Psychological Adjustment and Caregiver Attributes in Children Referred to Contact House

QUT Abused Child Trust Collaborative Study

FINAL REPORT

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Robert Schweitzer is currently the coordinator of professional programs in Clinical Psychology in the School of Psychology and Counselling at QUT. His research interests include phenomenological and quantitative research methodologies in relation to health and psychotherapy process and outcome studies. Robert has worked closely with the Abused Child Trust, developing post-graduate programs sensitive to the issues of child abuse and neglect and collaborating in research projects including: *Decision Making and Reporting Abuse and Neglect by Medical Practitioners.*

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Kerryann Walsh is a lecturer in early childhood education within the School of Early Childhood at QUT and is the course coordinator of the Bachelor of Education (Early Childhood). She is a member of the Early Years Program in the Centre for Learning Innovation at QUT. She has been involved in early childhood education and child protection since 1990 when she began a six-year term as the early childhood teacher at the Abused Child Trust's multidisciplinary treatment centre *Contact House.* Kerryann has continued her involvement with the Abused Child Trust leading a previous QUT Abused Child Trust collaborative research project *Critical Factors in Teachers' Detecting and Reporting Child Abuse and Neglect: Implications for Practice.*

Dr Jenny Fraser

Jenny Fraser, a current QUT senior lecturer in the School of Nursing, has published an impressive list of articles in various journals including Child Abuse and Neglect since 1999. With a theoretical focus upon experimental designs, Jenny's prolific research interests include: early parenting support and treatment for substance abuse, promotion of resilience in adolescents and the treatment of children with behavioural disturbances.

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The Abused Child Trust

The Abused Child Trust is an independent body which is not affiliated with any community or church group and functions as a leading provider of recognised, quality services for the prevention and treatment of all forms of child abuse and neglect in Queensland.

A primary role is that of advocacy, with the Abused Child Trust contributing towards education and research in the area of child abuse and neglect. The Abused Child Trust aims to create better communities, break the cycle of abuse and neglect and has the visionary goal of achieving zero child abuse and neglect.

The Abused Child Trust currently addresses the health, educational and welfare needs of children and their families who have experienced abuse and neglect via three Contact House facilities based in Brisbane, the Gold Coast and Townsville. Evidence-based individualised therapeutic and preventative practices are implemented by a multidisciplinary team which encompasses experienced practitioners in the following disciplines: psychology, social work, occupational therapy, speech pathology, health and early childhood education.

Further information about the Abused Child Trust can be found at

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Executive Summary

Background and Aims

Child abuse and neglect (CAN) encompasses a heterogenous group of adverse practices with devastating personal, social, educational, health, legal and welfare consequences. The term *child abuse and neglect* covers four types maltreatment: physical abuse, emotional abuse, sexual abuse, and neglect, with many children experiencing a combination of these types. Australian child protection notifications have more than doubled in the 5-year period to 2004. Of most concern is that, of all the Australian States and Territories, Queensland has the highest rate of substantiated cases with 14.1 per 1,000 children (AIHW, 2006).

Childhood abuse and neglect can have profound short- and long-term effects. Children with a history of abuse and neglect have been shown to experience insecure attachment, developmental delays, diminished social skills, violent behaviour and learning problems. Previous studies have also found that abused and neglected children frequently experience a higher incidence of a diverse range of adverse mental health outcomes including helplessness and sadness, lowered self-esteem and post traumatic stress disorder. However, relatively few studies have examined the psychological adjustment of children in more immediate terms especially within an Australian context. Furthermore, adults experiencing CAN during childhood frequently exhibit diverse psychopathologies.

The variability in adverse consequences suggests the existence of mediating and moderating factors influencing the level of distress experienced by children. While associations have been made between factors surrounding the type of abuse, the child's age and gender and negative outcomes, little is known about the role of the child's non-offending caregiver and the relationship between caregiver attributes and the level of distress experienced by the child.

A primary aim of this study was to investigate caregiver attributes and the psychological adjustment of children referred to a non-government treatment centre. This specific aims were: (i) to describe the psychological adjustment of children who have experienced abuse and/or neglect (ii) to compare the psychological functioning of children presenting for treatment with a community

sample of children (iii) to describe the level of psychosocial functioning of the caregivers in the clinical group across a range of psychosocial and parenting practice variables and (iv) to explore the relationship between demographic variables, factors relating to the abuse and neglect, and caregiver variables, which may predict, mediate, or moderate the child's psychological adjustment. In addition the study aimed to establish a database for future research into treatment outcomes.

Through the inclusion of a comparison community sample, this study provided evidence to complement existing research and develop a more complete picture of families living with and without CAN. The findings also offer preliminary evidence regarding the effectiveness of treatment and underscore the need for ongoing evaluation of service outcomes to optimise the quality of life for children and families affected by CAN.

Method

Fifty-three primary caregivers of children accepted into three Contact House facilities volunteered to participate in the study. Participants were interviewed at the end of a treatment session using a survey comprising a series of standardised measures. Information was obtained concerning the psychological adjustment of the caregivers' 86 children, their parenting practices and parenting stress. As a comparison group, we also surveyed 82 primary caregivers from four school communities and one long-day care centre, gathering similar information to compare the psychological adjustment of the children, the caregivers' parenting practices and their level of parenting stress.

For the Contact House families, wherever possible, data were collected a second time after 3 months had elapsed, in order to provide an indication of the impact of treatment on children's psychological adjustment, and caregivers' parenting practices and parenting stress.

Key findings

Key findings include:

Description of Abuse and Psychological Adjustment of Abused Children

1. While all children in the clinical sample had experienced abuse, the majority of children (74%) had experienced multiple types of abuse and neglect. Approximately half of these children experienced severe abuse or neglect (as rated by clinicians) and had two or more documented child protection notifications.

2. In the majority of cases (83%) the child's biological parent, with or without an accomplice, was the perpetrator of the reported abuse or neglect.

3. Compared to the community comparison group of children, children with a history of CAN demonstrated significantly higher levels of problematic behaviour in all assessed domains including emotional symptoms, conduct problems, hyperactivity or inattention, peer socialisation problems and prosocial behaviour.

4. The mean domain scores on the measure of child mental health attained by the abused and/or neglected children are comparable with admission scores reported for children attending national mental health service settings (Australian Mental Health Outcomes and Classification Network, 2005).

