the child development literature, and an in-depth review of available standardized tests was carried out. From this review, and with the advice of consultants[1] and demonstration project staff who had had experience in the evaluation and/or research of abused/neglected children, a preliminary recordkeeping form to be used for all children receiving direct services from the Adams County and St. Louis projects was developed in the Spring of 1975 (the Los Angeles project did not begin seeing children until October 1975). This recordkeeping form and accompanying instruction manual,

[1] We gratefully acknowledge the contributions to this evaluation design made by Elizabeth Elmer, Carolyn Newberger, Martha Rodeheffer, and Carol Schneider.

a paper discussing the development of the form, a paper on the general characteristics and problems of abused and neglected children, and a review of various standardized tests for children were distributed to the projects in June, 1975.[1] The preliminary recordkeeping instrument was pre-tested for six months on all children entering the project during that time. At the end of six months, the pre-test experiences with the form were explored and based on recommendations from the projects' staff and our consultants, the final instrument, the Children's Progress Booklet, was developed and put into practice in January, 1976.

Data Collection

The Children's Progress Booklet (Appendix C) required the clinician working most closely with an individual child to maintain a series of data on that child from the time he/she entered the project until termination. Background information, including the child's age, race, sex, type and severity of maltreatment sustained, and other special characteristics of the child were recorded at intake. Shortly thereafter, the clinicians recorded the child's initial achievement on various standardized developmental tests, primarily the Bayley Scales of Infant Development, the McCarthy Scales of Child Development, and the Peabody Picture Vocabulary Test, depending on the child's age (not all children, therefore, received a "battery" of tests.) These tests were chosen for two primary reasons:

(1) they are widely accepted, well-standardized tests for the age groups in question that provide assessments in various areas of child development hypothesized to be relevant to abused and neglected children, and

(2) they tended to be tests already in use at the projects, thus eliminating the need to duplicate, or interfere with the project's established testing sequence.

The tests were repeated at six months intervals and at termination.

---

[1] Copies are available from Berkeley Planning Associates.

Using a checklist of behaviors commonly thought to be problem areas for many abused and neglected children, the clinicians also recorded those problems which a child exhibited upon entry to the project. Up to sixteen behaviors per area were assessed in the functional areas of (1) physical growth and development, (2) socialization skills and behavior, (3) motor skill development, (4) cognitive/language development, and (5) interaction patterns with family, using categories of "no problem, mild problem, or severe problem." In the areas of motor skill development and cognitive/language development, narrative comments from clinicians were elicited in lieu of specific behavior assessments because of the wide variations in ages of the children (age appropriate behaviors in these areas were too numerous to be listed) and because the results of standardized tests present a more complete and accurate picture of a child's overall skills in these areas.

Progress toward overcoming identified problems in each functioning area were rated at quarterly intervals, and a final scoring was completed at termination. Narrative comments relevant to the child's progress were also recorded.

Finally, the frequency with which the children received any services from the project or other community agencies (if known to the project), any reincidence of abuse or continuing neglect, and the occurrence of a major event in the child's life (e.g., placement away from home, a family move, loss or gain of a family member) were recorded monthly.

The data were collected for all children entering the projects (or receiving services from the projects) between January 1976, and February 1977 (some data was also recorded retrospectively for children entering before January 1976, although this was an individual project's decision). A preliminary analysis of the data was conducted in June 1976, and all the forms were collected for the final analysis in March 1977.

Data Analysis

The data were edited and coded by BPA staff. Due to the nature of the data and the desire to conduct interpretive analysis as well as statistical analyses, some of the analysis was carried out manually, although certain analyses, such as frequency distributions of problems and all correlations

of variables were conducted by computer, using an SPSS package.

The data were analyzed first by individual projects, and then for children at the three projects combined. Frequency distributions and percentages for all intake and termination variables, including test scores, were computed.

For those children whose parents were also receiving services from the projects, certain data from the Adult Client component of this evaluation[1] relative to the child's family (e.g., socio-economic status, previous record of abuse/neglect, primary problems of the parents at intake) were also retrieved. These data were used primarily in a qualitative fashion in this analysis to further explore the familial characteristics of the child's environment.

Finally, simple correlations between variables hypothesized to be of interest (such as the correlations between progress in treatment and reincidence) were carried out. It was determined from these lower order analyses that there was too limited a sample (70 children total, many of whom had been receiving services for a short time) and insufficient variation among many variables to warrant higher order analyses.

The findings from these analyses are presented in the remaining sections of this report. Section II describes the similarities and differences in the Children's Programs at each of these projects. Section III presents a profile of the children and their families included in the study at each project and a description of the services received. Section IV describes the specific problems which the children exhibited at entry to the project, and Section V describes the progress made toward overcoming these problems while the children were in treatment and the variables associated with this progress. Section VI presents the overall conclusions and their implications, including an analysis of the costs of providing these services.

Interpretation of the findings must be made with caution. The numbers of children studied are small and the children do not necessarily represent abused and neglected children in general.

---

[1]See Adult Client Impact Report Evaluation of the Joint OCD/SRS Demonstration Projects in Child Abuse and Neglect, December 1977.

SECTION II: PROJECT DESCRIPTIONS

Although each of the three projects included in this component of the overall evaluation provided direct services to abused/neglected children, there were numerous differences among them in terms of the ways in which their programs were structured and the therapeutic activities which they pursued. Following are brief descriptions of the Children's Programs at each project.[1]

A. The Family Center; Adams County

The Family Center was a Protective Service Agency-based program, but was housed in separate quarters. The project provided intensive, thorough multidisciplinary intake and preliminary treatment of child abuse cases, which were then referred on to the Central Protective Services staff for on-going treatment. Some small number of cases (8-10 per staff member) were provided on-going services by Center staff as well.

Services for parents included individual counseling and therapy, family and/or marital counseling, lay therapy, group therapy, Parents Anonymous, child growth and development classes, and medical care.

The Children's Program was, in fact, a proliferation of numerous services and treatment approaches developed to ameliorate the effects of the abuse or neglect on the child in a variety of sitautions in which the child might be living.

A crisis nursery was established to care for children who had been abused or where there was a high potential for abuse to occur. Up to six children, between 0-12 years of age could be accommodated, on a short-term basis (60 days maximum) in the Nursery. The goals of the Crisis Nursery were to provide a place for crisis care, evaluation and treatment of abused children that would, hopefully, forestall future long-term placement, and would act as an incentive for parents to cooperate in receiving services themselves in order to secure the child's return.

---

[1] More detailed descriptions of each of the eleven projects in the evaluation are available on request; see Case Studies, Evaluation of the Joint OCD/SRS Demonstration Projects in Child Abuse and Neglect, December, 1977.

Parents were encouraged to spend significant amounts of time with their children in the Nursery. In addition to the provision of a safe and nurturing environment for the children, which was set up to resemble a "group home," the Houseparents of the Crisis Nursery provided eclectic therapeutic help for the children who exhibited behavioral or developmental problems. Most problems were dealt with in unstructured, but consistent, programs of behavior management, nurturing, discipline and educational/developmental "games," particularly directed at language and motor skill acquisition. Other than these attempts to help the children with their most obvious problems and to encourage interaction between the children and parents, the children placed in the Nursery maintained a schedule of activities quite similar to any normal child's (e.g., attending school, playing with friends, watching television, etc.).

Two therapeutic Day Care Homes and a Therapeutic Foster Home were also established. In both instances, the development of the programs were predicated upon finding ways of maximizing the use of resources already available in the community to provide more focused help for the problems which abused and neglected children exhibit. Staff of the Center spent extensive amounts of time training the foster care and day care parents (who were already involved in non-therapeutic foster care and day care) in the dynamics of child abuse, the kinds of problems these children often have, and appropriate methods of working with them. Staff continued to provide consultation and support to the foster care family and day care parent during the time the programs were operating. Emotional, developmental and cognitive/language/motor skill delays and deficits were the most common problems of the children placed in these settings. Structured and unstructured activities were developed in an effort to help the child overcome identified problems. One staff member also provided therapy to the child in therapeutic foster care on a weekly basis.

In the therapeutic day care setting, eight children between 15 months and 5 years attended all-day sessions usually 2-3 times a week. The scheduling was flexible for these sessions, but involved both group and individual times, free play as well as structured

activities, and the use of everyday situations such as eating, to promote development of specific skills in sharing and socialization. In both the day care and foster care settings, helping the children find appropriate ways of dealing with their feelings and reducing inappropriate behaviors (excessive crying, temper tantrums, aggressive behavior) was stressed. Overall, the focus of the program was on providing an atmosphere conducive to developing trust and support between the substitute parent and the child, and helping the child establish a more healthy, positive self-esteem essential to overcoming the specific developmental problems they were experiencing.

The final area of the Children's Program, and the one from which most of the data for this evaluation was collected, was the provision of direct services to children by the social work staff at the Center. These sessions included individual therapy, play therapy, group counseling and therapy, speech and language testing and coordination of other "systems" (e.g., school) with an influence on the child. Children were selected based on a staff member's interest in working intensively with the child. In total, 29 children received these services during the demonstration period.

Individual counseling and therapy were provided primarily to older children with more serious problems of interacting who could not be helped in a group setting. Group therapy was provided for children whose problems or behaviors were not as severe or disruptive, and who could benefit from the process of joint work and peer interactions. An Affective Language Group, comprised of children 2-1/2 to 3-1/2 years old was developed for children with speech and language problems. Activities included both structured language skill building exercises and a less structured free association espressive language component to help the children overcome the problems diagnosed through the speech and hearing testing administered at the University. The Children's Group was a more traditional play therapy group for children 6-8 years old. The purpose of the group was to increase the social interaction skills of the children and promote more expression of feelings and conflicts in a play setting. Much of the activity was focused, again, on helping the children develop more appropriate ways of dealing with their feelings of anger, aggression, anxiety and fear which were by-products of their home situations.

Coordination of the Children's Program was a clear focus of the Family Center. This involved extensive periods of working with the children's parents, teachers and other social workers dealing with the family in order to ensure that the methods being used by the Center were understood by those people having contact with the child and that the desired behavior/activities were reinforced outside specified "treatment" times.

B. The Family Care Center; Los Angeles

The Family Care Center, affiliated with the Drew/King Medical Complex in Watts, provided residential care for up to ten abused/neglected children at a time, and also offered individual and group services--primarily counseling and self-help services--to their parents. The children, all of whom were under 5 years of age and were physically abused, were housed at the two-building facility a few blocks from the medical complex.

Services provided to parents included individual counseling and therapy, a Self-Help Group patterned after Parents Anonymous, a Parents Involvement Group (to help reduce isolation) and Conjoint Therapy for parents and children around problems of behavior management. In addition, parents were expected to spend extensive amounts of time with their children while they were residing at the Center in order to learn more appropriate parenting skills and begin to better understand child development. In reality, few of the parents were ever as fully involved as staff had anticipated or would have preferred.

Services provided for the children in residence included primarily the provision of a warm, secure and nurturing environment in which they could learn to trust and interact with adults and peers in a way that was previously difficult for them, due to their disruptive home situations. Few therapeutic services for the children were available until the third year when several new staff with clinical skills were hired. At this time, the Milieu Coordinator instituted play therapy sessions for the older children, an infant stimulation program for the babies, and in general, developed a more structured approach for identifying the individual children's developmental and interaction weaknesses and providing structured activities to remediate these.

Staff of the Children's Program included the Milieu Coordinator as Director, an early childhood teacher, seven foster grandparents, and three volunteers. These staff were all responsible for carrying out the individual plans for each child, and for providing general guidance and support to the children during their stay at the Center.

After a child was accepted at the Center, a treatment plan was developed by the Center staff, in conjunction with advice from outside consultants if necessary. This often included input from a hospital child psychiatrist who was closely affiliated with the project over its lifetime. Because the majority of the children were very young (under 2 years), the primary therapeutic interventions were infant stimulation excercises, encouragement in the use of age-appropriate "learning" toys and games, and the fostering of a caring, supportive relationship between the children and staff, particularly the foster grandparents whose task it was to interact with the children on a daily basis and provide both guidance and support for their activities. The few older children who were in residence in the program received more structured intervention directed at ameliorating identified developmental lags. These tended to be most pronounced in the areas of language and cognitive development, although numerous behavioral problems such as aggressiveness, hyperactivity and extreme anxiety were also present in the older children. During the third year, the older children were also involved in play therapy sessions on a weekly basis to help them deal with the many negative feelings they had about themselves and their current situations.

The strength of the Family Care Center was its provision of an alternative to foster care for these children who came from severely abusive environments, rather than the provision of any specific "therapy."

C. The Family Resource Center

The Family Resource Center (FRC), affiliated with St. Louis Children's Hospital, but located in a separate building and operated semi-autonomously from the hospital, provided therapeutic and educational services to parents with problems of child abuse and neglect and therapeutic and enrichment programs for some of these parents'

pre-school children. The services provided for parents included: crisis intervention, diagnosis and referral, individual counseling and therapy, assignment of parent counselors (similar to parents-aides who are available to provide 24-hour support services to individual families on an as-needed basis), group therapy, a Parents Anonymous group, and both group parent education classes and individual parent education classes.

The services available to children of the parents receiving services from FRC include child development classes, play therapy, and child care (while parents are at the Center). These latter services, which are of interest in this report, are more fully described below.

Early in the project's history, the children's staff, consisting of a children's program coordinator, a diagnostic teacher, a head classroom teacher and several volunteers, began a half-day child development class. This "morning" program accepted children between the ages of 2-1/2 and 5-1/2 who exhibited behavioral problems or developmental deficits based on scores of screening tests such as the Denver Developmental Screening Test or the Peabody Picture Vocabulary Test. Further criteria for acceptance included: one parent must have been willing to receive services from the Center as well; the family must be geographically accessible for Center transportation or ensure the child's attendance themselves, and the child could not have severe autism, hearing or visual problems.

Children received some screening tests before entry to the program which pointed out the areas in which the child might be having problems (e.g., language, motor skills, affective behavior), and also received other standardized tests such as the McCarthy Scales of Children's Ability, the Preschool Behavior Questionnaire, or the Vineland Scale of Social Maturity, after they had been participating in the program long enough to be comfortable with the test situation. These test results were used in combination with the observations of the children's staff to develop specific prescriptive goals for each child corresponding to problems observed; these were then worked on individually by staff and the child during a structured time period each day. The prescriptive goals for children stressed

primarily receptive and expressive language and fine or gross motor skill acquisition. Examples of the types of goals developed for a child might include "will correctly label a square, circle or triangle," or "will hop on one foot without support." Specific activities and tasks to be used in helping the child reach stated goals were then implemented, and as goals were reached, new ones were established.

In addition to this prescriptive portion of the program during which time each child worked on activities designed to help him/her reach stated goals, the remainder of the schedule of the morning classes resembled a normal pre-school or day care problem. There were both structured group activities such as breakfast, story time, and snacks, and individual activity time to pursue fine motor activities, art, gross motor activities, and free play. At these times the child was free to choose his/her own activity from the equipment provided, under the supervision of the classroom staff. Supplementing the provision of these activities to augment normal learning experiences was the emphasis of the staff on providing consistency in the children's lives (e.g., maintaining a structured schedule and enforcing minimal standards for acceptable behavior) and attention to the social/emotional problems of the children (e.g., fear of adults, inability to interact with peers). Thus, the morning developmental program sought not only to remediate the developmental problems of the children enrolled, but also to provide an atmosphere where the child could gain the emotional, interactional skills that would be important as the child got older.

During the second year of the project, a second class was developed for children ages 3-1/2 to 5-1/2 who exhibited specific behavioral rather than developmental problems. Although the original criteria for acceptance was that the child exhibit some definite emotional or behavioral problems either at home or in a day care setting, it was later found, surprisingly, that the first group of children, in the afternoon program, contrary to their parents' reports, exhibited virtually no real emotional or behavioral problems while in the Center's program. Criteria for acceptance was then shifted to one of the need of the parents to have their children in this type of program. Thus, the afternoon program in the final year provided a preschool enrichment

program, including such activities as group time, gross motor play, art activities, drama, singing, and supervised free play, as well as providing some relief to parents in crisis.