5. According to scores attained on the *Strengths and Difficulties Questionnaire* (SDQ), 71% of the abused and/or neglected children, demonstrated clinically elevated levels of difficulties. In particular:

    - 73% demonstrated conduct behaviours which fell within the clinically problematic range;
    - 58% experienced abnormally elevated levels of emotional symptoms;
    - 53% demonstrated clinically elevated levels of hyperactivity and/or inattention;

- 51% experienced clinical levels of difficulty regarding peer relationships; and
- 23% demonstrated clinically low levels of pro-social behaviour.

Description of the Caregiver Attributes[1]

6. Fifty-nine percent of the abused children were in the care of their biological parents, while 26% lived with foster carers. Three-quarters of caregivers within the clinical group were not employed and half were living in sole parent families.

7. Fifty-three percent of caregivers within the clinical group reported being victims of abuse. Fifteen percent of caregivers stated that their abuse experiences occurred during childhood, 21% reported abuse experiences during adulthood, and 17% experienced abuse during both childhood and adulthood.

8. Sixty-nine percent of primary caregivers reported experiencing clinically elevated levels of parenting stress. These levels were significantly higher than caregivers within the general community.

9. Two differences were noted between the clinical and comparison community sample of caregivers regarding parenting practices. Caregivers of the abused and/or neglected children were less involved in their child's life, and used less corporal punishment.

10. A global assessment of interpersonal functioning found that caregivers within the clinical group functioned within the average range (based upon the total problem score on the Inventory of Interpersonal Problems). However, almost one-third of caregivers were found to experience significant difficulties in three areas: being overly accommodating, excessively self-sacrificing, and overly intrusive or needy.

11. Small and uneven group sizes prevented statistical analysis of the relationship between caregiver functioning and abuse history. However,

several trends were noted. Caregivers who were abused during both childhood and adulthood reported higher levels of parenting stress, yet were more empathetic than non-abused caregivers.

12. Caregivers, who experienced abuse only during adulthood, and those experiencing abuse both during adulthood and childhood, experienced higher levels of interpersonal problems.

Relationships between Caregiver Attributes and Childhood Psychological Adjustment

13. Caregivers experiencing high levels of parenting stress were more likely to care for a child who demonstrated clinically elevated levels of difficulties. Several factors were shown to be associated with higher levels of parenting stress including: lack of social support; poor parenting skills such as failure to adequately supervise or monitor their child and infrequent use of positive feedback.

14. Poor parenting practices were associated with several factors including:
    - limited practical support from family and friends;
    - low levels of empathy; and
    - higher levels of interpersonal difficulties.

Preliminary Outcome Findings

15. A three month follow-up reassessment of 13 children in the clinical sample who continued to receive services through Contact House Wooloowin revealed that:
    - the children's total level of difficulties reduced significantly over the course of treatment however treatment scores remained within the clinically elevated range; and
    - clinically significant functional improvement was found in two behavioural areas: emotional symptoms and level of hyperactivity or inattention.

[1] *All data unless stated refers to the clinical group*

16. Small sample size prohibited the statistical analysis of data associated with families ceasing therapy and attrition rates. However examination of average scores attained at the initial assessment and at therapy closure suggests a trend demonstrating a positive therapeutic outcome which is evidenced through a reduction in the child's level of hyperactivity or inattention and the level of stress experienced by the caregiver associated with parenting.

Recommendations

This project has established a database containing a significant amount of information on both children and their families receiving interventions via a CAN treatment service. It is strongly recommended that further longitudinal research is undertaken with these families and extended to include new clients, to continue assessing the effectiveness of therapeutic interventions and the sustainability of outcome gains.

In view of the statistical exploration of several variables (such as abuse types) being restricted by small sample size, it may be advantageous to include these factors within further studies to improve statistical power. Future research may profitably explore additional caregiver factors associated with the child's distress and to further develop and refine the conceptual model offered within this study. Such research holds potential for furthering understanding of abuse outcomes within an ecological framework and importantly, provides an evidenced-based framework to guide the refinement of intervention strategies. Such research will provide more effective and sustainable outcomes for child victims.

Conclusions

Abused and neglected children presenting for treatment, demonstrated significant levels of difficulty in relation to emotional symptomatology, conduct behaviour, hyperactivity and/or inattention, problems with peer socialisation and pro-social behaviour. However, the variability in outcomes and the associations with

caregiver attributes and functioning demonstrated by this study, suggest that family and community contexts influence the impact of abuse.

This study has provided a substantial body of evidence regarding the distress experienced by the predominantly non-offending caregivers of children with a history of abuse or neglect. Additionally, findings have contributed to existing knowledge and exposed several factors, which directly and indirectly influence the abused child's psychological functioning. Consistent with the ecological paradigm, the child's behaviour was influenced by proximal and distal agents: caregiver functioning and community support. The level of parenting stress experienced by the caregiver appeared to be a particularly critical factor along with parenting practices and social support. The caregiver's own abuse history, their level of empathy and interpersonal difficulties were also factors found to be enmeshed within this complex framework.

Current findings provide further evidence supporting the need to extend abuse treatment beyond interventions for the children, and include contextual influences. At the time of this study, the intervention program offered by Contact House appears consistent with this approach. Contact House treatment was individualised according to the family need and potentially included child therapy, family therapy, parenting support, health assessment and education and at one facility, an early childhood educational unit. It is noted that Contact House is further refining their intervention program to facilitate the connectivity of clients to community resources and support groups.

Preliminary findings based upon a small group of children with follow-up assessments provide tentative evidence of the effectiveness of the current Contact House intervention program. However, in order to evaluate the effectiveness of such broad interventions and, importantly, the sustainability of treatment gains, further longitudinal research based on increased numbers of children is warranted.

Literature Review

Introduction

Child abuse and neglect (CAN) is a relatively recently studied phenomenon which first appeared in the clinical literature approximately four decades ago. CAN encompasses a heterogenous group of adverse practices with devastating individual and societal consequences. This review will define abuse and neglect, overview Australian prevalence rates and highlight research findings regarding short and long-term consequences. Contemporary findings regarding factors which mediate outcomes and psychological interventions will also be outlined.

Despite vigorous debate and attention, a universal definition of child abuse and neglect remains elusive. Theoretically, categories of CAN vary according to underlying psychological, sociological, or ecological models (Vimpani, Frederico, & Barclay, 1996) while the dynamic nature of societal perception surrounding acceptable discipline, suggests that the definition will evolve over time. In general terms, CAN refers to a broad range of behaviours covering both (i) acts of commission related to physical, sexual, emotional, or psychological harm and (ii) acts of omission regarding physical and emotional neglect.

The current study adopts the definition of the Australian Institute of Health and Welfare (AIHW, 1998) which outlines childhood abuse and neglect criteria as follows:

- Physical abuse - any non-accidental physical injury inflicted on the child;
- Emotional abuse - any act which results in the child suffering any kind of significant emotional deprivation or trauma;
- Sexual abuse - any act which exposes a child to, or involves a child in, sexual process beyond his or her understanding or contrary to accepted community standards; and

- Neglect - any serious omissions or commissions which, within the bounds of cultural tradition, constitute a failure to provide conditions that are essential for the healthy physical and emotional development of a child and includes failure to thrive.

Research has confirmed that children may experience more than one type of abuse (Mullen, Martin, Anderson, Romans & Herbison, 1996) and for the majority of abused and/or neglected children, abuse is a chronic experience rather than a single isolated event (Zielinski & Bradshaw, 2006).

Incidence and Prevalence

The overall picture regarding the incidence of CAN in Australia appears similar to other developed countries. Australian abuse and neglect prevalence statistics are typically quantified in terms of child protection notifications and/or substantiations, however state and territory differences are noted with regards to legislation, policies and practices. Reliance upon administrative statistics infers that only a proportion of the abuse and neglect cases are represented, as many cases remain unreported. Notifications to Australian State and Territory child protection authorities more than doubled in the 6 year period to 2005, with total numbers increasing from 107,134 to 252,831 (AIHW, 2006). Several factors that may contribute to this trend include heightened community awareness, an increase in service facilities, and changes to jurisdictional legislation and policies that widen the criteria for reports. Substantiated cases have also increased from 24,732 in 1999–2000 to 46,154 in 2004–05 (AIHW, 2006). Queensland recorded the highest number of substantiations in the period 2004-05 with 14.1 per 1,000 children, compared to the Western Australian rate of 2.3 per 1,000.

The most recent figures indicate a change from physical abuse being the most common form of reported abuse to emotional abuse being the most frequently cited form of abuse. Girls are more likely to be the subject of sexual abuse substantiation while younger children more likely to be the subject of substantiation of any type of CAN. ASTI children are over represented in the rate of substantiated abuse with indigenous children being subject to a reporting rate

ten times higher than that for non-indigenous children. Current data indicates that children living in female-headed single-parent families, two-parent step families, and blended families are overly represented in the number of substantiated abuse cases (AIHW, 2006).

Potential Consequences

Childhood Consequences

Child abuse appears to be an extremely diverse phenomenon, particularly with respect to the underlying abuse types and patterns and associated consequences and intervention outcomes (Cicchetti & Rizley, 1981). Elements of variability are associated with the abuse itself, the timing of the abuse in terms of the child's development, the way in which children respond, and its developmental impact. This contributes to a 'multifinality' of outcomes (Cicchetti & Rizley, 1981). Empirical research has documented associations and correlates between adverse consequences and CAN during childhood. This research has also addressed potential outcomes particularly with regard to long-term consequences although it has focused mainly upon physical and sexual abuse (Widom, Raphael & DuMont, 2004). Emotional abuse and neglect have received considerably less attention and thus remain less clearly understood (Moran, Vuchinich & Hall, 2004).

Although no single predictable trajectory can explain the relationship between a child's abuse/neglect experiences and their consequences (Cicchetti & Toth, 1995), children abused and/or neglected during infancy frequently experience developmental problems (Egeland, Sroufe, & Erickson, 1983). Normal infant and early childhood development through milestones is reliant upon the gratification of basic needs, a safe stimulating environment and the establishment of a secure emotional bond with a primary caregiver. It is therefore not surprising that abuse and/or neglect during the early years has been associated with significant developmental delays including: growth retardation or failure to thrive, intellectual deficits, neurological dysfunction, language acquisition and impaired gross and fine motor skills (Eigsti & Cicchetti, 2004). Several studies have shown that children with a history of child abuse and/or neglect are more likely to be

considered at risk academically (Shonk & Cicchetti, 2001). For example children with a history of neglect have been found to exhibit more disciplinary problems and poorer academic performance (Kendall-Tackett & Eckenrode, 1996).

The association between early CAN and attachment difficulties is well documented and consistent with attachment theories (Ainsworth, Blehar, Waters, & Wall, 1978). According to Bandura's social learning theory, multiple interactions between the child and their caregiver assist the child to learn developmental consequences, and shape the child's and adult's behaviour within their environmental context (Wolfe & McGee, 1994). Consistent nurturing parenting practices are believed to be essential for the development of prosocial behaviour while minimal displays of affection, acceptance or responsivity by the parent towards their child has been shown to impede healthy secure attachment and influence the development of maladaptive behaviour (Wolfe & McGee). Similarly, excessively harsh or inappropriate discipline, parenting practices which constitute emotional or psychological abuse, and/or interacting with caregivers who exhibit poor socialisation skills may result in diminished learning opportunities and dire consequences: maladaptive socialisation, diminished altruistic behaviour, dependency and/or submissiveness (Grusec & Walters, 1991).

Research has shown that maltreated children aged between 1 and 3 years assaulted peers and caregivers more frequently, displayed diminished responsiveness to friendly initiations and demonstrated more avoidant behaviour than their non-abused peers (George & Main, 1979). Observational research confirms that abused children experience difficulty displaying concern for distressed peers and frequently react inappropriately with aggression, fear or anger (e.g., Main & George, 1985; Klimes-Dougan & Kistner, 1990). Similarly, abused children tend to respond to aggression with aggression or resistance, compared to non-abused children who generally responded with distress (Howes & Eldredge, 1985). Abused children frequently experience difficulty initiating peer interaction (Darwish, Esquivel, Houtz & Alfonso, 2001). Such findings provide further evidence of abuse and/or neglect adversely impacting upon the child's ability to discriminate between and identify emotions, which further compromises the development of social competency.