In addition to these two structured programs, FRC also provided play therapy to several children in need of a one-to-one relationship with a therapist to work on resolving specific problems. This was primarily provided to the older children of FRC adult clients.

SECTION III: CHARACTERISTICS OF THE CHILDREN, THEIR FAMILIES, AND THE SERVICES RECEIVED

A. Characteristics of the Children

In order to develop a profile of both the children receiving services from these projects and the familial situation from which they came, the following two tables present information on certain characteristics of the children and their parents.

Typically, the child receiving services from the project was a white male, between 2 and 7 years old who had been the victim of emotional abuse or neglect, or was in danger of being abused, as shown on Table II.1. The injuries tended to be mild or moderate, and few of the children were premature, adopted, mentally retarded or emotionally disturbed. The child was in treatment an average of nine months.

There are some differences among the projects worth noting. The Los Angeles project only served Black children while the others saw predominantly Caucasian children. The Los Angeles project also saw much younger children (almost 90% were under 3 years of age). Those children all were physically injured children or failure to thrive cases, with 66% having received moderate or severe injuries. Twenty-two percent of the children in the Los Angeles caseload were premature at birth, a common occurrence among this very poor Black population due to poor prenatal care. The Adams County project tended to serve older children (almost 50% were over 5 years old), close to half of whom were potential abuse cases.

B. Characteristics of the Family

Select information about their families is available for seven of the 17 children in Adams County and for 27 of the 44 children in St. Louis who received direct services from the project from data gathered for the Adult Client Component of this evaluation. No family data were available from Los

TABLE III.1: CHARACTERISTICS OF CHILDREN RECEIVING DIRECT SERVICES FROM THE PROJECTS

CHARACTERISTICS	Adams County (N=17)	Los Angeles (N=9)	St. Louis (N=44)	Total (N=70)
GENDER				
Female	35 %	33 %	41 %	39 %
Male	65	67	59	61
RACE				
Caucasian	94	--	70	67
Black	6	100	27	31
Other	--	--	3	2
AGE				
0-2 years	--	55.6	--	7.1
2-3 years	23.5	33.3	11.4	17.1
3-5 years	23.5	11.1	59.1	44.3
5-7 years	29.5	--	13.6	21.4
7-12 years	23.5	--	15.9	10.07
LENTH OF TIME IN TREATMENT (MONTHS)				
Average	9 mo.	9 mo.	8 mo.	9 mo.
Minimum	3 mo.	6 mo.	1 mo.	1 mo.
Maximum	17 mo.	14 mo	29 mo.	29 mo.
TYPE OF ABUSE/NEGLECT[1]				
Potential abuse	41	--	20	23
Potential neglect	--	--	--	--
Mild abuse	--	--	--	--
Mild neglect	--	--	5	--
Moderate abuse	--	--	--	--
Moderate neglect	18	--	2	6
Emotional abuse	12	--	41	29
Emotional neglect	--	--	25	16
Sexual abuse	--	--	2	9
Failure to thrive	24	22	2	5
Mild injury	24	11	23	14
Moderate injury	29	44	7	16
Severe injury	12	22	27	7
Sibling of abused	--	--	18	7
Unknown	--	--	5	1
SPECIAL CHARACTERISTICS				
Premature child	--	22.2	--	2.9
Adopted child	5.8	--	4.6	4.3
Multiple birth	--	--	2.3	1.4
Mentally retarded	11.7	--	2.3	4.3
Emotionally disturbed	17.6	11.1	--	5.7
Learning disabled	5.8	--	--	1.4

[1] Percentages may not sum to 100% since more than one category could be checked.

Angeles. These parents present a typical profile of families in which child abuse or neglect has occurred, as shown in Table III.2. Almost half the parents were abused themselves as children, and the same proportion of families have a teenage parent in the household. In a large proportion of cases (38%), no one in the family is employed. Close to three-quarters of the families include pre-school children, but few have more than three children. Although many of the families tend to be socially isolated, only 35% exhibited real family conflict according to the clinician keeping the parent's records. The parent(s) had been in treatment for an average of 16 months before or during which time some legal intervention was taken in the case.

The children served by the project and their parents tend to be quite similar in family composition, socioeconomic status and type of problems existing in the family to those served by all eleven demonstration projects, and to the families served by Protective Services Agencies in thirty states as reported to the American Humane (AH) in 1976, with a few exceptions. Close to 50% of the parents of the children in this sample reported being abused themselves as children, while only 21% of the demonstration evaluation adults, and 10% of the adults reported to AH reported a similar occurrence. Social isolation was a problem for 56% of the families in this group, but only 29% of the demonstration families and 14% of the families in the national sample were so isolated according to the data gathered.

Since there is little interpretation to be made of these differences, it must be concluded that, in general, these families and their children are quite similar to those being served across the country both in demonstration (or private) projects, as well as in the larger Protective Service Agencies. These similarities, particularly with respect to the type and severity of the maltreatment sustained by the child, raises interesting questions about the need for service among the remainder of the abused/neglected children in the country who are <u>not</u> receiving any direct therapeutic intervention, even though they have almost the same general characteristics as the group of children in this sample, whom clinicians believed required direct intervention.

TABLE III.2: DISTRIBUTION OF SPECIFIC FAMILY CHARACTERISTICS[1]

Characteristics	Adams County (N=7)	St. Louis (N=27)	Total
Parent was abused as a child	43%	48%	47%
Teenage parent in household	14	56	47
All known parents unemployed	14	44	38
Preschool children in household	57	70	68
Four or more children in household	14	4	6
Social isolation is a problem	29	63	56
Family conflict is a problem	43	33	35
Substance abuse is a problem	--	7	6
Legal intervention was required in case	100	56	65
Average length of time parent(s) in treatment	17.3 months	15.6 months	15.9 months

[1]Data was available on the families of the children receiving services for only 34 cases. This information, represents only a fraction of all the data available on all families (over 2000 cases), from the Adult Client Analysis component of the overall evaluation. For further information on the families, see Adult Client Impact Report, Evaluation of the Joint OCD/RSR Demonstration Projects in Child Abuse and Neglect, December, 1977.

C. Services Received

Table III.3 illustrates the proportion of children provided specific treatment or ancillary services from the projects and the average amount of those services which were received. By far, the greatest proportion of children were enrolled in child development programs (42.8%), and the next largest group received play therapy while at the projects (21.4%). Less than 15% of all children received any of the remaining services, although, obviously, there is wide variation among projects. Thus, many children in Adams county received a broad range of services (child development services, play therapy, individual therapy and therapeutic day care), while most children in St. Louis (66.6%), received primarily child development sessions. All children in Los Angeles were in residential care, and because of this, over 75% also received play therapy while housed at the Center.

The amount of a particular service received by the children also varied from project to project. Thus, on average children received child development sessions five times per month in Adams County, but children in St. Louis received the same service over thirteen times per month. Therapeutic day care in Adams was provided an average of 48 hours per month, but only averaged 23 hours per month in St. Louis; Los Angeles provided almost three times as many medical care units as did the other projects, primarily due to the young ages of the children and their residential status (i.e., all childhood illnesses were the responsibility of the Center). The remaining services were provided about the same number of times per month or over the course of treatment at each project.

Table III.3: SERVICES RECEIVED, BY PROJECT

SERVICE	Adams County		Los Angeles		St. Louis		Total	
	Percent Receiving	Average Amount Received	Percent Receiving	Average Amount Received	Percent Receiving	Average Amount Received	Percent Receiving	Average Amount Received
Child Development Sessions	23.5% (4)	4.5 times/mo.	--	--	66.6% (28)	13.3 times/mo.	42.8% (30)	12.5 times/mo.
Play Therapy	35.3 (6)	2.6 times/mo.	77.7% (7)	3 times/mo.	18.2 (8)	1.9 times/mo.	21.4 (15)	2.4 times/mo.
Individual Therapy	41.2 (7)	3.6 times/mo.	--	--	--	--	8.6 (6)	39.3 times/mo.
Residential Care	5.9 (1)	222 days during treatment	100.0 (9)	283 days during treatment	--	--	12.9 (9)	283 days during treatment
Therapeutic Day Care	23.5 (4)	48.2 hours/mo.	--	--	4.5 (2)	23.25 hours/mo.	5.7 (4)	191 days during treatment
Medical Care	5.8 (1)	1 visit during treatment	22.2 (2)	6.5 visits during treatment	9.1 (4)	2.7 visits during treatment	11.4 (8)	3.12 visits during treatment
Crisis Nursery	11.8 (2)	5 days/mo.						
Child Group Therapy					15.9 (7)	3.7 sessions/mo.	10.0 (7)	3.7 sessions/mo.

SECTION IV: PROBLEMS OF ABUSED/NEGLECTED CHILDREN AT INTAKE

Beyond the desire to profile these children and their parents socio-economically and according to major problems being experienced in the household, we were primarily interested in assessing the specific type of developmental or behavioral problems which the children exhibited when entering the project's caseloads. Many of the physical, emotional and psycho-social effects of child abuse/neglect on the child him/herself have been looked into by previous researchers in the field [Elmer and Gregg (1967, 1968); Bannatyne (1971); Harmon, Durfee and Klein (1976); Roth (1975); Morse et al. (1970); Millome and Laurie (1967); Eisenberg (1962); Greene (1968); Martin (1976)]. There have been, however, far too few longitudinal studies with sufficiently large samples of children to make generalizations about either the specific type of problems children who have been abused or neglected exhibit, or how effective various treatment modalities for these children seem to be. To date, the most far-reaching observations of the characteristics of abused and neglected children can be found in The Abused Child: A Multidisciplinary Approach to Developmental Issues and Treatment, by Harold Martin (1976). Based on the experiences of the National Center for Child Abuse in Denver, the chapters of the book (authored by different people) deal with such issues as the environment of the abused child, the personality of abused children, special problems in developmental assessment, and treatment approaches to children, often in anecdotal or summary form.

For this evaluation, data were collected on the problems which the children in the sample appeared to have at intake in the functional/developmental areas of Physical Growth and Development, Socialization Skills, Interaction Patterns with Family Members, and Cognitive/Language/Motor Skill Development. Specific behaviors or problems were delineated in the first three areas and clinicians recorded the existence of any problems as well as their severity. Standardized tests were employed to measure the status of cognitive/language/motor skill development of the children at intake.

The following tables present the proportion of children exhibiting specific problems at the time they entered the projects in various developmental or functioning areas by project and for the total sample of children.

A. Physical Growth and Development Problems

In general, the prevalence of specific physical problems at any of the given projects or for the sample of children as a group, is low except for Los Angeles, as shown in Table IV.1. Less than 15% of the total group had any specific physical problem, and fewer than 25% at either the Adams County or St. Louis projects had a specific physical problem. Many of the children in the sample, in fact, had no physical problem at intake as judged by clinicians. However, in Los Angeles over half of the children were underweight (below the third percentile) and exhibited specific problems around eating. Additionally, over one-third of the children in this project were below the third percentile in height and head circumference and had unusually prolonged or uncontrollable periods of crying. As noted before, these children tended to be more severely abused and were also younger than the remainder of the sample, which may account for the greater prevalence of physical problems in this group. Finally, it is interesting to note that in many cases, when the children did exhibit physical problems, they were as likely to be judged severe as mild, indicating that these are not akin to slight variations in physical development common to groups of children, but are, in fact, manifestations of serious physical problems.

B. Socialization Skill Deficits

Table IV.2 illustrates the areas of socialization skills judged by clinicians to be poorly developed (defined as below age-expectation) in the children. As can be seen, many more children had problems in these areas than had physical problems. The differences among the projects is not as clear in this instance, except that the Los Angeles project saw fewer children with aggressive behavior, again probably due to the younger ages of the children. Overall, the children in Adams County had more problems with individual socialization behaviors than did the other two projects.

TABLE IV.1: PROPORTION OF CHILDREN WITH PHYSICAL PROBLEMS AT INTAKE, BY PROJECT

Problem	Adams County	Los Angeles	St. Louis	Total Sample[1]		
				Mild	Severe	Total
Height	--	44.4% (4)	2.3% (1)	1.4% (1)	5.7% (4)	7.1% (5)
Weight	5.9% (1)	55.6 (5)	2.3 (1)	2.9 (2)	7.1 (5)	10.0 (7)
Head Circumference	5.9 (1)	33.3 (3)	--	--	5.7 (4)	5.7 (4)
Physical Defects	--	22.2 (2)	2.3 (1)	2.9 (2)	1.4 (1)	4.3 (3)
Sleeping Patterns	11.8 (2)	22.2 (2)	2.3 (1)	7.1 (5)	--	7.1 (5)
Eating Patterns	11.8 (2)	55.6 (5)	6.8 (3)	12.9 (9)	1.4 (1)	14.3 (10)
Malnutrition	5.9 (1)	22.2 (2)	4.5 (2)	4.3 (3)	2.9 (2)	7.1 (5)
Crying	17.6 (3)	33.3 (3)	6.8 (3)	12.9 (9)	--	12.9 (9)
Pain Agnosia	5.9 (1)	--	2.3 (1)	2.9 (2)	--	2.9 (2)
Pain Dependent Behavior	--	--	11.4 (5)	5.7 (4)	1.4 (1)	7.1 (5)
Psychosomatic Illness	17.6 (3)	--	2.3 (1)	2.9 (2)	2.9 (2)	5.7 (4)
Hyperactive	23.5 (4)	11.1 (1)	18.2 (8)	11.4 (8)	7.1 (5)	18.6 (13)
Tics/Twitches	11.8 (2)	22.2 (2)	11.4 (5)	10.0 (7)	2.9 (2)	12.9 (9)
Bites Nails	5.9 (1)	--	4.5 (2)	2.9 (2)	1.4 (1)	4.3 (3)
Poor Recuperation Following Physical Illness	--	--	4.5 (2)	1.4 (1)	1.4 (1)	2.9 (2)
	N = 17	N = 9	N = 44	N = 70		

[1]Determinations of problem severity were calculated only for the total sample due to the small number of cases at individual projects.

TABLE IV.2 : PROPORTION OF CHILDREN WITH SOCIALIZATION PROBLEMS AT INTAKE, BY PROJECT

SOCIALIZATION PROBLEMS	Adams County	Los Angeles	St. Louis	Total Sample		
				Mild	Severe	Total
Aggression	58.8% (10)	11.1% (1)	47.7% (21)	29.1% (19)	18.6% (13)	45.7% (32)
Apathy	41.2 (7)	55.6 (5)	40.9 (18)	32.9 (23)	10.0 (17)	42.9 (30)
Affection	47.1 (8)	77.8 (7)	47.7 (21)	42.9 (30)	8.6 (6)	51.5 (36)
General Happiness	58.8 (10)	66.7 (6)	43.2 (19)	35.7 (25)	14.3 (10)	50.0 (35)
Hypermonitoring	41.2 (7)	0	27.3 (12)	20.0 (14)	7.1 (5)	27.1 (19)
Attention Span	64.7 (11)	22.2 (2)	50.0 (22)	28.6 (20)	21.4 (15)	50.0 (35)
Accident Proneness	17.6 (3)	0	11.4 (5)	8.6 (6)	2.9 (2)	11.5 (8)
Ability to Protect Oneself	35.3 (6)	33.3 (3)	20.5 (9)	21.4 (15)	4.3 (3)	25.7 (18)
Sense of Self	82.4 (14)	66.7 (6)	40.9 (18)	42.9 (30)	11.4 (8)	54.3 (38)
Attachment/Detachment	82.4 (14)	88.9 (8)	25.0 (11)	31.4 (22)	15.7 (11)	47.1 (33)
Reaction to Frustration	82.4 (14)	77.8 (7)	50.0 (22)	44.3 (31)	17.1 (12)	61.4 (43)
Reaction to Change	47.1 (8)	66.7 (6)	36.4 (16)	32.9 (23)	10.0 (7)	42.9 (30)
General Interaction with Adults	76.5 (13)	44.4 (4)	52.3 (23)	40.0 (28)	17.1 (12)	57.1 (40)
General Interaction with Peers	88.2 (15)	44.4 (4)	68.2 (30)	54.3 (38)	15.7 (11)	70.0 (49)
	N = 17	N = 9	N = 44	N = 70		

[1]Determinations of problem severity were calculated only for the total sample due to the small number of cases at individual projects.

In general, a large proportion of the children in the total sample had socialization problems at intake, although fewer than 25% had a severe problem in any area. Over half the children exhibited problems in seven different areas, and among the remaining areas, with the exception of accident proneness, over 25% of the children showed some age-inappropriate behavior. The most common problems were in general interaction with adults (57%) and general interaction with peers (70%), illustrating again the inability of the majority of these children to deal with adults or children in ways that are acceptable, and, more importantly, are likely to secure for them the support and recognition necessary for adequate development of a healthy self-esteem. As has been noted often in the literature, many of the children displayed either aggressive or apathetic behavior (46 and 43%, respectively), often thought to be a direct response to the abuse/neglect recieved.

Again, many children exhibited multiple socialization problems, although no distinct patterns (i.e., one problem commonly occurring with another problem) were evident except for interaction with adult/peers, which frequently varied together. As with physical problems, many of the socialization problems were judged severe; over 15% of the children exhibited severe problems in five different areas of socialization skills.

C. Problems Interacting with Family Members

The prevalence of interactional and relational problems between family members, particularly the child in treatment and the parent(s) were widespread in the sample, as indicated in Table IV.3.

Over 40% of the children in both Adams County and Los Angeles exhibited problems in six or more of the ten possible areas; in Adams County no less than 70% of the children had problems at entry to the project in seven areas of family interaction. Clinicians in Adams County and Los Angeles believed that the parents' perception of the child's needs were inappropriate for every child provided services, and, in addition, as might be expected, the same was true, when assessing the parents' response to the child's needs, except for one family.

In general, the children at the St. Louis project exhibited far fewer problems in interacting with family members than did the children at either

TABLE IV.3: PROPORTION OF CHILDREN WITH FAMILY INTERACTION PROBLEMS AT INTAKE, BY PROJECT

PROBLEM AREA	Adams County	Los Angeles	St. Louis	Total Sample		
				Mild	Severe	Total
Weak Child/Parent Bond	76.5% (13)	77.8% (7)	22.7% (10)	22.9% (16)	20.0% (14)	42.9% (30)
Fearfulness Toward Parent	47.1 (8)	22.2 (2)	13.6 (6)	15.7 (11)	7.1 (5)	29.8 (16)
Responsiveness Toward Parent	70.6 (12)	33.3 (3)	38.6 (17)	25.7 (18)	20.0 (14)	45.7 (32)
Parent's Perception of Child's Needs	100.0 (17)	100.0 (9)	50.0 (22)	38.6 (27)	30.0 (21)	68.6 (48)
Parent's Response to Child's Needs	94.1 (16)	100.0 (9)	47.7 (21)	35.7 (25)	30.0 (21)	65.7 (46)
Child's Ability to Share Feelings	88.2 (15)	44.4 (4)	31.8 (14)	27.1 (19)	20.0 (14)	47.1 (33)
Provocative Behavior	70.6 (12)	11.1 (1)	45.5 (20)	31.4 (22)	15.7 (11)	47.1 (33)
Role Reversal	47.1 (8)	---	13.6 (6)	11.4 (8)	8.6 (6)	20.0 (14)
Differences from Parents' Expectations	88.2 (15)	55.6 (5)	50.0 (22)	38.6 (29)	21.4 (15)	60.0 (42)
Harsh Discipline	70.6 (12)	44.4 (4)	27.3 (12)	24.3 (17)	15.7 (11)	40.0 (28)
	N = 17	N = 9	N = 44	N = 70		

the Adams County or Los Angeles projects. One possible explanation of this is the different contexts in which the programs operate. In both Adams County and Los Angeles, staff had much more opportunity to observe the child interacting with the parent(s) than was possible at St. Louis, since at that project the child was most often seen only with other children in the treatment setting; because children were transported to and from the project in St. Louis, observations of the parents when dropping or or picking up children were also curtailed. Given the similarity in the prevalence of other types of children's problems among all three projects, this explanation seems slightly more plausible than one which ascribes significant variation between the population groups on these specific measures.

Although the proportion of children with family interaction problems for the total sample are smaller, given the effect of the St. Louis data, there are nonetheless some significant findings. Over 40% of the children had family interaction problems at intake in eight of the ten possible areas, and 60% or more had problems in three areas. Both a weak parent-child bond and provocative behavior on the part of the child have been hypothesized by experts in the field to be precursors to abusive/neglectful behavior; over 40% of the children in this sample had these problems. Again, it is worthwhile noting that, in many cases, the problems identified were as likely to be categorized severe as mild; these problems, then, do not appear to be similar to the relatively benign "friction" which occurs in many families, but rather more serious, perhaps more long-lasting and detrimental behaviors.

D. Cognitive, Language and Motor Skill Problems

The final area of functioning observed at intake to determine the children's problems was their acquisition of age-appropriate skills in cognition, language and both fine and gross motor activities.

No specific problems or characteristics related to these developmental areas were specified on the record keeping instrument due both to the difficulty of accurately identifying behaviors to assess and to the variation in skill acquisition at different age levels; rather, space for the clinicians' narrative comments both at intake and termination was provided. The paucity of narrative comments for individual children in these areas, however, leads

us to suspect that clinicians preferred to rely on standardized tests (often a battery of tests) to determine the functioning levels of the children in these areas, assuming them obviously to be more accurate than observation might be. Our analysis, then, also relies most heavily on these test results.

The validity of standardized test scores for abused and neglected children has come into serious question during the past several years. Clinicians working closely with these children have observed that the residual effects of the abuse or neglect sustained, particularly an acute "hypermonitoring" of adults, often preclude the child being able to give full attention to the test itself being, rather, much more concerned with the tester. This situation appears to depress their scores below what, in fact, is their actual ability. There are excellent discussions of this problem in Martin's book as well as in the Final Report of the Family Center in Adams County (17 of the children in this sample were served at that project). Since the evaluation staff was not present during the administration of the tests at the projects, we are, however, unable to adequately assess the extent or ramifications of the problem and therefore must rely on the scores as received by us. Caution, therefore, should be used in the interpretation of the following data, and, of course, no strict categorization of the "intelligence" of these children should be construed from these data.

Almost three-quarters of the children in the total sample received at least one standardized test; most, except for the nine very young children at Los Angeles, received several, including the Denver Developmental Screening Test, the McCarthy Scale of Children's Abilities, the Peabody Picture Vocabulary Test, and the Vineland Scale of Social Maturity.[1] Results of these tests for the group of children as a whole are summarized below.

---

[1]Several other tests, including the Weschler Intelligence Test for Children and the Pre-School Behavior Questionnaire were often administered in St. Louis and Adams County, but these were part of the projects' internal procedures and are not analyzed here.

Denver Developmental Screening Test

This test is not a standardized test of ability, but rather a screening instrument designed to identify whether a child's overall functioning appears to be within a normal range for his/her age group. Children are categorized roughtly as "normal," "questionable," and "abnormal."

Twenty-nine children were administered the Denver at intake. Of these, 19, or 65.5%, scored within normal limtis, five children (18.5%) were "questionable," and the same number were clearly "abnormal," indicating the need for additional testing to identify the specific areas in which the children were weak. Thus, 10 of the 29 children, or 34.5%, were outside the normal range for their age group when judged by this test.

McCarthy Scales of Children's Abilities

This test, appropriate for children ages 2-1/2 through 8-1/2, was administered to 38 children in the sample at, or shortly after, intake. The test provides scores in a variety of sub-test areas (verbal, perceptual-performance, quantitative, memory, motor), as well as a General Cognitive Index (GCI), combining the verbal, perceptual performance and quantitative score. The standardization of the test indicated a mean of 100 and a standard deviation of 16 for the GCI. The average scores and ranges of scores for the 39 children administered the test are presented in Table IV.4 by age group.

As can be seen from the table, the children are scoring lower than one standard deviation below the mean on two of the sub-tests, verbal and quantitative, and also on the General Cognitive Index, indicating below average functioning, technically classified in the dull-normal range. The ranges of scores are particularly interesting; in the perceptual performance area only one child scored over one standard deviation above the mean, while the lowest scores in three of the sub-tests were close to three standard deviations below the mean, indicating extremely delayed functioning. The same is generally true for the GCI; no child scored over one standard deviation above the mean, and the low scores were closer to 2-1/2 standard deviations below the mean, again indicating very poor functioning.

TABLE IV.4: DISTRIBUTION OF McCARTHY SCORES AT INTAKE BY AGE GROUP

Test Areas	2-3 years		3-5 years		5-7 years		7-12 years		Total	
Sub-tests	Mean Score	Range of Scores	Mean Score	Range of Scores	Mean Score	Range of Scores	Mean Score	Range of Scores	Mean Score	Range of Scores
Verbal	42	28-56	43	23-59	38	33-41	34	32-36	37	23-59
Perceptual-Performance	45	34-54	44	22-59	42	32-65	45	34-56	44	22-65
Quantitative	41	28-52	43	22-58	39	34-43	34	22-45	38	22-58
Memory	44	34-52	45	30-58	39	29-48	35	22-48	41	22-58
Motor (mean 50, S.D. 10)	44	25-63	43	22-65	42	31-64	39	25-53	42	22-65
General Cognitive Index (mean 100, S.D. 16)	87	60-99	90	66-112	79	73-88	76	63-88	83	60-112
	N = 8		N = 22		N = 6		N = 2		N = 38	

It is interesting to note that the lowest sub-test score was in the Verbal area, one area of abused and neglected children's functioning which has been shown by many researchers to be significantly delayed (Elmer, 1968; Martin, 1976). There were no significant differences in mean scores, or in the range of scores, among children of different age groups, although there was clearly some variation.

Peabody Picture Vocabulary Test

Twenty-nine children received this test at, or shortly after, entry into the projects. The test provides both an IQ score and a Mental Age score, although only the IQ scores were used in this analysis. The standardization of this test indicated a mean of 100 and a standard deviation of 15. The following scores were reported for the children administered this test.

Table IV.5: Peabody Picture Vocabulary Test Scores

	Ages 2-3		Ages 3-5		Ages 5-7		Ages 7-12		Total	
	Mean Score	Range of Scores	Mean Score	Range of Scores	Mean Score	Range of Scores	Mean Score	Range of Scores	Mean Score	Range of Scores
IQ Score	73	59-84	86	58-116	82	81-82	--	--	83	59-116
	N = 5		N = 22		N = 2		--		N = 29	

As compared to the scores on the McCarthy, the children administered the Peabody were also generally scoring lower than one standard deviation below the mean, but, again, not significantly below. In both the 2-3 and the 5-7 age groups, no child scored higher than one standard deviation above the mean, indicating generally poor functioning for all children in these groups.

Vineland Scale of Social Maturity

The Vineland Scale of Social Maturity relies on determining a child's abilities to carry out certain day-to-day tasks from answers provided by the child's parent; thus, for this group of children whose parent(s) often have inaccurate perceptions about the child to start, the result may not be as illuminating as the results of other tests. Twenty children were administered the test at intake; their scores follow.

Table IV.6: Vineland Scale of Social Maturity Test Scores

	Ages 2-3		Ages 3-5		Ages 5-7		Ages 7-12		Total	
	Mean Score	Range of Scores	Mean Score	Range of Scores	Mean Score	Range of Scores	Mean Score	Range of Scores	Mean Score	Range of Scores
IQ Score	81	68-93	92	53-143	95	75-114	--	--	89	53-143
	N = 2		N = 16		N = 2				N = 20	

The children receiving this test generally fared better, particularly in the older age groups, than did the children administered the other standardized tests. The mean score for the group as a whole is within normal limits, and although there was a wide range in scores (53 to 143) and some very low scores, there were more children scoring well above average than was true for the other tests, on which very few children scored in the higher ranges.

Bayley Scales of Infant Development

This test is appropriate for infants between the ages of 2 and 30 months. It provides both a Mental Development Index and a Psychomotor Index, each with a standardized mean of 100 and standard deviation of 16. Eight children at the Los Angeles project under 24 months of age were administered this test, although the testing did not occur until all of the children had been at the project for quite some time. These scores, then, cannot be considered an adequate representation of the children's functioning at "intake," but are presented here as indicators of a special group of children who were younger

and more seriously abused than the other children in the overall sample. The scores for these children on this test follow.

	Mean Score	Range of Scores
Mental Development Index	86	65-128
Psychomotor Index	69	<50-101

The cognitive functioning of these infants appears to be generally within normal limits; however, their psychomotor abilities are far below normal, on average almost two standard deviations below the mean. Eliminating the one child whose score was 101 on the psychomotor scale, the remaining children scored below 69, with one child whose raw scores were so low no index scale was able to be computed.

E. Discussion of Findings

The foregoing information presents a general profile of the problems the 70 abused and neglected children in this sample had when they entered the projects, which is entirely consistent with much of the research completed to date. By far the most important finding about the developmental and functional delays or deficits of these children at the time they entered the projects is that, as a group, they exhibit an extremely wide range of problems; there is no single area of functioning in which they are deficient, nor any specific behaviors within functioning areas which stand out as universally problematic, although certain dysfunctional behavior is evident in the majority of all children (or between child and parent) of all ages. There is, in short, no composite picture of "the" abused child, but, rather, a whole series of behaviors and problems which emerge for different children. This concept of the multiple emotional and developmental needs of abused children is perhaps best described in Harold Martin's book, The Abused Child. Running throughout the chapters in the book related to diagnosis, testing, developmental issues and treatment is the theme that:

> there is no one classical or typical personality profile for abused children. One does repeatedly see certain traits in many abused children which are quite striking, such as hypervigilance, anxiety, and diminished self-esteem. But all children are not alike. Some are cooperative; some are oppositional. Some are apathetic; some are hyperactive. Some are quite charming; others can be quite unpleasant (p. 107).

In all areas assessed for this evaluation, numerous problems of the children were evident; the functional areas of inquiry did not cluster together, nor did patterns emerge where a child with a certain problem or problems was also likely to have another problem as a matter of course. Both individual children and the sample as a whole had numerous problems in different functioning areas, but they were not the same problems.

Indeed, fewer children had specific growth or physical problems than had other developmental problems. When present, the problems were generally ones of erratic eating patterns, hyperactivity, presence of tics and twitches, and excessive or prolonged crying (in a few cases, crying problems were also the complete absence of crying behavior when it would have been appropriate).

Many more children exhibited problems around acquisition of socialization skills. Over 50% of the sample had either mild or severe problems in most of their interactions with peers and adults (70% of the children did not relate well with their peers), their reaction to frustration, their development of a healthy sense of self, their ability to give and receive affection, their attention span, and around issues of their general happiness. The prevalence of other socialization problems among these children ranged from 11.5% of the sample to close to 50%.

Family interaction patterns were also problematic for many of these children and their parents, particularly at the Adams County and Los Angeles projects. At these projects, over 50% of the family interaction patterns were marred by the parent's inappropriate perception of the child's needs and parent's response to those needs, a weak parent-child bond, and problems due to the child being different from the parent's expectation. Over 40% of the children also exhibited problems responding to his/her parent, sharing their feelings with others, or developing behaviors which were not provocative. Only 20% of the children showed any form of role reversal, a commonly referred-to behavior of abused/neglected children.

The children's cognitive/language and motor skill problems at intake appear widespread, but not always severe according to the results

of several standardized tests administered to the children at, or shortly after, they entered the projects. On the standardized tests with IQ scores, the group was generally scoring at or lower than one standard deviation below the mean indicating generally poor functioning, but not seriously delayed. When subtest scores were calculable, they were all relatively depressed; no one area was significantly more deficient than others, although verbal and language delays, often thought to be particular problems for these children, showed the lowest mean scores. The very young children in the Los Angeles project, in contrast to the older children at the other projects, appeared to be well within normal limits in terms of their mental development. They were, however, severely delayed with respect to psychomotor activities, scoring, on average, almost two standard deviations below the mean in psychomotor ability on the Bayley Scales of Infant Development.