It has been theorised that emotional development and establishment of self-concept, originate in early childhood experiences. Six-year-old children with a history of abuse have been shown to have less adaptive personality types or more specifically, appear less agreeable, conscientious or open to new experiences, and demonstrate more neurotic behaviour (Rogosch & Cicchetti, 2004). These personality traits continued to remain evident at a 3-year follow-up. Children with a history of physical and emotional abuse have reported high levels of depression and helplessness and low self-esteem (Cerezo & Frias, 1994). Post Traumatic Stress Disorder (PTSD) is also common among victims of abuse, particularly sexual abuse (Walsh, MacMillan & Steiner, 2005) and is evident in children as young as 7 years (Ackerman, Newton, McPherson, Jones & Dykman, 1998). Abused children in early primary school years demonstrated multiple academic risks, diminished academic engagement, deficient social skills and lower ego resiliency (Shonk & Cicchetti, 2001).

A longitudinal study of children who experienced sexual abuse reported a diverse range of difficulties which included: anxiety, depression, anger, attentional and learning difficulties, somatic symptoms, sexualised behaviour, insomnia, problems with elimination, eating disorders, speech disturbances, substance abuse and suicide attempts or self-harm (Calam, Horne, Glasgow & Cox, 1998). Similar associations (e.g., depression, anxiety, low self-esteem, maladaptive behaviours, substance misuse and eating disorders) have been demonstrated within an Australian sample of sexually abused children (Swanston et al., 2003). Additionally, children of women who had experienced childhood sexual abuse, have demonstrated high levels of hyperactivity, conduct problems, peer problems and emotional difficulties as measured by the Strengths and Difficulties Questionnaire (Roberts, O'Connor, Dunn & Golding, 2004). These findings attest to the potential repercussions impacting upon succeeding generations.

Adolescent Consequences

Adolescents reporting a history of childhood abuse and/or neglect are more likely to demonstrate antisocial behaviour, delinquency, be involved in violent criminal activity, have more frequent accidents and illnesses, demonstrate poor social skills and be physically aggressive towards their partners (Bank & Burraston, 2001). Child abuse, particularly sexual abuse, has been found to be a predictor of suicide behaviour in adolescents (Oates, 2004). Thabet, Tischler and Vostanis (2004) found maltreated adolescents to be more reliant upon avoidant or emotion-focused coping strategies (e.g., denial or self-blame) rather than more active and adaptive strategies (e.g., rationally seek and apply information) used in problem solving by non-abused adolescents. Additionally, an association has been made between witnessing domestic violence by adolescents and their reporting increased levels of hopelessness, psychological maladjustment, and low self-esteem (Haj-Yahia, 2001).

Adult Consequences

Nurcombe (2000) reviewed literature regarding adults who reported experiencing CAN. Adverse outcomes were found to include social-emotional difficulties, interpersonal problems and self-hatred. Further associations were made between childhood abuse and psychopathology which included eating disorders, suicidal tendencies, borderline personality disorder, dissociative identity disorder, somatisation disorder and depression or anxiety. It has also been suggested that long-term childhood abuse consequences such as depression, anxiety, substance abuse and anti-social behaviour may contribute to the underlying negative sequelae involved within the phenomenon of intergenerational transmission of child abuse and neglect (Frias-Armenta, 2002).

The Diagnostic and Statistical Manual of Mental Disorders produced by the American Psychiatric Association (1996) identified childhood sexual abuse as a contributing factor in the development of adult psychopathology. The long-term consequences of sexual abuse for women include diminished psychological well-being, teenage pregnancy, poor parenting behaviours and difficulty adjusting to their offspring (Roberts, O'Connor, Dunn & Golding, 2004). Sexual abuse has also

been associated with adult sexual problems, increased risk of rape, coercive sexual experiences, and domestic violence (Arias, 2004).

The long-term psychological consequences of childhood emotional abuse and neglect have received limited empirical attention. However, Spertus, Yehuda, Wong, Halligan and Seremetis (2003) found that women presenting to their primary care medical practitioner with a history of emotional abuse and neglect reported higher levels of anxiety, depression, post-traumatic stress symptoms and somatic symptoms.

Childhood abuse appears to place victims at a higher risk of criminal activity. Early studies have supported a link between abuse and later criminal activity in both men (e.g. McCord, 1983) and women (e.g., Rosenbaum, 1989). Bank and Burraston (2001) confirmed that incarcerated felons reported receiving higher levels of punitive discipline during their childhood compared to individuals within the general population. Similarly, the Australian Childhood Foundation (2005) reported that approximately 80% of incarcerated women have experienced childhood abuse as had more than 70% of individuals who attended drug and alcohol treatment services. Bank and Burraston (2001) also found that adults abused during childhood were more likely to have been charged with non-traffic offences had committed more violent offences and started delinquent activity at a younger age. Associations have been found between a history of childhood physical abuse and later involvement in violent sex crimes and between childhood sexual abuse and the perpetration of rape and child molestation.

Research Challenges

Much of the research investigating long-term consequences is based upon retrospective study within a cross-sectional design (i.e., adults presenting with psychological or behavioural difficulty report that they have experienced childhood abuse). Reliance upon such retrospective studies has been criticised and remains controversial with doubts being raised regarding the reliability and validity of findings (Widom et al., 2004). Potential research biases, including reporting and recall bias, sampling bias (i.e., only including adults seeking intervention later in life) and the difficulty in assigning causal relationships (e.g., negative consequences may be more directly related to co-occurring negative life experiences) create problems for researchers and clinicians. In defence of these methods, Paivo (2001) found that measures of retrospective reporting of abuse were relatively stable over a 6-month follow-up period.

Widom et al. (2004) postulated that the most empirically sound research design to evaluate abuse consequences is a prospective, longitudinal study based upon a large representative sample size involving reassessment over time. It is noted however, that prospective research is also subject to potential confounds and difficulties. For example, once children have been identified as “at risk”or as experiencing difficulties, ethical standards demand that appropriate interventions are implemented. Intervention may, therefore, inadvertently disrupt the natural course of the child’s response and prevent the establishment of a true control group.