These findings, again, point to the existence of varied, but pervasive problems for children who have been abused and neglected, not only in the more developmentally-based areas of cognitive, language, and motor skill abilities, but also in the more behaviorally-related areas of their abilities to interact with their parents and their socialization skills. The problems are numerous; many are of a mild type, but quite a few are of a more severe type which seriously jeopardize their ability to function adequately in future years.

V. Children's Progress During Treatment

As had been hypothesized at the outset of this study, the children who received direct services from the projects displayed numerous developmental/functional deficits and problems at the time they were accepted for treatment. These deficits cut across a variety of areas and were illustrated through numerous inappropriate behaviors which the children had developed, one suspects, as coping mechanisms to alleviate underlying anxiety about their lives and environments. Each of the projects was attempting to remedy these deficits through provision of therapeutic interventions using either a group or individual approach or a combination of these. As part of the evaluation, we were particularly interested in determining both the overall amount of progress the children made while in treatment and the specific problem areas which appear to be most amenable to positive influence in treatment programs such as these. We were also interested in learning what factors were associated either positively or negatively with the progress made.

A. Progress in Specific Problem Areas

The following three tables depict the changes in specific problems from intake to termination[1] in areas of physical growth and development, socialization skills and interaction patterns of family members for the sample of 70 children as a group. The categories for improvement are the same on each table and reflect the following definitions:

1) regressed -- the child's problem became worse (i.e., changed from "mild" to "severe" or the child developed the problem during the course of treatment);
2) no change -- the child's problem remained as it was at intake;
3) moderate improvement -- the child's problem was "severe" at intake and "mild" at termination.

---

[1]Not all children were terminated at the time of final data collection; clinicians, however, rated the children's behavior as if they were terminated and also administered the final battery of standardized tests. An analysis of the data from both children who had actually been terminated and those who had not showed no significant difference in the amount or direction of change, and thus the two groups are treated identically in these analyses.

4) major improvement -- the child's problem was remediated during the treatment period (i.e., went from "mild" or "severe" to "no problem").

Children who never exhibited the problems in question were excluded from the analysis; percentages reflect "the proportion of children with the specific problem that regressed, made no change, or improved."

Changes in Physical Problems

As Table V.1 portrays, there is very mixed improvement among the children in overcoming specific physical problems, even though the largest number of children with any specific problems was only 13. In ten of the 15 problem areas, at least half the children made either moderate or major improvements, with total remediation of the problems for over 50% of the children occurring in areas of low height and head circumference, poor eating patterns, malnutrition, and pain dependent behaviors. There are, however, several areas, such as physical defects, sleeping patterns, excessive crying, pain agnosia, pain dependent behavior, and poor recuperation following physical illness in which over half the children with these problems at intake made no progress or actually regressed by the time they were terminated.

In at least two categories, physical defects and poor recuperation following illness this finding is to be expected since most of these problems would be unlikely to be remediated by the types of services provided by these projects. However, there is no additional information available with which to interpret the other findings, especially for those children who appeared to regress during treatment. One possible explanation is that a child's actual physical problems were not completely diagnosed at intake, but were subsequently discovered and rated on the forms; this would cause a "regressed" rating to be given in that problem area. It is equally plausible, however, that some problems in fact become more pronounced over time.

In general, the conclusion must be that, although the projects were successful in making moderate to major improvements in many of the children with physical problems, over one-third of the children made no gains or regressed in fully 13 of the 15 areas in which they had problems at intake.

TABLE V.1

FREQUENCY DISTRIBUTION OF CHILDREN'S CHANGE IN PHYSICAL PROBLEMS FROM INTAKE TO TERMINATION FOR ALL CASES

Physical Problem	Regressed	No Change	Moderate Improvement	Major Improvement
Height	16.7% (1)		16.7% (1)	66.7% (4)
Weight	12.5 (1)	25.0 (2)	25.0 (2)	37.5 (3)
Head Circumference	--	25.0 (1)	--	75.0 (3)
Physical Defects	25.0 (1)	50.0 (2)	--	25.0 (1)
Sleeping Patterns	37.5 (3)	25.0 (2)	--	37.5 (3)
Eating Patterns	28.6 (4)	7.1 (1)	--	64.3 (9)
Malnutrition	--	--	--	100.0 (5)
Crying	27.3 (3)	27.3 (3)	--	45.5 (5)
Pain Agnosia	33.3 (1)	33.3 (1)	--	33.3 (1)
Pain Dependent Behavior	37.5 (3)	12.5 (1)	--	50.0 (4)
Psychosomatic Disorders	20.0 (1)	20.0 (1)	40.0 (2)	20.0 (1)
Hyperactive	7.7 (1)	38.5 (5)	15.4 (2)	38.5 (5)
Tics, Twitches	--	44.4 (4)	11.1 (1)	44.4 (4)
Bites Nails	--	33.3 (1)	33.3 (1)	33.3 (1)
Poor Recuperation Following Physical Illness	66.7 (4)	--	--	33.3 (2)
	Total N = 70			

Changes in Socialization Problems

A much higher proportion of children with socialization problems at intake made moderate or major improvements toward resolving those problems than did children with physical problems, as shown in Table V.2. Fifty percent or more of the sample were improved in all problem areas except accident proneness, and in six of the 15 areas, over half the children's problems were completely remediated. As with physical problems, however, there were still sizable numbers of children, approaching 50% in some instances, who made no gains or regressed during treatment. Some of these findings are surprising in that they occurred in problem areas that one might have expected the treatment strategies employed to have been quite successful, such as problems with aggression, sense of self, attachment/detachment, reaction to frustration and change, and general interaction with adults and peers. However, as with all problemmatic human behavior, particularly among children, both the underlying causes and the child's reactions to a variety of situations, including an abusive/neglectful environment, are highly complex interrelationships of variables, only some of which are either identifiable or able to be remediated, particularly when clinicians are only working with the children for a fraction of the day over relatively short time periods.

It is also interesting to note that, although often alluded to in the literature, there did not appear to be a large number of children exhibiting the classic apathy/aggression reversal while in treatment; rather, about half the children exhibiting these behaviors at intake improved and slightly less than half stayed the same or regressed (more apathetic children improved than did aggressive children). There was, however, little to suggest that originally aggressive children became apathetic while in treatment or vice versa.

Changes in Family Interaction Problems

There was major or moderate improvement in the family interaction problems which were evident at intake for many of these children and their parent(s) as shown in Table V.3. In over 50% of the families with problems related to weak parent-child bonds, fearfulness toward parents, the child's ability to share feelings, role reversal, differences from parents' expectations and harsh discipline

TABLE V.2

FREQUENCY DISTRIBUTION OF CHILDREN'S CHANGE IN SOCIALIZATION SKILLS PROBLEMS FROM INTAKE TO TERMINATION FOR ALL CASES

Socialization Problems	Regressed	No Change	Moderate Improvement	Major Improvement
Aggression	11.1% (4)	30.6 % (11)	25.0% (9)	33.3% (12)
Apathy	9.1 (3)	15.2 (5)	12.1 (4)	63.6 (21)
Affection	5.3 (2)	15.8 (6)	2.6 (1)	76.3 (29)
General Happiness	12.8 (5)	20.5 (8)	10.3 (4)	56.4 (22)
Hypermonitoring	--	15.8 (3)	10.5 (2)	73.7 (14)
Attention Span	5.6 (2)	36.1 (13)	16.0 (6)	41. (15)
Accident Proneness	27.3 (3)	36.4 (4)	9.1 (1)	27.3 (3)
Ability to Protect Oneself	15.0 (3)	15.0 (3)	--	70.0 (14)
Sense of Self	11.9 (5)	31.0 (13)	9.5 (4)	47.6 (20)
Attachment/Detachment	8.3 (3)	38.9 (14)	8.3 (3)	44.4 (16)
Reaction to Frustration	4.5 (2)	45.5 (20)	15.9 (7)	34.1 (15)
Reaction to Change	16.7 (6)	30.6 (11)	11.1 (4)	41.7 (15)
General Interaction with Adults	4.9 (2)	29.3 (12)	17.1 (7)	48.8 (20)
General Interaction with Peers	3.9 (2)	37.3 (19)	7.8 (4)	51.0 (26)
	TOTAL N = 70			

TABLE V.3

FREQUENCY DISTRIBUTION OF CHILDREN'S CHANGE IN PROBLEMS IN INTERACTING WITH FAMILY MEMBERS FROM INTAKE TO TERMINATION FOR ALL CASES

Interaction Problem	Regressed	No Change	Moderate Improvement	Major Improvement
Weak Child/Parent Bond	12.5% (4)	37.5% (12)	18.8% (6)	31.3% (10)
Fearfulness Toward Parent	21.1 (4)	26.3 (5)	15.8 (3)	36.8 (7)
Responsiveness Toward Parent	14.7 (5)	38.2 (13)	17.6 (6)	29.4 (10)
Parent's Perception of Child's Needs	4.2 (2)	54.2 (26)	14.6 (7)	27.1 (13)
Parent's Response to Child's Needs	8.5 (4)	51.1 (24)	17.0 (8)	23.4 (11)
Child's Ability to Share Feelings	8.8 (3)	35.3 (12)	11.8 (4)	44.1 (15)
Provocative Behavior	14.7 (5)	38.2 (13)	11.8 (4)	35.3 (12)
Role Reversal	12.5 (2)	37.5 (6)	6.3 (1)	43.8 (7)
Differences From Parents' Expectations	15.2 (7)	26.1 (12)	19.6 (9)	39.1 (18)
Harsh Discipline	10.3 (3)	27.6 (8)	3.4 (1)	58.6 (17)
	TOTAL N = 70			

used as a matter of course, these problems were somewhat improved by the time the child was terminated. Only in the case of harsh discipline, however, did more than 50% of the families achieve complete remediation of the problem. In the remaining areas, from 23% to 44% of the families and children saw the early problems completely eliminated.

Except for fearfulness toward parents, less than 15% of the families and children regressed on any family interaction measure, but there was "no change" in status of interaction problems for between 26% and 54% of the families on all measures. In the areas of parent's perception of child's needs and parent's response to child's needs, there was no change in problem status for over 50% of the families; this is somewhat surprising since one would assume most of the parent's would have been provided substantial guidance in changing these aspects of their behavior while receiving treatment themselves from the demonstration projects.

Changes in Cognitive/Language/Motor Skill Problems

Analyzing actual changes in these children's delays related to cognition, language, and motor skills through assessment of standardized test scores is difficult for several reasons. The first, as mentioned previously, is related to their general inability, as a group, to perform adequately on these types of tests, not necessarily because of any inherent deficits (although this may be the case), but because of a hypervigilance which colors all their interactions with adults. This hypervigilance, however, seems to recede in some cases after sufficient exposure to the tester and test situation; thus, positive gains seen may be the result of this lessening anxiety rather than any real gain in ability, or, the gains may signify actual change. It is precisely this inability to differentiate between interpretations of the findings which makes reliance on standardized tests as a yardstick of functioning for these children very risky.

The second problem, relevant only to this particular sample of children, is that not all children received termination tests, and of those who did, not all children received the same test or tests they had been administered at intake. In the interest of accurate analysis, we were able only to compare the intake and termination scores of children who received the same

test(s) at both points in time, thereby limiting somewhat the strength of the analysis due to small sample sizes. However, since the direction and approximate magnitude of change was similar for all test scores looked at, there can be slightly more confidence in the results.

At intake 29 children received the Denver Developmental Screening Test. Of these, 65.5% were judged "normal," 18.5% were "questionable" and 18.5% were "abnormal." Seventeen of these children were administered this test at termination; 12 children or 70% were rated "normal," two children or 11.8% were "questionable," and three children or 17.6% were "abnormal." Thus, very little improvement had been made by the children between the time of intake and termination for those children with problems, although fewer than 35% of the children tested at either time were, in fact, scoring below what would be considered "normal" for their age.

The Vineland Scale of Social Maturity was administered to 20 children at intake. The mean I.Q. score for these children was 89, generally within normal limits; however, the range of scores was from 53 - 143, and many of the children were scoring below normal limits on the test at intake. Only four of the original children receiving the Vineland test at intake were re-administered the test at termination. The average termination score was 99, reflecting a mean change of 12.5 points (these four children's mean score at intake was 86.5, lower than the average for all 20 children administered intake tests). Although the sample is extremely small, the gain of over 12 points represents a sizable increase in functioning ability from the time they entered the project.

The McCarthy Scales of Children's Abilities was administered at intake and termination to thirteen children. As Table IV.4 illustrates, there were mixed changes among the children in sub-test areas, but the General Cognitive Index (a composite of the verbal, perceptual performance and quantitative scores) indicated a gain of 4.4 points. Although statistically significant, this change does not signify a major gain for the children from intake to termination. As contrasted with the whole sample of 38 children receiving the McCarthy at intake, this group of 13 children was generally scoring within or very close to a normal range for their age, at intake. All scores at intake were within one standard deviation from the standardized mean of the tests except for the verbal and

quantitative sub-test scores which were only two-tenths of one point below this range. At termination, all scores were within one standard deviation from the mean. Reasons for the differences between the mean score change for sub-test areas, which ranges from -2.1 to 4.4, are unclear, although the variation is small. In particular, there is no explanation for a drop in mean score on the memory sub-test.

TABLE V.4

CHANGE IN McCARTHY TEST SCORES FROM INTAKE TO TERMINATION (N=13)

SUB-TEST	AVERAGE INTAKE TEST SCORE	AVERAGE TERMINATION TEST SCORE	AVERAGE CHANGE IN TEST SCORES
Verbal	39.8	41.2	1.4
Perception Performance	42.3	46.3	4.0
Quantitative	39.8	40.9	1.1
Memory	42.3	40.2	-2.1
Motor	40.3	43.0	2.7
GCI	84.6	89.0	4.4

Perceptual performance t = 2.82 sig. at .01.
GCI t = 2.73 sig. at .025.
All others not significant.

In order to determine differences among groups of children in terms of the gains made on the McCarthy, another method of analyzing these scores was devised. Children were grouped into three classes based on their intake and termination scores on the General Cognitive Index since this is the most representative score for this test. The groupings were "low" (score of less than 84), "medium" (84-100) and "high" (greater than 100). These cut-off points were chosen because they correspond to the standard deviation for the test, representing normal limits for the standardizing sample. We were interested in knowing whether those children originally scoring at different levels showed differential scores at termination. The following table (Table V.5) illustrates the results of this analysis.

As can be seen, of those children who scored low at intake, 72.7% still scored low at termination, but 27.3% had improved their scores to a medium or average range. There was no change in scores for 81.8% of the children originally scoring in the "average" category at intake; one child's score, however, placed him in the low category at termination, while another had moved into the "high" category. All of the children scoring in the high category at intake similarly scored high at termination. Thus, the greatest gains while in treatment were made by children who had originally scored low on the test; over 25% of these children improved their score at termination. In the other categories, most children's scores remained relatively stable, with gains and losses balancing each other out in the two cases where they occurred.

Twenty-nine children received the Peabody Picture Vocabular Test at intake. Their mean I.Q. score was 83, 2 points lower than one standard deviation below the mean. Twenty children were subsequently retested at termination; these children had gained an average of 10.1 (average termination score=93.3) points during treatment, bringing them well within the normal range for the test.

The analysis of changes in test scores by categories of intake scores (as above) was conducted on the I.Q. scores of the children receiving the Peabody at intake and termination, but a change was made in the cut-off scores for category definitions to correspond to a standard deviation of 15 for this test.

TABLE V.5

CHANGES IN McCARTHY TERMINATION TEST SCORES

BY CLASS OF INTAKE SCORE

Termination Test Scores	Intake Test Scores		
	Low (Less than 84)	Average (84-100)	High (More than 100)
Low (Less than 84)	72.7% (8)	9.1% (1)	0
Average (84-100)	27.3 (3)	81.8 (9)	0
High (More than 100)	0	9.1 (1)	100.0% (3)

Chi-squared = 19.28 sig. at .01.

TABLE V.6

CHANGES IN PEABODY TERMINATION TEST SCORES

BY CLASS OF INTAKE SCORE

Termination Test Scores	Intake Test Scores		
	Low (Less than 85)	Average (85-100)	High (More than 100)
Low (Less than 85)	43.8% (7)	0	0
Average (85-100)	50.0 (8)	25.0% (1)	0
High (More than 100)	6.3 (1)	75.0 (3)	100.0%

Chi-squared = 10.71 sig. at .05.

Table V.6 shows the results of this analysis. As can be seen, although the general trend is the same, the relationships are much stronger in the case of these scores. Over half of the children originally scoring low scored in the average or high category at termination and the scores of three of the four children who had scored in the average category at intake now placed them in the high category. As with the scores on the McCarthy, none of the original high scorers had regressed at the time of the test's re-administration; in fact, none of the children receiving tests both at intake and termination showed a regression when looked at in these categories (although some children may have regressed according to raw scores).

None of the children originally receiving the Bayley Scales of Infant Development had that test repeated at termination, so no data on changes in their functioning relative to psychomotor skills or mental development is available for this group of very young children at the Los Angeles project.

B. Variables Affecting Progress While in Treatment

Having identified both the overall gains and losses in the various functioning areas and the specific problem areas in which children were more likely to make progress, we were interested in looking at whether certain variables were associated with these gains and/or losses. In particular, we were interested in knowing whether the seriousness of the case at intake, the reincidence of abuse or neglect while receiving services, or the length of time in treatment were related to the amount of progress made by the child (or the child/family unit). For these analyses we looked specifically at changes in the areas of improved physical growth and development, socialization skills, and family interaction patterns, since the data in these areas provided much more specific information on "amount" of improvement than does the general I.Q. or similar score on standardized tests.

Tables V.7-9 illustrate the relationship of the seriousness of the case at intake and problem improvement. Of those cases in the sample that were serious at intake and had physical problems, an equal proportion (33.3%) made gains in the low, medium and high categories. A much higher percentage of the cases that were not serious at intake, however, were highly improved at termination (58.8%) than fell into the other categories (21.1% in each category). Thus, the non-serious cases were more likely to improve on a

TABLE V.7

PERCENT DISTRIBUTION OF IMPROVEMENT IN PHYSICAL PROBLEMS BY SERIOUSNESS OF CASE

Physical Problems	Serious Case No	Yes	Unknown
Low Improvement (0-25%)[1]	21.1 (4)	33.3 (5)	50.0 (1)
Moderate Improvement (26-75%)	21.1 (4)	33.3 (5)	0
Major Improvement (76-100%)	58.8 (11)	33.3 (5)	50.0 (1)

Not significant

[1]Percentages refer to the proportion of problems identified at intake which were improved upon by termination.

TABLE V.8

PERCENT DISTRIBUTION OF IMPROVEMENT IN SOCIALIZATION PROBLEMS BY SERIOUSNESS OF CASE

Socialization Problems	Serious Case No	Yes	Unknown
Low Improvement (0-25%)[1]	8.1 (3)	21.7 (5)	50.0 (1)
Moderate Improvement (26-75%)	48.6 (18)	43.5 (10)	0
Major Improvement (76-100%)	43.2 (16)	34.8 (8)	50.0 (1)

Not significant

[1]Percentages refer to the proportion of problems identified at intake which were improved upon by termination.

TABLE V.9

PERCENT DISTRIBUTION OF IMPROVEMENT ON INTERACTION PROBLEMS BY SERIOUSNESS OF CASE

Interaction Problems	Serious Case No	Yes	Unknown
Low Improvement (0-25%)[1]	41.4 (12)	37.5 (9)	100.0 (1)
Moderate Improvement (26-75%)	24.1 (7)	33.3 (8)	0
Major Improvement (76-100%)	34.5 (10)	29.2 (7)	0

Not significant

[1]Percentages refer to the proportion of problems identified at intake which were improved upon by termination.

large proportion of the physical problems they had at intake than were serious cases.

Looking at the seriousness of the case in relationship to socialization problems, the trend is the same, although the relationship is not as strong. A higher proportion of the non-serious cases (91.8%) made moderate or major improvements in their diagnosed problems than did the serious cases (78.3%), and, conversely, 21.7% of the serious cases showed minimal improvements compared with 8.1% of the non-serious cases.

The seriousness of the case, however, has little relationship to the distribution of improvement on interaction patterns with family as shown in the last table. In this case, about the same percentage of cases showed low improvement and high improvement whether or not the case was a serious one at intake. A lower proportion of non-serious cases (24.1%) showed moderate improvement than did serious cases.

Thus, in general, only improvements in physical problems show any strong relationship to the seriousness of the case, with a relatively higher proportion of non-serious cases achieving major improvement in this problem area than non-serious cases; the findings, however, were not statistically significant.

Another factor often assumed to have a negative effect on improved outcome is reincidence of abuse or neglect while the child is in treatment. The following tables (Tables V.10-12) illustrate the relationship between different ranges of improvement and whether or not reincidence occurred (as judged by the clinicians) in areas of physical, socialization skill and family interaction problems. As with the analysis of the seriousness of the case, only improvements in physical problems showed a strong relationship to reincidence and, in this case, only in the category of major improvement where 62.5% of the cases in which no reincidence occurred showed major improvements, compared to only 36.4% of the cases where reincidence did occur. However, if the moderate and major improvement categories are combined, the relationship is reversed and a higher proportion of cases in which reincidence occurred show moderate/major improvement than cases in which no reincidence occurred. In areas of socialization problems and family interaction patterns, there is very little difference in improvement whether or not reincidence occurs; this generally holds if the three "improvement" categories are looked at separately or if moderate and major improvements are combined. Thus,

TABLE V.10

PERCENT DISTRIBUTION OF IMPROVEMENT IN PHYSICAL PROBLEMS BY REINCIDENCE

Physical Problems	Reincidence No	Yes
Low Improvement (0-25%)[1]	31.3 (5)	18.2 (2)
Medium Improvement (26-75%)	6.3 (1)	45.5 (5)
High Improvement (76-100%)	62.5 (10)	36.4 (4)

Chi-squared = 6.03 sig. at .05.

[1]Percentages refer to the proportion of problems identified at intake that were improved upon by termination.

TABLE V.11

PERCENT DISTRIBUTION OF IMPROVEMENT IN SOCIALIZATION PROBLEMS BY REINCIDENCE

Socialization Problems	Reincidence No	Yes
Low Improvement (0-25%)[1]	13.2 (5)	26.6 (4)
Medium Improvement (26-75%)	50.0 (19)	40.0 (6)
High Improvement (76-100%)	36.8 (14)	33.3 (5)

Not significant

[1]Percentages refer to the proportion of problems identified at intake that were improved upon by termination.

TABLE V.12

PERCENT DISTRIBUTION OF IMPROVEMENT IN INTERACTION PROBLEMS BY REINCIDENCE

Interaction Problems	Reincidence No	Yes
Low Improvement (0-25%)[1]	46.6 (14)	37.5 (6)
Medium Improvement (26-75%)	26.6 (8)	25.0 (4)
High Improvement (76-100%)	26.6 (8)	37.5 (6)

Not significant

[1]Percentages refer to the proportion of problems identified at intake that were improved upon by termination.

overall, reincidence of abuse or neglect does not appear to be a good indicator of how much improvement the child will make while receiving direct treatment services.

Finally, we were interested in determining whether the length of time the child was in treatment was associated with overall improvements in functioning. In this case, the presence or absence of improvements were calculated in the areas of physical, socialization and family interaction pattern problems combined, and the correlation of both the number and percentage of total problems improved on while in treatment were calculated. The correlation of number of problems improved on and length of time in treatment was -.182, while the correlation of the percentage of problems improved on and length of time in treatment was -.142. Both of these are very weak associations, although it is interesting that the correlations are negative, indicating that children are somewhat less likely to improve the longer they are in treatment. One obvious explanation for this finding is that the children who are in treatment the longest receive services over a longer time period than other children precisely because their problems have not improved significantly, or they were more serious to begin with. The lack of qualitative information on this hypothesis precluded any testing to determine whether or not this was the case.

C. Discussion of Findings

The conclusions to be reached from the foregoing analysis of the relative amount and specific areas of problem improvement while the sample of children were in treatment are not overly positive; neither, however, do they present a bleak picture for either the usefulness or necessity of providing direct therapeutic intervention for children who have been abused and/or neglected by their parents. While there was not complete amelioration of the majority of these children's problems during the course of treatment, in fact, many of the children were seen to have made substantial strides toward overcoming a whole series of problems which they had upon entry to the projects. Over half the children with physical problems at intake improved on two-thirds of the problem areas assessed, with major

improvements being noted for a majority of the children in areas of height and head circumference deficits and problems with malnutrition and eating patterns.

Analysis of gains made toward overcoming problems in both socialization skill development and family interaction patterns showed an even greater proportion of the children making moderate or major improvement in almost all behaviors assessed. Over half of the children with socialization problems at intake improved relative to their original behavior in 14 of the 15 areas looked at, and over 70% of the children who were apathetic, could not give or receive affection, were hypervigilant, or could not protect themselves made advances in these problem areas during treatment. And, finally, over 50% of the children had improved interaction with family members in half of the measures used to assess this problem area. The most significant increases were related to the child's ability to share his/her feelings and a reduction in the parent's use of harsh discipline as a matter of course.

There were, as has been shown, some children whose problems became worse while they were in treatment, but the proportions were generally under 25% and all of these problems but one were in areas of physical growth and development.

There were also a number of children (larger than the number of children who regressed) whose status for a variety of problems did not change while in treatment. Many of these problems, again, were physical problems, including the presence of physical defects, hyperactivity and the presence of tics or twitches, but some were in patterns of family interactions such as the parent's perceptions of the child's needs and subsequent response to those needs, presence of a weak parent/child bond and provocative or role/reversal behavior on the part of the child.

Some gains were also made by the children in terms of enhanced cognitive, language and motor skills as measured by standardized tests. The mean score increases on the tests from intake to termination were, in many cases, large enough to move the children from borderline categories into categories of "normal" functioning for their age group. On both the McCarthy and Peabody tests, those children who had scored in the low range originally appeared able to make significant progress, and only one child regressed on these tests if analyzed in categories of improvement.

Several factors, including the seriousness of the case at intake, reincidence of abuse/neglect while the child was receiving services, and the length of time in treatment were shown to be poor predictors of how much a child would improve in select problem areas, although non-serious cases have a significantly greater chance to make major improvements in physical problem resolution than do serious cases.

In much the same way that the children in this sample exhibited a wide range of different problems at intake, so they appear to have very different patterns of "improvement" while receiving treatment; some improved a great deal with most of their problems, while others seem to make little or no progress. Some made consistent gains or losses across a variety of problem areas, while others made major improvements in some areas, but regressed or stayed the same in others. Although it was not possible to analyze which of the various services provided were more or less effective for reducing specific types of problems, it is clear that different types of services will need to be made available for many abused/neglected children if they are to be assisted in overcoming most or all of the deficits they have upon entry into treatment.

VI. CONCLUSIONS AND IMPLICATIONS

Children who have been abused and neglected have a number of emotional, developmental, and psycho-social delays or deficits as a result of the abuse/neglect sustained, and the generally deprived environments in which they are growing up. They have specific problems in numerous functional areas: physical growth and development, socialization skills and behavior, interaction patterns with family members, and cognitive, language, and motor skill development.

In order to begin to remedy these deficits in a meaningful way, child abuse and neglect programs need to make available, either directly or by contact/referral, specific therapeutic services for children in addition to services to parents. Although most existing high quality programs for children with general emotional or developmental delays would probably provide an adequate setting for dealing with these children's problems, some specific considerations related to the abused/neglected child's particular background and situation should be considered in developing therapeutic services for them. These considerations include:

- Breadth of Problems: Abused/neglected children exhibit problems in a wide range of areas, not only in developmentally related areas such as language, cognitive, and motor skills, but also in the more emotionally related areas of socialization skills with adults and peers and interaction patterns with family members. Almost as many of these problems are "severe" as are considered "mild". Programs must be able, therefore, to provide a variety of interventions, with different goals, in order to deal with the different types of problems they are likely to encounter among the children they are serving.

- Specific Behaviors: Although the breadth of problems is wide, there are some common behavioral characteristics which are likely to influence service provision and effectiveness; these include an overly aggressive or apathetic posture, extreme anxiety and hypervigilence

which is likely to depress the child's scores on standardized tests, an inability to relate to either adults or peers in any acceptable manner, a very poor relationship with their parents which may preclude enlisting much support in the therapeutic process from the parents.

- Coordination of Parent and Child Interventions: Because many of the problems exhibited by the children are the result of their environmental situations, particularly their relationship with the parent(s), treating either the parent(s) or the child alone is unlikely to be effective. Although separate service strategies are required for each, coordination between service providers, such that each understands what the other is attempting to accomplish is likely to be more effective than services provided totally independently of each other.

- Effectiveness of Services: Many problems of these children are not able to be remidiated during the therapeutic process; projects should not expect to have complete success with all children, but rather strive for maximum effectivenesss while realizing their limitations due to the actual amount of time they are able to spend with the children. The seriousness of the case at intake, reincidence of abuse or neglect while the child is in treatment or the length of time in treatment have not been shown to be good predictors of how well a child will progress.

As mentioned previously, services to ameliorate the problems being experienced by abused and neglected children need to become a part of every communities' strategy of dealing with problems of child abuse and neglect. Some of the required services (child development or play therapy programs) may already exist under the auspices of agencies other than Child Protective Services or child abuse and neglect projects in some communities; in this case referral and financing mechanisms should be developed to make maximum use of these services for abused and neglected children. In other communities, few resources for therapeutic intervention with children are currently available and new programs will need to be developed.

Providing the types of services in sufficient quantity and with attention to quality which are necessary to ameliorate many of the problems which plague abused and neglected children is both a time-consuming and costly endeavor. The following table depicts the average annual volume of services provided, the average unit costs of these services, and the annual project costs at each of the three projects included in this study (Table VI.1).

As can been seen, there is wide variation in the unit costs, much of which can be attributed to the effects of the addition of voluntary contributions (either time, dollars or equipment/facilities) that some of the projects were able to foster. Despite this variation, however, some costs are routinely going to be high. Residential care, at $35.94 per child-day represents a very expensive outlay if, as in the case of Los Angeles, up to 10 children are to be cared for over several months. Psychological testing at the projects ranged from a low of $.44 to over $55; the low figure representing almost total contributed services, and the high figure representing the cost of contracting with an outside specialist to administer developmental tests to all children in residence at the Center. The variation in unit costs of other servies (child development programs, play therapy and medical care), which run as much as $10 per unit difference, reflect mostly differences in staff salary, intensity of service provision, or actual charges (medical care).