Potential Mediating and Moderating Factors

Theory and General Findings

Despite general consensus regarding associations between childhood abuse and psychological, behavioural, social and/or developmental impairment, adverse consequences vary considerably and are “by no means a certainty” (Zielinski & Bradshaw, 2006, p. 49). Additionally, while the intergenerational transmission of abuse is common, it is not inevitable as many parents abused in childhood have been able to break this cycle of abuse (Hall, Hanagriff, Hensley & Fuqua, 2004).

The heterogenous nature of abuse and neglect consequences suggests the existence of factors, which may moderate or mediate outcomes. Individual differences regarding the ways in which the abused child perceives, appraises, and processes their traumatic experiences may influence outcomes (Williams, 1993, as cited in Steel, Sanna, Hammond, Whipple & Cross, 2004). Additionally, child abuse and/or neglect may co-occur with other adverse circumstances including: substance abuse, criminal activity and domestic violence (Dong et al., 2004), thus making it difficult to determine the interaction between, and potential cumulative effect of, different traumatic experiences and to isolate the effects of abuse.

Through the lens of an ecological framework, variations in outcomes for abused children may be attributed to the interaction of multiple individual and environmental risk and protective factors (Rutter, 1990). Consistent with an ecological model of development originally proposed by Bronfenbrenner (1979), children develop within a number of social contexts with the family initially providing the proximal influence upon childhood development, with more distant influences being exerted from interactions with peers, the school environment, neighbourhood and communities. The ecological model is dynamic in that individuals are not only influenced by their environment but, in turn, influence their environment. When applying this model to child abuse and neglect it is possible to conceive that factors entwined within more proximal contexts (e.g., maternal depression) will have a greater influence upon child functioning compared to more distal influences (Zielinski & Bradshaw, 2006). However, as a child matures, peers, schools, neighbourhoods and communities become more influential and may exert a greater influence upon the child's level of functioning. Consequently, the complex interaction between a child's individual resources and vulnerabilities, and environmental factors may mediate the effects of abuse and neglect (Nurcombe, 2000).

One such interaction is the concept of resiliency which has received considerable attention in adolescent research and has been shown to mediate abuse outcomes (e.g., Perkins & Jones, 2004). Resiliency is frequently conceptualised as more

than just a trait, and considered to be comprised of personality features, family cohesion, and access to external supports (Garmezy, 1985).

Contemporary research has explored the relationship between the child's contextual environment (e.g., low socioeconomic household) and increased risk of childhood abuse and neglect. However, relatively minimal research has addressed the potential influence of abuse and neglect outcomes upon the surrounding social-emotional and physical environments (Zielinski & Bradshaw, 2006). Nurcombe (2000) classified risk and mediating factors into four groups: antecedent factors (e.g., family functioning), abuse-related factors (e.g., frequency of abuse), subsequent events (e.g., support from non- offending parent) and mediating factors (e.g., negative self-concept). Betz (1998) found that social support, self-blame and coping styles mediated the effects of childhood physical, sexual and psychological abuse on self-esteem and psychological distress. Parental psychopathology, such as maternal depression (e.g. Kelly, Faust, Runyon & Kenny, 2002) and familial stress (Compas, 1987), have also been shown to negatively influence the psychological adjustment of abused children.

Child Characteristics and Abuse Factors

An expanding body of research has investigated gender and age correlates and associations between abuse types and outcomes. For example, Steel et al. (2004) found that the number of sexual perpetrators, the age of the child at the onset of abuse (i.e. prepubescent children experience greater distress in adulthood), and the duration of the abuse, influenced long-term psychological distress. Feiring, Taska and Lewis (1999) demonstrated that sexually abused adolescents reported higher levels of psychological difficulties, including self-esteem and depression, compared to younger sexually abused children. However, the presence of conflicting findings highlights the complexity of the child's response within varied and dynamic environments.

Diverse findings have also been reported regarding the existence of differential effects associated with abuse types. For example, a study involving adults found childhood neglect was associated with more severe psychological difficulties and anxious attachment than physical abuse (Gauthier, Stollak, Messe & Aronoff,

1996). Emotionally abused adolescents were less likely to abuse substances than their physically or sexually abused peers (Moran et al., 2004). Conversely, Mullen et al. (1996) failed to demonstrate any significant associations between different types of abuse and subsequent problems.

Studies comparing the adverse consequences of children experiencing single or multiple forms of abuse have been more consistent in their findings. For example, homeless youths with a history of both physical and sexual abuse demonstrated higher levels of psychopathology regarding internalising problems and impaired cognitive function than those experiencing either abuse singularly (Ryan, Kilmer, Cauce, Watanabe & Hoyt, 2000). Children who experienced concomitant sexual and physical abuse demonstrated higher levels of psychological difficulties over children who experienced either form of the abuse singularly (Ackerman et al., 1998). Similarly, an Australian group of children experiencing multiple forms of abuse demonstrated significantly higher levels of psychological dysfunction compared to those experiencing single abuse types (Martin and Bergen, in press).

Relatively minimal research is available regarding the potential relationship between gender and psychological dysfunction. Feiring et al. (1999) explored gender differences in abused children, finding that girls reported higher levels of intrusive thoughts, hyperarousal, sexual anxiety and perception of the world being dangerous. While Calam et al. (1998) failed to find gender differences for sexually abused children at the time of assessment, boys were found to demonstrate more problems at a 9-month follow-up. Interestingly, it has been demonstrated that adults who were emotionally neglected by a female caregiver, experienced greater psychological distress than those neglected by a male caregiver (Wark, Kruczek & Boley, 2003) suggesting the possible existence of differential effects related to the perpetrator gender.

Parenting

Numerous studies have drawn associations between offending parents and poor parenting practices (Zielinski & Bradshaw, 2006). However, few studies have examined the attributes and functional characteristics of non-offending parents or caregivers (who may be, for example, relatives or foster carers) and the impact of their parenting on the child's adjustment. Abundant research has confirmed that inconsistent parenting, poor monitoring or supervision, the degree of parental involvement, excessive use of corporal punishment and failure to positively reinforce appropriate behaviour, are frequently associated with child conduct problems (Frick, Christian & Wootton, 1999). Poor parenting practices have been linked with diverse psychosocial problems including criminality, antisocial behaviour and psychopathology, which become evident later in adulthood (Haapasalo & Pokela, 1999). Additionally, associations have been made between poor parenting practices and parents' own history of abuse during childhood. Bower-Russa, Knutson and Winebarger (2001) argue that children who experience excessively harsh and abusive discipline during childhood frequently normalise this behaviour and subsequently revert to using similar practices with their own children. The relationship between parenting practices of non-offending caregivers and the psychological adjustment of their children is unknown.

Parenting Stress

Parenting stress, as measured by the Parenting Stress Index (Abidin, 1995) has shown strong association with parental attitudes which increase the risk of parents abusing their children (e.g. Chan, 1994; Rodriguez & Green, 1997). For example mothers experiencing increased levels of maternal stress tend to be more in favour of using corporal punishment methods when disciplining their child (McCurdy, 2005). Family stress has also been associated with unsupportive parenting styles (Wind & Silvern, 1994). Research supports an association between parental psychopathology and the level of difficulty experienced by maltreated children (Zielinski & Bradshaw, 2006). Parenting stress appears to be associated with parenting practices and may potentially influence the child's adjustment. Interestingly, Pithers, Gray, Busconi and Houchens (1997) found the

parents of sexually abused children report clinically higher levels of parenting stress compared to foster carers.

Empathy

Several studies have shown that abusive parents are more likely to lack parental warmth, compassion and concern and experience difficulty in perspective taking (e.g., Wiehe, 2003). Donald and Jureidini (2004) include empathy within their basic definition of parenting capacity: the need for parents "to empathically understand and give priority to their child's needs" (p.5). Contemporary research has begun to address the potential role of empathy as a moderator of abuse consequences. For example, Wind and Silvern (1994) demonstrated that perceived parental warmth mediated the relationship between child abuse and low levels of self-esteem and depression, which were experienced later in adulthood. However, parental empathy failed to mediate the relationship between abuse and associated trauma symptoms.

Social Support

Research in child abuse and neglect has demonstrated a direct relationship between social support and diminished levels of adverse outcomes. For example, abused youths receiving strong social support from their family and friends displayed less negative outcomes than those reporting lower levels of support (Murthi & Espelage, 2005). Additionally, youths receiving high levels of social support from their family were less likely to abuse substances compared to non-supported maltreated adolescents (Perkins & Jones, 2004). The role and impact of social support given to the caregiver of abused children is less well understood.

Further, research has demonstrated an association between social support and parenting behaviour (Zielinski & Bradshaw, 2006). Within the general community, women reporting high levels of social support tended not to rely upon corporal punishment as a disciplinary method (McCurdy, 2005). Additionally, social support may attenuate parental stress. In fact, Rogers (1998) demonstrated that social support buffered the relationship between parenting stress and parenting practices. Grandparents who provide the primary care for their grandchild, and receive high levels of social support experience lower levels of psychological distress

compared to grandparents who have weaker support networks (Kelley, Whitley, Sipe & Yorker, 2000).

Interestingly, biological parents of abused children have reported significantly reduced levels of social support and relatively high levels of interpersonal difficulties (e.g., withdrawal and alienation) compared to foster carers (Pithers, Gray, Busconi & Houchens, 1998). Considering the association between social support and parenting, an ecological perspective suggests that parents and caregivers are the most proximal influences in a child's life. Further research is therefore required to uncover the role of social support in child outcomes for this particular group of parents and caregivers.

Treatment and Prevention of Child Abuse and Neglect

Interventions for child abuse and neglect range from: early intervention and prevention during childhood; prevention programs and services for at-risk families; to later-life treatments for adults seeking assistance for social and psychological problems. As this research focuses on early intervention and prevention, so, too, will this part of the review.

Traditionally, early interventions were individually focused upon the child and/or adult (Swenson & Chaffin, 2006). However, the emphasis within contemporary intervention programs has incorporated research findings regarding the child's ecology and considers multiple factors impacting the child's psychological adjustment (Swenson & Chaffin, 2006). Additionally, there is a strong trend guiding interventions towards evidenced-based practice, necessitating collaboration between clinical practitioners and researchers as they attempt to evaluate "progressively more refined and effective treatment protocols" (Chaffin & Friedrich, 2004, p. 1106). Efficacy studies within the area of child abuse and neglect present ethical issues, for example, when randomising (allocating) children into treatment and control group. Consequently, treatment outcome studies have mostly been undertaken in the field and constitute effectiveness or evaluation studies. Few studies of this nature have been undertaken within Australia.

In recent years two major projects have examined the available research evidence to determine the efficacy and effectiveness of current treatments according to pre-established criteria. The first review group, The Office for Victims of Crime in the United States (OVC), determined that only one single treatment type met the top criteria, Trauma-focused Cognitive Behavioural Therapy (Saunders, Berliner & Hanson, 2004). While the majority of interventions received some empirical support, of concern was the finding that one therapy, Attachment Therapy, was considered as having potential for significant harm (Chaffin & Friedrich, 2004). Two additional interventions were considered to demonstrate acceptable levels of efficacy by a second review group, The Kauffman Foundation: Abuse-focused Cognitive Behavioural Therapy (CBT) and Parent-Child Interaction Therapy (Saunders et al.2004).

While many child abuse interventions have been evaluated and have shown benefits, Chaffin and Friedrich (2004) suggest that the validity of findings are frequently questioned due to the reliance upon flawed research methodology and poor operationalisation of outcomes benchmarks. Confidence in the effectiveness of abuse interventions may be best achieved via well-designed and controlled randomized trials, which can be generalised into effectiveness studies within the field (Chaffin & Friedrich 2004). A recent meta-analysis of 21 studies conducted to investigate the effectiveness of diverse interventions for all types of child abuse and neglect, reported a moderate effect size with treated children reporting higher levels of functioning than of the majority of abused children on therapy waiting lists (Skowron, 2005). However when intervention effectiveness was based upon clinician observations rather than family perception, only a small effect size was demonstrated suggesting that interventions were less effective. Unfortunately, the meta-analysis did not provide data regarding clinical effectiveness or degree to which level of functioning was restored to normal ranges. The effectiveness of CAN interventions therefore appears inconclusive.