Despite what appears to be high costs for some of these services, they are quite likely comparable to costs of operating day-treatment services for non-abused or neglected children with psychological deficits, and/or developmental delays, categories in which, based on the previous analysis, these children clearly belong. The costs are also obviously lower than the costs of foster care and/or institutionalization of these children, which for many of them, would be a likely alternative if both they and their parents were not receiving intensive therapeutic services to curb the abusive/neglectful behavior and help these children overcome their resulting handicaps. And finally, the future costs to the community in terms of caring for these children--special education programs, long-term intensive psychotherapy, curbing

TABLE VI.1: AVERAGE COSTS OF SERVICE, BY PROJECT

	Adams County			Los Angeles				St. Louis	
Service	Average Volume	Average Annual Unit Cost[b]	Average Annual Cost[b]	Average Volume	Average Annual Unit Cost	Average Annual Cost	Average Volume	Average Annual Unit Cost	Average Annual Cost
Child Development Program	264 child-sessions	$ 6.71	$ 1,771	1860 child-sessions	$16.16	$30,058	3420 child-sessions	$ 5.96	$20,383
Play Therapy	120 child-sessions	13.16	1,579	120 child sessions	3.18	382	192 child-sessions	5.24	1,006
Crisis Nursery	1524 child-days	12.63	19,248	--	--	--	-	--	--
Residential Care	--	--	--	2484 child-days	35.94	89,275	--	--	--
Psychological/Other Testing[c]	96 person-tests	.44	42	48 person-tests	55.96	2,686	216 person-tests	8.31	1,795
Medical Care[c]	396 visits	5.70	2,257	228 visits	10.05	2,991	48 visits	5.94	285
Babysitting/Child Care				--	--	--	1044 child hours	1.10	1,148

[a]Volume and Costs are an average of the project's experiences during the three-year demonstration period. For a complete discussion of the methodology used for this analysis and the overall cost findings, see Final Cost Report, Berkeley Planning Associates, December 1977.

[b]These costs reflect actual costs to the projects; numerous volunteer services and donated items were available to the projects which are not accounted for in these figures. For an analysis of these different "costs," see the above report.

[c]These are average volumes and costs for both adult and child services combined.

juvenile delinquency and adult criminal behavior, and future intervention if these children mature and continue the cycle of abuse/neglect with their own children (all of which studies have shown to be the future problems of abused/neglected children) are clearly monumental compared with the costs of these early-intervention strategies. Given the current alternatives, there can be no question that from a community responsibility perspective, as well as a cost-benefit one, specific services for children who have been abused and neglected must become a major component of the country's social service system. The only questions are how and when.

Related to this, finally, is the need for additional research to identify the relationship of specific service provision to remediation of abused/neglected children's various problems, and the long-term effects of these services. In order for local communities to develop effective programs much more needs to be known about the interactive effects of different services, the dynamics of families in which both parent(s) and child are receiving separate therapeutic services, and the functioning status of children several years after they have received therapeutic intervention and are enrolled in the school system. The required studies should be sufficiently large for generalizations to be drawn, have control groups, and be of long enough duration to permit assessment of long-term effects.

APPENDIX A

Listing of Major Evaluation Reports and Papers

Reports

(1) A Comparative Description of the Eleven Joint OCD/SRS Child Abuse and Neglect Demonstration Projects; December 1977.

(2) Historical Case Studies: Eleven Child Abuse and Neglect Projects, 1974-1977; December 1977.

(3) Cost Report; December 1977.

(4) Community Systems Impact Report; December 1977.

(5) Adult Client Impact Report; December 1977.

(6) Child Impact Report; December 1977.

(7) Quality of the Case Management Process Report; December 1977.

(8) Project Management and Worker Burnout Report; December 1977.

(9) Methodology for Evaluating Child Abuse and Neglect Service Programs; December 1977.

(10) Guide for Planning and Implementing Child Abuse and Neglect Programs; December 1977.

(11) Child Abuse and Neglect Treatment Programs: Final Report and Summary of Findings; December 1977.

Papers

"Evaluating New Modes of Treatment for Child Abusers and Neglectors: The Experience of Federally Funded Demonstration Projects in the USA," presented by Anne Cohn and Mary Kay Miller, First International Conference on Child Abuse and Neglect, Geneva, Switzerland; September 1976 (published in International Journal on Child Abuse and Neglect, Winter 1977).

"Assessing the Cost-Effectiveness of Child Abuse and Neglect Preventive Service Programs," presented by Mary Kay Miller, American Public Health Association Annual Meeting, Miami, Florida; October 1976 (written with Anne Cohn).

"Developing an Interdisciplinary System for Treatment of Abuse and Neglect: What Works and What Doesn't?", presented by Anne Cohn, Statewide Governor's Conference on Child Abuse and Neglect, Jefferson City, Missouri; March 1977 (published in conference proceedings).

"Future Planning for Child Abuse and Neglect Programs: What Have We Learned from Federal Demonstrations?", presented by Anne Cohn and Mary Kay Miller, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"What Kinds of Alternative Delivery Systems Do We Need?", presented by Anne Cohn, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"How Can We Avoid Burnout?", presented by Katherine Armstrong, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"Evaluation Case Management", presented by Beverly DeGraaf, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"Quality Assurance in Social Services: Catching up with the Medical Field", presented by Beverly DeGraaf, National Conference on Social Welfare, Chicago, Illinois; May 1977.

APPENDIX B

BIBLIOGRAPHY

Balin, H. "Loneliness in infants," Am. J. of Diseases in Children 63:30-40, 1942.

Bannatyne, Alexander, Language Reading and Learning Disabilities, Springfield: Charles C. Thurmon, 1971.

Barbero, G.J. et al., 1963, "Mal- identification of mother-baby-father relationships expressed in infant failure to thrive" The Neglected Battered Child Syndrome, NY: Child Welfare League of America.

Barbero, G.J. & Shaheen, E. "Environmental Failure to Thrive: A Clinical View" J. Pediatrics 71:639 (1967).

Button, Alan, "Some antecedents of felonious and delinquent behavior" J. of Clinical Child Psychology 2(3):35-37, Fall 1973.

Caffey, John, "On the theory and practice of shaking infants," American Journal of Diseases of Children 24(2):161-169 (August 1972).

Caffey, John "The Parent-Infant Traumatic Stress Syndrome" American Journal of Roentgenology, Radium Therapy and Nuclear Medicine 114:218-229 (February 1972)

Caldwell, B.M. "The effects of psychological deprivation on human development in infancy," Merrill-Palmer Quarterly 3:260-270, 1970.

Chers & Hassibi in Annual Progress in Child Psychiatry & Development, 1971, p. 353-366.

Eisenberg, L., "The sins of the fathers: urban decay and social pathology." American Journal of Orthopsychiatry 32:5-27, 1962.

Elmer, Elizabeth and Grace S. Gregg, M.D., "Developmental characteristics of abused children," Pediatrics 40:596-602 (October 1967).

Elmer, Elizabeth, Children in Jeopardy: Abused Minors and Their Families, Pittsburgh, University of Pittsburg Press, 1967.

Evans, S.L., et al., "Failure to thrive: a study of 45 children and their families" American Academy of Child Psychiatry Journal, 2:440-457 (1972).

Fontana, Vincent J., "Which Parents Abuse Children?" Medical Insight, 3(10): 16-21, 1971; Galdston, Richard, quoted in Gil (Infra) 28-29.

Galdston, R., "Observations on Children Who Have Been Physically Abused by Their Parents," American Journal of Psychiatry 122:440 (October 1965).

Gesell, Arnold & Amatruda, Catherine, Developmental Diagnosis, NY: Paul Hober, 1962, first copyright 1941.

Gil, David G., Violence Against Children: Physical Child Abuse in the U.S. Cambridge: Harvard University Press, 1970.

Glaser, Helen H., et al., "Physical and Psychological Development of Children with Early Failure to Thrive," Journal of Pediatrics 73:690-698, November, 1968.

Goldston, R., "Observations on Children Who Have Been Physically Abused by Their Parents," American Journal of Psychiatry, 122:440 (October 1965).

Greene, Arthur H., "Self-Destructive Behavior in Physically Abused Schizophrenic Children," Archives of General Psychiatry 19:171-179, August 1968.

Harmon, R., Durfee, J., and Klein, R. "Relationship Between an Infant's Ability to Discriminate an Unfamiliar Adult and the Development of Attachment." Paper presented at the American Academy of Child Psychiatry Meeting, October, 1967.

Helfer, Ray E., in Kempe, C. Henry, and Ray E. Helfer, eds., Helping the Battered Child and His Family, J.B. Lippincott, Philadelphia, 1972.

Hurt, Maure, Jr., Child Abuse and Neglect: A Report on the Status of Research, DHEW Publication No. (OHD)-747-20, Washington: G.P.O., 1974.

Leonard, et al., "Failure to Thrive," American Journal of the Diseases of Children, v. III: 600-612 (June 1966).

Levenstein, P., & Sunday, R., "An effect of stimulating verbal interaction between mothers and children around play materials." American Journal of Orthopsych 37:334-335, 1967.

Meacham, William F., "The Neurosurgical Aspects of the Battered Child," Southern Medical Bulletin, June 1970, 33-36.

Miller, A., "On therapeutic technique regarding the so-called narcissistic neuroses." Psyche, Stuttgart, 25:641-668, 1971.

Milowe, Irwin D., and Reginald S. Lourie, "The child's role in the battered child syndrome," Journal of Pediatrics 65(6):1079-1087, December 1967.

Minuchin, S., et al., "Families of the slums: an exploration of their structure and treatment," NY: Basic Books, 1967.

Morse, Carol W., et al., "A 3-Year Follow-Up Study of Abused and Neglected Children," American Journal of Diseases of Children 120:439-446, November, 1970.

Carolyn Newburger -- appx to Richmond et al., proposal.

Oliman, J. and Friedman S., "Parental deprivation in psychiatric conditions. III. In Personality Disorders and Other Conditions. "Diseases of the Nervous System," 28:298-303, 1967.

Martin, Harold (ed.). The Abused Child: A Multidisciplinary Approach to Developmental Issues and Treatment, Ballinger Publishing Company, Cambridge, 1976.

Patton, R.G. and Gardner, L.I., "Growth and Developmental Potential" vulnerable in critical periods in early growth (hypothesis from 6 cases). Growth Failure in Maternal Deprivation Springfield, Illinois, Charles C. Thomas, 1963.

Polansky, Norman A., Hally, Carolyn and Polansky, Nancy F., Child Neglect: State of Knowledge, Regional Institute of Social Welfare Research, School of Social Work, University of Georgia, July 1974 (SRS Grant 09-P-56015/5).

Roth, F. A Practice Regimen for Diagnosis and Treatment of Child Abuse, Journal of Child Welfare League of America, Vol. LIV, No. 4, pp. 268-73, Avail. 1975.

Starlin, S.A. and Polansky, N.A. 1972. "The process of infantilization," American Journal of Orthopsych 42:92-102.

Sherman, E.A. et al., Children Adrift in Foster Care, NY: Child Welfare League of America, 1973.

Skeels, H.M., Dye, H.B., 1939. "A study of the effects of differential stimulation on mentally retarded children," Proceedings of American Association on Mental Deficiency, 44:114-136, 1939.

Steele, Brandt F. and Carl B. Pollock, "A psychiatric study of parents who abuse infants and small children," in Ray Helfer & C. Henry Kempe, The Battered Child, pp. 128-130.

Stern, Leo. "Prematurity as a factor in child abuse," Hospital Practice 8(5): 117-123 (May 1973).

Swischuck, Leonard E., "The Battered Child Syndrome," Southern Medical Bulletin June 1970, 21-26.

Talbert, James L. and Alvin H. Felman, "Identification and Treatment of Thoracoabdominal Injuries in 'Battered Children' " Southern Medical Bulletin, June 1970, 37-43.

Terr, Lenore C., "A family study of child abuse" American Journal of Psychiatry 27(5):665-671, 1970.

APPENDIX C

DATA COLLECTION INSTRUMENT
AND
INSTRUCTION MANUAL

I.D. No. _____

CHILDREN'S PROGRESS FORM

Intake Information

Child's Name _____ Date of Birth ___/___/___ (mo. day yr.)

Sex: _____ Race: White ____ Black ____ Spanish Speaking ____ Other _____

Date Entered Program: ___/___/___ (mo. day yr.) Date Terminated: ___/___/___ (mo. day yr.)

Special Characteristics:

____ Premature
____ Product of Multiple Birth
____ Adopted/Foster Child
____ Mentally Retarded
____ Emotionally Disturbed
____ Learning Disorder
____ Other (specify) _____
_____
_____

Severity of Case:

For Abuse	For Neglect
____ Severely injured	____ Severely neglected
____ Moderately injured	____ Moderately neglected
____ Mildly injured	____ Mildly neglected
____ Emotional abuse	____ Emotional neglect
____ Sexual abuse	____ Failure to thrive
____ Potential abuse	____ Potential neglect

With whom is child living? _____

Who has legal custody of child? _____

Explain the circumstances surrounding the current abuse/neglect situation, and the specific maltreatment received by the child.

BERKELEY PLANNING ASSOCIATES

Worker's Name _____

TESTING RECORD

(Please circle any Termination Tests)

VINELAND SOCIAL MATURITY SCALE	Date Tested: / / / /	Date Tested: / / / /	Date Tested: / / / /	Date Tested: / / / /
Age Equivalent Score				
I.Q. Score				
McCARTHY SCALES OF CHILDREN'S ABILITIES	**Date Tested: / / / /**	**Date Tested: / / / /**	**Date Tested: / / / /**	**Date Tested: / / / /**
Verbal Score				
Perceptual Performance Score				
Quantitative Score				
Memory Score				
Motor Score				
General Cognitive Score				
BAYLEY SCALES OF INFANT DEVELOPMENT	**Date Tested: / / / /**	**Date Tested: / / / /**	**Date Tested: / / / /**	**Date Tested: / / / /**
Mental Development Score				
Psychomotor Development Score				

Other Tests (Specify test and sub-test area. Write in dates and skip one line between tests)

Test	Date Tested: / / / /	Date Tested: / / / /	Date Tested: / / / /	Date Tested: / / / /

Physical Characteristics and Growth Patterns at Intake

Date Completed: /____/____/____/
mo. day yr.

Physical Exam Performed? _____

Results: _____

Re-Exams Scheduled? _____

CHILD'S PROBLEMS AT INTAKE	NO PROBLEM	MILD PROBLEM	SEVERE PROBLEM	NO ASSESSMENT POSSIBLE
Height				
Weight				
Head circumference				
Physical defects				
Sleeping patterns				
Eating patterns				
Malnutrition				
Crying				
Pain agnosia				
Pain dependent behavior				
Psychosomatic physical problems				
Hyperactivity and hyperresponsiveness				
Tics, twitches, body rocking				
Bites nails or fingers				
Failure to recuperate following physical illness				
Stuttering, stammering, other speech disorders				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER OBSERVATIONS:

GOALS:

TREATMENT PATTERNS:

Socialization Skills and Behavior at Intake

Date Completed: /___/___/___/
mo. day yr.

CHILD'S PROBLEMS AT INTAKE	NO PROBLEM	MILD PROBLEM	SEVERE PROBLEM	NO ASSESSMENT POSSIBLE
Agression/acting out				
Apathy/withdrawal				
Affection				
General happiness				
Hypermonitoring				
Attention span				
Accident proneness				
Ability to protect self				
Sense of self				
Attachment/detachment				
Reaction to frustration				
Reaction to change				
General interaction with adults				
General interaction with peers				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER OBSERVATIONS:

GOALS:

TREATMENT PLAN:

Cognitive/Language Development At Intake

Date Completed: ___/___/___/___.
mo. day yr.

INITIAL OBSERVATIONS AND PROBLEMS NOTED:

GOALS:

TREATMENT PLAN:

Motor Skill Development At Intake

Date Completed: / / / /
mo. day yr.

INITIAL OBSERVATIONS AND PROBLEMS NOTED:

GOALS:

TREATMENT PLAN:

Interaction Patterns With Family at Intake

Date Completed: ___/___/___/___
mo. day yr.