Summary

Extensive research has provided evidence of extremely varied adverse short- and long-term consequences of childhood abuse and neglect. Abuse and neglect symptomatology frequently persists into adulthood and may contribute to the intergenerational transmission of abuse. The majority of abuse research has explored long-term consequences and has relied heavily upon retrospective reporting of abuse. Reliance upon this research method can be problematic. In comparison much less research has focused upon the consequences of emotional abuse and neglect or consequences emerging immediately at the time of any type of child abuse or neglect. The strongest and most sound research design, facilitating a more reliable understanding of the complex relationship between abuse and poor outcomes, is a prospective longitudinal study, which follows a substantial number of children and evaluates their progress over time. This study extends upon the existing body of knowledge on the psychological adjustment of children who have experienced abuse and neglect by exploring relationships between contextual factors such as age, gender, abuse type, abuse severity, and the psychological functioning of affected children.

Several variables have been shown to mediate the effects of abuse and neglect on children and focus upon individual attributes (e.g. cognitive appraisal), family functioning (eg., parenting beliefs, parent-child interaction), and broader contextual factors (eg., external support, socioeconomic situation). Additionally, parental attributes such as diminished empathy, history of abuse and psychological dysfunction have been associated with poor treatment outcomes. This study further explores potential factors associated with the primary caregiver, which may mediate the impact of abuse and neglect on children. Importantly, this study fills a gap in the research by providing data with an Australian sample in an Australian context.

The intervention program offered by Contact House is modelled upon a strengths-based developmental approach within a child protection framework. Programs are individually developed to suit the needs of individual families and are delivered via a multidisciplinary team. The efficacy of such a family-based holistic intervention is yet to be empirically validated. This study will establish a database for future

outcome research and within the confines of the research period, present trends regarding changes in the level of the child's psychological distress over time.

Project Aims

The broad aim of this project was to investigate caregiver attributes and the psychological adjustment of children referred to a non-government treatment centre. This was achieved via several specific aims.

1. To describe the psychological adjustment of children who have experienced abuse and/or neglect based upon the *Strengths and Difficulties Questionnaire*.
2. To compare the psychological functioning of children presenting for treatment with a community sample of children.
3. To describe the level of psychosocial functioning of the caregivers in the clinical group regarding their level of empathy, interpersonal problems, parenting stress, social network and support and parenting practices.
4. To explore the relationship between the child's demographic variables, factors relating to the abuse and neglect, or caregiver variables, which may predict, mediate, or moderate the child's psychological adjustment.
5. To establish a database for future research into treatment outcomes.
6. To examine the relationship between research variables and attrition.

Information was gathered during this project in preparation for future research into treatment outcomes. Within the limitations of a small sample size, preliminary findings regarding changes in the psychological functioning of the child, parenting practices and parenting stress will be offered for families completing interventions during the study assessment phase. Additionally, where collected and provided by clinicians, changes in child functioning at a 3-month follow-up assessment will be explored.

Methodology

Participants

Contact House Clinical Group

Participants in the clinical group for the study were 53 families (including 86 abused and/or neglected children) referred to and accepted into Contact House child abuse treatment programs based at Wooloowin, Brisbane (64), Townsville (13), and the Gold Coast (9). Two caregivers accepted into the Wooloowin Centre declined to participate. Sixty-nine percent of the children (n59) were considered as new clients (i.e., on the waiting list or having been accepted into the services within a 3-month period) while 39% (n27) had been receiving Contact House services for a period of at least 3 months. Table 1 provides a breakdown of family distribution across the three centres.

Table 1

Distribution and Classification of Caregivers and Children across Treatment Facilities

	Number of Families		Number of Children	
Centre	New	Existing	New	Existing
Wooloowin	28	6	50	14
Gold Coast	4	3	6	3
Townsville	3	9	3	13

Note. New clients included those who were on the waiting list or had been accepted into a treatment facility within the previous 3-month period. Existing clients were those who had been receiving services from the facilities for a minimum of 3 months.

Clinicians administered the follow-up *Strengths and Difficulties Questionnaire* (SDQ) to 13 children at a 3-month period following the initial assessment. Of this group, eight children (from 5 families) ceased services at Contact House within the assessment phase with 1 caregiver declining the invitation to complete a closure assessment and 1 caregiver providing information about their child (i.e. completed the SDQ) but did not want to complete the remainder of the closure assessment. Closure information was thus available on 7 children and 3 caregivers. Only 2 out

of the 4 families had completed interventions, 1 family had ceased intervention due to moving out of the service area and the remaining family ceased intervention due to legal proceedings.

Community Comparison Group

Participants in the community group for the study were 82 primary caregivers (representing at least 82 children). These families were recruited via four state primary schools, and one long day care centre. Principals of the schools and the director of the long day care centre agreed to distribute surveys to families using their services. In all, four hundred and seventy-seven questionnaire protocols were distributed to families within these five facilities. Seventy-four protocols were returned from the primary schools, and eight from the day care centre. This represents a response rate of 17%.

Procedure

Approval to conduct the study was obtained from the QUT University Human Research Ethics Committee and Education Queensland.

Clinical Group

All families with at least one child over the age of two, referred to and subsequently accepted at the Contact House services between February 2005 and November 2005 were eligible for inclusion within this study. After informing newly referred clients, existing clients and clients on the waiting list of the research project, clinicians referred interested clients to the research assistants. Where feasible, the research assistant based at Contact House Wooloowin attended the initial intake meeting and was introduced to the primary caregiver.

The research assistant met with the primary caregiver at the treatment centre or at the client's home. Participants completed an informed consent process. The research protocol was delivered in the form of a semi-structured interview. Five clients preferred to complete the protocol by themselves at home and later returned the completed protocol by post.

Families who completed their intervention or ceased receiving Contact House services during the study period, were invited to participate in a closure interview. Additionally, clinicians were asked to invite the primary caregiver to complete the *Strengths and Difficulties Questionnaire* for their child/children during a routine therapy session three months following the initial interview.

Interventions Offered at Contact House Facilities

The interventions offered by Contact House facilities during this study period were individually tailored to meet the needs of the child and family within a multi-disciplinary strengths-based framework. Individual child, educational, family and/or parenting interventions were delivered either in the facility centres, within the home environment or within other appropriate venues (e.g., school).

Community Control Group

Principals of 13 state primary schools with previous research links with QUT, within the outer Brisbane metropolitan area were approached to obtain the community sample of families operating as a comparison group. Principals who were interested in participating organised the dispersal of questionnaire packages to all the families within randomly selected classes across the preschool and primary years. The Director of a private day care facility also approved and facilitated the questionnaire dispersal to all families using her service who had children aged 3 years and over.