CHILD'S PROBLEMS AT INTAKE	NO PROBLEM	MILD PROBLEM	SEVERE PROBLEM	NO ASSESS-MENT POSSIBLE
Weak parent-child bond				
Fearfulness toward parent				
Responsiveness toward parent				
Parent's perception of child's needs				
Parent's response to child's needs				
Child's ability to share feelings				
Provocativeness/pain dependent behavior				
Role reversal				
Differences from parent's expectations				
Harsh discipline				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER OBSERVATIONS:

GOALS:

TREATMENT PLAN:

Diagnostic Summary

Quarterly Progress

Month: _____ (write in)

Physical Characteristics and Growth Patterns

Physical Exam Performed? _____

Results: _____

PROBLEM AREAS	PROGRESSED	REGRESSED	NO CHANGE	NO ASSESSMENT POSSIBLE
Height				
Weight				
Head circumference				
Physical defects				
Sleeping patterns				
Eating patterns				
Malnutrition				
Crying				
Pain agnosia				
Pain dependent behavior				
Hyperactivity and hyperresponsiveness				
Tics, twitches, body rocking				
Bites nails or fingers				
Failure to recuperate following physical illness				
Stuttering, stammering, other speech disorder				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER NOTES AND OBSERVATIONS:

Quarterly Progress

Socialization Skills and Behavior

Month: _____ (write in)

PROBLEM AREAS	PROGRESSED	REGRESSED	NO CHANGE	NO ASSESS-MENT POSSIBLE
Aggression/acting out				
Apathy/withdrawal				
Affection				
General happiness				
Hypermonitoring				
Attention span				
Accident proneness				
Ability to protect self				
Sense of self				
Attachment/detachment				
Reaction to frustration				
Reaction to change				
General interaction with adults				
General interaction with peers				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER NOTES AND OBSERVATIONS:

Quarterly Progress
Cognitive/Language Development

Month: _____ (write in)

PROGRESS NOTES AND OBSERVATIONS:

Cognitive:

Language:

Progressed ____
Regressed ____
No Change ____
No Assessment Possible ____

Quarterly Progress
Motor Skill Development

Month: _____
(write in)

PROGRESS NOTES AND OBSERVATIONS:

Progressed ____
Regressed ____
No Change ____
No Assessment Possible ____

Quarterly Progress

Interaction Patterns with Family

Month: _____ (write in)

PROBLEM AREAS	PROGRESSED	REGRESSED	NO CHANGE	NO ASSESS-MENT POSSIBLE
Weak parent-child bond				
Fearfulness toward parent				
Unresponsiveness toward parent				
Parent's perception of child's needs				
Parent's response to child's needs				
Child's ability to share feelings				
Provocativeness/pain dependent behavior				
Role reversal				
Differences from parents' expectations				
Harsh discipline				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER NOTES AND OBSERVATIONS:

Quarterly Progress

Physical Characteristics and Growth Patterns

Month: _____ (write in)

Physical Exam Performed? _____

Results: _____

PROBLEM AREAS	PROGRESSED	REGRESSED	NO CHANGE	NO ASSESS-MENT POSSIBLE
Height				
Weight				
Head circumference				
Physical defects				
Sleeping patterns				
Eating patterns				
Malnutrition				
Crying				
Pain agnosia				
Pain dependent behavior				
Hyperactivity and hyperresponsiveness				
Tics, twitches, body rocking				
Bites nails or fingers				
Failure to recuperate following physical illness				
Stuttering, stammering, other speech disorder				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER NOTES AND OBSERVATIONS:

Quarterly Progress

Socialization Skills and Behavior

Month: _____ (write in)

PROBLEM AREAS	PROGRESSED	REGRESSED	NO CHANGE	NO ASSESSMENT POSSIBLE
Aggression/acting out				
Apathy/withdrawal				
Affection				
General happiness				
Hypermonitoring				
Attention span				
Accident proneness				
Ability to protect self				
Sense of self				
Attachment/detachment				
Reaction to frustration				
Reaction to change				
General interaction with adults				
General interaction with peers				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER NOTES AND OBSERVATIONS:

Quarterly Progress
Cognitive/Language Development

Month: _____ (write in)

PROGRESS NOTES AND OBSERVATIONS:

Cognitive:

Language:

Progressed ____
Regressed ____
No Change ____
No Assessment Possible ____

Quarterly Progress
Motor Skill Development

Month: _____ (write in)

PROGRESS NOTES AND OBSERVATIONS:

Progressed _____
Regressed _____
No Change _____
No Assessment Possible _____

Quarterly Progress

Interaction Patterns with Family

Month: _____ (write in)

PROBLEM AREAS	PROGRESSED	REGRESSED	NO CHANGE	NO ASSESS-MENT POSSIBLE
Weak parent-child bond				
Fearfulness toward parent				
Unresponsiveness toward parent				
Parent's perception of child's needs				
Parent's response to child's needs				
Child's ability to share feelings				
Provocativeness/pain dependent behavior				
Role reversal				
Differences from parents' expectations				
Harsh discipline				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER NOTES AND OBSERVATIONS:

Quarterly Progress

Month: _____ (write in)

Physical Characteristics and Growth Patterns

Physical Exam Performed? _____ Results: _____

PROBLEM AREAS	PROGRESSED	REGRESSED	NO CHANGE	NO ASSESS-MENT POSSIBLE
Height				
Weight				
Head circumference				
Physical defects				
Sleeping patterns				
Eating patterns				
Malnutrition				
Crying				
Pain agnosia				
Pain dependent behavior				
Hyperactivity and hyperresponsiveness				
Tics, twitches, body rocking				
Bites nails or fingers				
Failure to recuperate following physical illness				
Stuttering, stammering, other speech disorder				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER NOTES AND OBSERVATIONS:

Quarterly Progress

Socialization Skills and Behavior

Month: _____ (write in)

PROBLEM AREAS	PROGRESSED	REGRESSED	NO CHANGE	NO ASSESS-MENT POSSIBLE
Aggression/acting out				
Apathy/withdrawal				
Affection				
General happiness				
Hypermonitoring				
Attention span				
Accident proneness				
Ability to protect self				
Sense of self				
Attachment/detachment				
Reaction to frustration				
Reaction to change				
General interaction with adults				
General interaction with peers				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER NOTES AND OBSERVATIONS:

Quarterly Progress

Cognitive/Language Development

Month: _____ (write in)

PROGRESS NOTES AND OBSERVATIONS:

Cognitive:

Language:

Progressed ____

Regressed ____

No Change ____

No Assessment Possible ____

Quarterly Progress
Motor Skill Development

Month: _____ (write in)

PROGRESS NOTES AND OBSERVATIONS:

Progressed ____
Regressed ____
No Change ____
No Assessment Possible ____

Quarterly Progress

Interaction Patterns with Family

Month: _____ (write in)

PROBLEM AREAS	PROGRESSED	REGRESSED	NO CHANGE	NO ASSESS-MENT POSSIBLE
Weak parent-child bond				
Fearfulness toward parent				
Unresponsivenss toward parent				
Parent's perception of child's needs				
Parent's response to child's needs				
Child's ability to share feelings				
Provocativeness/pain dependent behavior				
Role reversal				
Differences from parents' expectations				
Harsh discipline				
Other (specify)				
Other (specify)				
Other (specify)				

OTHER NOTES AND OBSERVATIONS:

Termination Information

Date Terminated: ___/___/___/
mo. day yr.

Reason for Termination:

What arrangements for child have been made:

Physical Characteristics and Growth Patterns at Termination

CHILD'S PROBLEMS AT TERMINATION	NO PROBLEM	MILD PROBLEM	SEVERE PROBLEM	NO ASSESSMENT POSSIBLE
Height				
Weight				
Head circumference				
Physical defects				
Sleeping patterns				
Eating patterns				
Malnutrition				
Crying				
Pain agnosia				
Pain dependent behavior				
Psychosomatic physical problems				
Hyperactivity and hyperresponsiveness				
Tics, twitches, body-rocking				
Bites nails or fingers				
Failure to recuperate following physical illness				
Stuttering, stammering, other speech disorders				
Other (specify)				
Other (specify)				
Other (specify)				

GOALS ACCOMPLISHED:

PROBLEMS REMAINING:

RECOMMENDATIONS:

Socialization Skills and Behavior at Termination

CHILD'S PROBLEMS AT TERMINATION	NO PROBLEM	MILD PROBLEM	SEVERE PROBLEM	NO ASSESSMENT POSSIBLE
Aggression/acting out				
Apathy/withdrawal				
Affection				
General happiness				
Hypermonitoring				
Attention span				
Accident proneness				
Ability to protect self				
Sense of self				
Attachment/detachment				
Reaction to frustration				
Reaction to change				
General interaction with adults				
General interaction with peers				
Other (specify)				
Other (specify)				
Other (specify)				

GOALS ACCOMPLISHED:

PROBLEMS REMAINING:

RECOMMENDATIONS:

Cognitive/Language Development at Termination

FINAL OBSERVATIONS

Cognitive:

Language:

GOALS ACCOMPLISHED:

PROBLEMS REMAINING:

RECOMMENDATIONS:

Motor Skills at Termination

FINAL OBSERVATIONS:

GOALS ACCOMPLISHED:

PROBLEMS REMAINING:

RECOMMENDATIONS:

Interaction Patterns with Family at Termination

CHILD'S PROBLEMS AT TERMINATION	NO PROBLEM	MILD PROBLEM	SEVERE PROBLEM	NO ASSESS-MENT POSSIBLE
Weak parent-child bond				
Fearfulness toward parent				
Responsiveness toward parent				
Parent's perception of child's needs				
Parent's response to child's needs				
Child's ability to share feelings				
Provocativeness/pain dependent behavior				
Role reversal				
Differences from parent's expectations				
Harsh discipline				
Other (specify)				
Other (specify)				
Other (specify)				

GOALS ACCOMPLISHED:

PROBLEMS REMAINING:

RECOMMENDATIONS:

I.D. No. _____ (BPA Use Only)

Services Provided to Child by Project or Other Agency

SERVICE CATEGORIES	August		September		October		November		December					
	Pro.	Other	Pro.	Other	Pro.	Other	Pro.	Other	Pro.	Other	Pro.	Other	Pro.	Other
Day Care (no. hours) (23-24)														
Child Development Program (no. sessions) (25-26)														
Play Therapy (no. sessions) (27-28)														
Individual Therapy (no. contacts) (29-30)														
Medical Care (no. visits) (31-32)														
Testing (no. tests) (33-34)														
Speech or Other Specialized Therapy (no. sessions) SPECIFY TYPE_____ (35-36)														
Foster Care ("X" if Yes) (37)														
Residential Care (no. days) (38-39)														
Crisis Nursery (no. days) (40-41)														
Advocacy Services (no. times) (42-43)														
Other (specify) (44-45)														
Other (specify) (46-47)														
	(175)		(176)		(177)		(178)		(179)					

Place an (X) in the box if any of the following occurred during a given month:

	August	September	October	November	December		
Death of child, due to abuse (48)							
Severe physical abuse (49)							
Moderate physical abuse (50)							
Mild physical abuse (51)							
Sexual abuse (52)							
Emotional abuse (53)							
Death of child, due to neglect (54)							
Severe physical neglect (55)							
Moderate physical neglect (56)							
Mild physical neglect (57)							
Failure to thrive (58)							
Emotional neglect (59)							
Child moved (60)							
Loss of family member (61)							
Gain of family member (62)							
Court Action (63)							
Child removed from home (64)							
Child returned to home (65)							
	(175)	(176)	(177)	(178)	(179)		

INSTRUCTION MANUAL

FOR

CHILDREN'S PROGRESS FORMS

EVALUATION

OF THE

NATIONAL DEMONSTRATION PROJECT

IN

CHILD ABUSE AND NEGLECT

(January 1976)

BERKELEY PLANNING ASSOCIATES

TABLE OF CONTENTS

THE CHILDREN'S PROGRESS FORM - OVERVIEW

The Children's Progress Form was developed as an evaluative instrument for assessing the development and progress of children who are receiving direct services from any of the Demonstration Projects. In addition, it will, hopefully, serve as a means for the clinicians working with children to maintain adequate information on these children for case management purposes.

There are basically 7 sections to this booklet for children. The first page requires minimal Intake Information on the child (which is supplemented by Intake Information on the family recorded on the regular BPA Intake Sheet). Page 2, the Testing Record, provides space to record the scores of all tests administered to the child. The third section (pages 3 through 7) is to be used for recording initial information on the child's functioning in the areas of Physical Growth and Development, Socialization Skills and Behavior, Cognitive and Language Development, Motor Skills, and Interaction with Parents and Other Family Members. The fourth section of the booklet (page 8) is the Diagnostic Summary Sheet to be used for synthesizing the total information. The fifth section (pages 9 through 23) contains quarterly forms on which the progress of the child in each of the functioning areas specified above. The sixth section of the booklet (pages 24 through 28) are the forms to be filled out when a child is terminated from services. There are separate forms, again, for each of the five functioning areas. The final page of the booklet (page 29) is the Services to Children form, which is to be filled out monthly.

The forms in this booklet may be used as the case record for the child if they prove adequate for that purpose in the projects' opinion. If, on the other hand, projects feel they require more information than this booklet calls for, or they would like the information more frequently than quarterly, the booklet may be used to summarize information from the projects' weekly or monthly record-keeping instruments. Our interest at the current time is in having a mechanism which describes the status of the child at entrance to the program, the services he/she receives, his/her progress at quarterly intervals, and the status of the child at termination, as well as an indication of the tests (or observations) used by each project to make this determination of "progress."

WHO SHOULD FILL OUT THE BOOKLET?

The clinician(s) working most closely with the child should fill out the forms in the booklet. If other individuals are responsible for various portions of the child's program or therapy (e.g. testing specialists), the primary clinician(s) should consult with these individuals when completing the forms.

WHEN SHOULD THE FORMS BE FILLED OUT?

The Intake Form (page 1) should be filled out at the time the child is entered into the project. (The regular Intake Form [gold] is also filled out for the family at that time.)

The Testing Record (page 2) form should be filled out each time any test (standardized tests, checklist forms, structured observations, etc.) are administered to the child.

The five Initial Functioning (pages 3 through 7) and Diagnostic Summary (page 8) forms are to be filled out at the time the initial diagnostic and treatment planning phase for the child has been completed. For some projects, this phase may not be completed for several weeks in order to space out any tests which are to be administered and/or allow the clinician(s) to become somewhat more familiar with the child. However, these forms should definitely be completed within one month after the child's entry into the project.

The Quarterly Progress forms (pages 9 through 23) are to be filled out three months after the Initial Functioning form, and every three months thereafter. Thus if a child entered the project in January, and the Initial Functioning forms were completed that month, the Quarterly Progress forms for that child would be filled out in April, July, and October. Children currently in the project's caseload should have Quarterly Progress Forms filled out in January, April, July and October of 1976. Because this booklet is intended to be used only through July, 1976, only three sets of Quarterly Progress forms have been included.

The five Termination forms (pages 24 through 27) are to be completed at the time the child is terminated (or drops out) from services.

The Services to Children form (page 28) is to be filled out each month that the child remains in the project.

EXPLANATION OF FORMS

1. Intake Form:

All required information on the Intake Form should be recorded when the child first enters the project. Please provide sufficient detail in describing the circumstances of the current abuse/neglect incident and the maltreatment (i.e. broken bones, burns, psychological trauma) received by the child. If more than one clinician is working with the child, the primary worker's name should appear on the form.

2. Test Record Form:

This form provides spaces for recording the scores of the three standardized tests which are to be administered to all children, the

Vineland Scale of Social Maturity, the McCarthy Scale of Children's Abilities, and the Bayley Scales of Infant Development (for children under 30 months only).

The righthand side of the form may also be used for recording the scores of any other tests administered to the child. The name of the test and the sub-test areas should be specified.

Please be sure to date all test results.

3. Initial Functioning Forms:

These five forms provide spaces for evaluating the child's level of performance and behavior when he/she enters the project in five specific areas. The Physical Characteristics and Growth Patterns, Socialization Skills and Behavior and Interaction Patterns with Family forms contain both a checklist of specific problems which are each to be rated and space for narrative related to other observations, the goals and treatment plans. The forms for Cognitive/Language Development and Motor Skill Development contain space for a narrative explanation of the child's problems at Intake in these areas, the goals of treatment and the treatment plans.

On the forms with checklists, please be sure to rate each problem area (definitions of these areas are found on pages 5 through 11 of the Manual. If there are other specific problems in the three functioning areas with checklists, these may be written in the "other" lines, and assessed in the same manner as the checklist indicates. If the "other" line is used, however, the same problems should be assessed each quarter on the Progress forms, and a final rating should be given them on the Termination form. On the forms without checklists, the problems noted should be as specific as possible.

The Goals established for the child in each functioning area should relate to the problems noted for that area. For example, if the problem is a lack of ability to play cooperatively, the goal might be to have the child "play with at least two other children for 15 minutes."

The Treatment Plans should explain what programs, therapies, or activities are to be undertaken with the child to help reach the established goals.

4. Diagnostic Summary Forms:

The Diagnostic Summary form is to be used for an overall assessment or description of the child which incorporates information from the preceeding forms, the results of tests, and the clinician's observations. The comments or recommendations of outside consultants, therapists, testing specialists, etc., should be incorporated in this overall assessment.

5. Quarterly Progress Forms:

There are three sets of five Quarterly Progress forms. Each of the five forms is to be filled out every 2 months, beginning with the third month after the child has been accepted for services and the five Initial Functioning Forms have been completed. As with the Initial Functioning Forms, the Progress forms for Physical Characteristics and Growth Patterns, Socialization Skills and Behavior and Interaction Pattern with Family include both a checklist for depicting progress (or the lack of it) on specific indicators, and space for narrative comments. The Cognitive/Language Development and Motor Skill Development forms contain an overall rating scale for the whole functioning area, and space for narrative comments.

For both the checklist of specific indicators and the overall ratings, the ratings of progress should be made in comparison to the rating made the preceeding quarter, not from the time the child entered the project. For example, even though a child's motor skills may have improved overall since entering the project, if they have not improved during the preceeding 3 months, the "no change" column should be checked. Also, if some behavior has gotten worse during the last 3 months, even though, overall, the child has made improvements in that area since entering the project, the "regressed" column should be checked.

Please remember to write in, and assess the progress of any problems which were written in the "other" category on the Initial Functioning Forms with checklists.

On the forms without checklists (Cognitive/Language and Motor Skills) reference should be made in the progress notes to those problems identified for each area in the Initial Functioning Forms.

The "No Assessment Possible" category should be used only if, for some reason, the clinician has been unable to sufficiently observe or test the child in a specific area in order to make a judgment (e.g. the child has been hospitalized for a long period or placed in a foster home).

6. Termination Forms:

The five Termination Forms are to be filled out at the time the child ceases to be considered a project "case." The "Reason for Termination" should be as specific as possible, e.g. "all goals accomplished" or "parent withdrew child from the project." "What Arrangements Have Been Made for the Child"refers to any special plans for the child after termination, e.g. "child has been enrolled in pre-school/day-care," or "child has been placed with foster parents."

In addition to these questions, the five forms have both checklists for rating the status of specific indicators at termination and spaces for

narrative explanation of the Goals Accomplished, Problems Remaining, and Recommendations.

NOTE: Any final tests administered to the child should be recorded on the Testing Record (page 2).

7. Services to Children Form:

The Services to Children Form is to be completed each month to detail all services received by the child. The first column, marked "Pro.," refers to all services provided directly by the project. The second column, marked "Other," includes all services received by the child from other sources, e.g. Day Care Program, Child Guidance Clinic, etc. This column should also be used to show all services purchased for the child by the project from other sources.

When completing the Services form, please be sure to use the unit (e.g. sessions/contacts/times, etc.) specified for the particular service category.

The bottom half of the Services form has spaces for noting whether any significant events have occurred during the month which may help to explain changes in the child's functioning. An (X) should be placed in the appropriate box if any of these events have taken place during the month.

EXPLANATION OF THE FIVE DEVELOPMENTAL/FUNCTIONING AREAS

The five developmental/functioning areas we have delineated for the evaluation of children's progress cover most of the specific characteristics, behaviors and situations which clinicians have found some abused/neglected children exhibit during treatment. Some of these areas, such as social behavior, are best evaluated through observation in the treatment setting, while others, such as cognitive development, require the administration of some test(s) which have been standardized to provide normative information on a large number of children. The possible drawbacks of these tests for use for abused/neglected children are discussed in the accompanying review of standardized tests. However, at the moment, they are still the best mechanisms available for assessing cognitive, language, and motor skill development.

Within the generic areas outlined (physical characteristics and growth patterns, socialization skills and behaviors, cognitive and language development, motor skill development, and interaction with family), there are numerous indicators of the strengths and weaknesses of the child. The following list of indicators are the ones felt to be applicable to abused and neglected children, and those in which negative findings would indicate deficits which require remediation. With the exception of some

of the standardized tests, particularly the Intelligence tests, the following indicators are most appropriate for children ages 0+ to 10 years. Other indicators will need to be developed if projects begin to work with older children.

These indicators, again, represent only a beginning list, and clinicians working with children should feel free to add other indicators as their experience uncovers additional problems which appear characteristic of abused/neglected children.

A. Physical Characteristics and Growth Patterns

The following are indicators which help to pinpoint problems in this area.

1. Height/weight/head circumference: Are each of these within the normal range for the child's age?

2. Physical defects: Does the child display any untreated fractures, sprains, hematomas, eye or ear damage, or general physical weakness? These are usually best assessed through a physical examination and the injuries may be pre or post abuse/neglect.

3. Sleeping patterns: Does the child have any sleeping pattern disturbances, including an inability to sleep regularly, prolonged sleep, animal dreams, or an inability to wake up refreshed? This is usually best ascertained from the mother or caretaker, although programs which include "nap time" may provide the opportunity for assessing this indicator.

4. Eating patterns: Does the child eat incessantly if given the chance, does he hoard food, or is he totally unresponsive to food and eats, if at all, mechanically? This should be distinguished from the "finicky" eater, a stage most children go through at some time.

5. Malnutrition: Is there any evidence of malnutrition in the child?

6. Crying: Does the child cry incessantly, cry through seemingly unprovoked, or not cry when he is obviously distressed or hurt? Is his crying of the lusty, angry variety, or does he withhold that emotion and merely whimper and whine?

7. Pain agnosia: Is the child immune to pain, e.g. appears not to feel pain even when obviously hurt fairly seriously?

8. Pain dependent behavior: Does the child purposefully injure himself or engage in activities which are painful or self-mutilating, e.g. head banging?

9. Psychosomatic physical problems: Does the child exhibit emotionally related physical problems such as persistent eczema, asthma, enuresis or bowel problems? These should be distinguished from occasional wetting or soiling problems when highly excited or engrossed in a certain task or play.

10. Hyperactivity and hyperresponsiveness: Is the child in constant motion, unable to control his body movements, or unable to respond to situations at a level appropriate for his age?

11. Tics, twitches, body rocking: Does the child exhibit facial or other tics, twitches, or engage in excessive body-rocking?

12. Bites nails or fingers: Does the child incessantly bite his nails and fingers, particularly in normally non-stressful situations?

13. Failure to recuperate following physical illness: Does the child require an excessive amount of time to recover from normal childhood illnesses, including lack of energy, prolonged sleeping, constant irritability? Is he/she sick more than usual, or does he/she appear to be generally physically weak?

14. Stuttering/stammering/other speech disorders: Does the child exhibit these or any other speech disorders which interfere with his ability to verbalize? These should be distinguished from baby talk (unless the child is past 5 years of age) or an inability to correctly pronounce certain words or consonants, e.g. "wight" for "right."

B. Socialization Skills and Behaviors

1. Aggression/acting out: Is the child overly aggressive; fights constantly with others, bullies, or ridicules other children?

2. Apathy/withdrawal: Is the child generally uninvolved with his surroundings, stares blankly, unresponsive to stimuli both painful and pleasant?

3. Affection: Is the child able to give, and receive, affection from others?

4. Happiness quotient: Is the child generally happy, smiling, content, or is he unhappy, crying, distressed, generally worred about many things?

5. Hypermonitoring: Is the child constantly "on his guard," vigilant about the situation or people (particularly adults), appearing to expect trouble or adversity to the point of interfering with his/her involvement with tasks or play?

6. Attention span: Does the child wander aimlessly from one activity to another, have trouble becoming or staying involved with playthings?

7. Accident proneness: Does the child constantly run into things, spill things, or fall? (Although this may be a sign of neurological problems, it is more often a lack of body awareness.)

8. Ability to protect self: Can the child protect himself in dangerous situations, or from other bullying children, or does he/she seem oblivious to peril and acquiescent when threatened?

9. Sense of self: Does the child have an age-appropriate sense of who he/she is? Does he respond to his name, appear proud of his accomplishments?

10. Attachment/detachment to parents/other adults, objects: Does the child indicate a strong sense of feeling for his family; is he/she discriminating in his acceptance of strangers; is he/she overly attached to certain objects or ways of doing things? Is he/she reasonably distractable when familiar people must depart or when objects are left behind?

11. Reaction to frustration: Does the child over-react to an inability to perform, e.g. throw temper tantrums? Is he/she somewhat creative in his approach to problem solving? Does he give up easily?

12. Reaction to change: Does the child overreact to changes (moving, a change of routine, a new activity) by screaming, withdrawing or constantly referring to the previous situation? Can he be distracted with a new situation? Is the reaction of severely long duration?

13. General interaction with adults: Does the child generally enjoy and get along with adults, and while initially wary of strangers, does he/she usually "warm up" given some time and encouragement? Is he/she looking for constant attention, or always prefer children to adults for compansionship? Does he/she deliberately "test" or provoke adults?

14. General interaction with peers: Is the child able to enjoy and play cooperatively with other children for a time period appropriate to his/her age? Is she/she able to perform adequately in either the "leader" or "follower" role? Is the child a constant loner, or does he/she usually enjoy compansionship? Is he/she looking for constant attention or always prefer adults to children for compansionship? Does he/she kick, bite or tease other children? Do other children avoid interacting with him/her?

C. Cognitive and Language Development

The areas of cognitive and language development do not lend themselves easily to the kinds of specific indicators used for the other areas. Both

involve a long process of building upon previous skills and knowledge learned at different times for different children.

For younger children, cognition usually includes the child's ability to understand signs and symbols; his discrimination of form, size, color, depth, space, position, and permanence of objects, and the internalizing of certain repeated activities and situations. For the older child, cognition involves an increasing ability to receive and process information, to solve concrete problems, to conceptualize quantities, numbers, and time, and an ability to generalize and to see relationships and think logically.

In younger children, verbal skills include discriminating among sounds, beginning to articulate certain sounds, and eventually speaking in a reasonably coherent fashion although often omitting pronouns and articles. The older child will begin to use phrases, to speak in appropriate tenses and to verbalize his experiences (story-telling) as well as just articulating his needs or repeating what he has heard.

Although there are some obvious signs that a child's cognitive and language development is lagging, e.g., the child of three does not speak at all, or the child of five cannot recognize very simple pictures he has seen repeatedly, it is difficult in many cases to clearly recognize deficits in these areas, because the child's cognitive and language skills change so rapidly between the ages of 2 and 7 years.

In general, cognitive and language development is most easily assessed through the use of standardized tests which normally include sub-tests in five or six areas, all of which, when combined, make up a general cognitive or language (verbal ability) score. Some of these tests include the Bayley Scales of Infant Development, the Denver Developmental Screening Test, the Goodenough Harris Drawing Test, and the Illinois Test of Psycholinguistic Abilities. Any of these tests might be used to measure a child's cognitive and language ability, although each test is designed for different age ranges.

D. Motor Skills

Like cognitive and language development, the development of motor skills, both normative and perceptual, are less easily evaluated without the aides of some standardized tests or checklists to enable the child's performance to be measured against other children of his/her age group. Again, as with cognitive and language development, motor skills are acquired by building on previous skills and through repetition.

Examples of gross motor skills in children include walking, running, hopping on one foot, throwing a ball, balancing on a beam, etc. Fine motor skills include finger and hand dexterity measures such as unbuttoning a coat, picking up small items, catching a ball, etc. Perceptual motor

abilities involve associating a motor image with its corresponding visual, auditory or tactile one. This includes copying a circle or line, drawing a man or woman, tracing a line in a maze, or building a block tower.

Although it is certainly possible to assess the child who cannot perform the above tasks (or other motor skill tasks) without age-specific standards of "normal" children, it is difficult to determine whether a child's inability to perform at a certain age is a definite deficit in that area or merely that his motor skills are developing at a slightly decelerated pace which will accelerate eventually of its own accord.

Some of the tests which assess a child's motor skills include the Bayley Scales of Infant Development, the Denver Developmental Screening Test, and the McCarthy Scales of Children's Abilities.

E. Interaction Patterns with Family

1. Weak child-parent bond: Does there appear to be little understanding, caring or interest between parent (particularly mother) and child? Especially in infants and toddlers, is there an overt affection and interest by the parent in the child's activities and interests?

2. Fearfulness toward parent: Does the child appear afraid of the parent, hesitant to approach him/her, or resist physical closeness?

3. Unresponsiveness toward parent: Does the child ignore the presence of the parent; does he physically or otherwise remove himself from any interaction, or deliberately not listen to the parent?

4. Parent's perception of child's needs: Does the parent appear to perceive what the child is asking for when exhibiting certain behaviors? Can he/she discern the difference between the child's need for attention, companionship, help, direction or comforting by the behavior of the child?

5. Parent's response to child's needs: Does the parent appear to understand/accept the child's needs and provide an appropriate response? Does the parent respond with anger, embarrassment or indifference to child's fear, distress or pain?

6. Child's ability to share feelings: Is the child included in sharing experiences; can the child explain his/her feelings appropriately? Is there a sense between family members that they constitute a close, intimate unit? Do family members support one another?

7. Provocativeness/pain dependent behavior: Does the child deliberately do things to provoke the parents' anger; does he persist in an activity when repeatedly requested to refrain from it? Does the child appear to expect punishment, and seem almost resigned/pleased when it occurs.

8. Role reversal: Does the child adopt a "parenting," protective attitude toward the parent, becoming solicitous and over-anxious to please? Is he constantly looking for signs and signals as to what the parent needs and then providing an appropriate response?

9. "Differences" from parents' expectations: Does the parent give clues that the child's personality, looks or behaviors are inherently different from what he/she expected or desired? Some examples might be, "All my other children talked (or walked, played games, etc.) by this age," "She's so unattractive," or "He's always in the way."

10. Harsh discipline: Does the parent exact extreme punishment for seemingly minor infractions? Is corporal punishment very harsh or inappropriate to the child's age? Is there a reconciliation period quite soon after the punishment?

In using the above indicators as guides for determining the strengths and weaknesses of individual children, there are some important things which should be kept in mind. First, these indicators (and any standardized tests administered) are not toally comprehensive in nature. There may be other characteristics, behaviors or deficits beyond those we have collected which constitute a warning signal that the child is having problems in a particular area. The workers should feel free to include other indicators in either the checklists or the narrative descriptions which they believe to be important manifestations of developmental lags or maladjustments.

Second, there will obviously be times when a child exhibits a variety of negative behaviors or the parent-child interaction appears less than satisfactory. No isolated incident of behavior nor an infrequent constellation of behaviors should be cause for diagnosing a child as having a major problem, since children, like adults, have marked mood swings and "off-days." What should be looked for are patterns of behavior which are both consistent and of long duration, as it is these patterns which are most indicative of major problems.

Finally, in completing those sections of the booklet requiring information on the five functioning areas (the initial functioning form, quarterly progress notes, and termination information), it should not be inferred either that a child will (or should) be tested in each area, or that he would exhibit problems in each area. It is quite possible that a child would manifest deficits in only one or two of the areas, or that within a given category, the child might display negative behaviors or test scores on only a few of the indicators. It remains with the clinicians working most closely with the child to determine whether the preponderence of evidence suggests that the number of deficits exhibited, or the intensity of the deficit warrants that they be labeled as real problems, and that they therefore are to be included in the child's goals of treatment and treatment plan. For any of the five areas where a child exhibits only one problem,

and this is not severe, it is unlikely that the clinician would consider the child to have a general deficit in that area. If, for example, the child appears competent in all socialization areas for his age group, but is prone to accidents, it is doubtful whether the clinician would diagnose the child as having a significant socialization/behavior problem.