Instruments

A battery of self-report instruments was administered within the clinical research protocol (see Appendix A). This battery included: a study specific demographic section, the *Strengths and Difficulties Questionnaire* (SDQ), the *Eyberg Child Behavior Inventory* (ECBI), the *Working Alliance Inventory* (WAI), the *Parenting Stress Inventory* (PSI), the *Social Support Scale*, the *Interpersonal Reactivity Index* (IRI), the *Inventory of Interpersonal Problems* (IIP), and the *Alabama Parenting Questionnaire* (APQ). An *abridged* version of the research protocol was

completed by the control group and consisted of demographical information, the SDQ, the PSI and the APQ.

Demographic Questionnaire

This study-specific section obtains basic demographic information regarding the children included within the study (e.g., age, gender and educational attendance), the family situation (e.g., composition and income source), and primary caregiver (e.g., educational attainment, occupation and substance usage). Additional sections obtain information regarding the family's therapy situation with the clinical case coordinator completing details concerning the abuse and neglect history of both the child and caregiver.

Strengths and Difficulties Questionnaire

The SDQ is a brief behavioural screening inventory, designed specifically for use by researchers, clinicians and educators to assess areas of behavioural difficulties and positive attributes in children aged 3 to 17 years (Goodman, 1999). In this parental version the primary caregiver rates whether each of the 25 behavioural items are not true, somewhat true or certainly true based upon their child's behaviour over the previous 6-month period. Five domains are assessed via subscales: emotional symptoms, conduct difficulties, hyperactivity, peer problems and prosocial behaviour, with potential scores ranging between 0 and 10. The total distress score measures the overall level of difficulty experienced by the child and ranges between 0 and 40, with higher scores indicating significant levels of difficulty. An optional impact supplement has also been included, which identifies problem chronicity and measures the impact of the child's distress upon psychosocial functioning (e.g., home life or classroom learning). The caregiver also rates the degree of family burden experienced as a result of the child's behaviour. Where possible the SDQ was repeated at a 3-month interval based on the child's behaviour over the previous month and upon therapy closure with additional questions assessing caregiver's perception of intervention outcomes. Strong correlations regarding the total difficulty score (.87) and the subscales (.59 to .84) have been demonstrated between the SDQ and the Child Behavior checklist (Goodman & Scott, 1999).

The Eyberg Child Behavior Inventory

The ECBI is an established parent rating scale used as a multidimensional assessment for disruptive behaviour in children aged 2 to 17 years (Burns & Patterson, 1991). This 36-item scale has been used for the assessment of conduct problems, in program evaluation research and to explore potential relationships between problematic behaviour and family functioning (Burns & Patterson). The frequency of target behaviours is rated on a 7-point scale ranging from never to always and these scores are combined to form an Intensity Behavior scale, which ranges between 36 and 252. Higher scores indicate greater frequency and the cut-off score for normal behaviour is 127 (McGain & McKinzey, 1995). Caregivers also record whether each behaviour is perceived as being problematic for them by a yes/no response. These scores combine to form a Problem Behavior Scale which potentially ranges between 0 and 36 with 11 being considered as the cut-off point for normal behaviour (McGain & McKinzey, 1995). The CCBI has demonstrated good reliability and validity with reported test-retest reliability ranging from .86 to .88 and internal consistency from .88 to .95 (Violence Institute of New Jersey, 1992). This measure is administered to all children between the ages of 2 to 3 years who are included within this study.

The Working Alliance Inventory – Short Form, Client Version

The WAI-S is a 12-item scale which measures the client's perception of the therapeutic relationship according to a 7-point scale ranging from never to always. The WAI-S has received copious empirical attention in recent years and has been found to be interchangeable with the full-scale version of the WAI (Busseri & Tyler, 2003). This inventory is based upon theory which considers the therapeutic relationship to be comprised of three major areas: the emotional bond established between the client and the practitioner, the degree of consensus regarding goal setting and the level of collaboration regarding therapeutic tasks (Cloitre, Stovall-McClough, Miranda & Chemtob, 2004). These 3 areas can be individually measured with possible scores ranging from 4 to 28. The total score, which represents the composite score of all 12 items potentially, ranges between 12 and 84, with higher scores reflecting greater client perceived alliance satisfaction. Consistent with previous studies (e.g., Cloitre, Stovall-McClough, Miranda &

Chemtob, 2004), the present study will assess the client's perception of the working alliance using the total score.

Parenting Stress Index (short form)

The PSI/SF is a 36 item inventory designed to measure the magnitude of stress involved in the parent-child relationship and has been administered with perpetrators of child abuse (Milner, 1991). Responses are scored on a 5-point likert like scale from strongly agree, agree to strongly disagree with three items having a forced choice format offering 5 options. Parenting stress is assessed via an overall stress score and three subscale scores that reflect areas contributing to the stress involved with parenting. The first subscale, Parental Distress, measures the degree to which the individual experiences stress related to their parental role and questions areas such as depression, social isolation, perceived parenting competence, partner conflict related to parenting, and lifestyle restrictions (Abidin, 1995). The Parent-Child Dysfunctional Interaction Subscale examines parental expectations for their child and whether the parent is satisfied with this relationship. The final subscale, Difficult Child, focuses on the child's characteristics such as self-regulation, which may trigger perceptions of this child as being problematic or "difficult to manage" (Abidin, p. 56). The total stress score which excludes the seven defensive responding questions, provides an indication of the overall degree of stress experienced in the parental role. Test-retest reliability has been found to range between .80 and .91 and the PSI/SF has shown moderate to strong correlation with full-length PSI (Abidin).

Alabama Parenting Questionnaire

The APQ is a 42 item self-report inventory specifically developed for research examining the relationship between parenting practices and children's disruptive behaviour (Shelton, Frisk & Wootton, 1996). The APQ measures the use of positive and negative parenting practices via a 5-point scale ranging from never to always. Parenting behaviour is assessed via five subscales: parental involvement, positive parenting practices, parental supervision or monitoring of children, inconsistent discipline and corporal punishment. Seven of the items do not contribute to these scales but provide information regarding other forms of

punishment practices in order to prevent bias towards corporal punishment (Shelton, Frisk & Wootton). Initial internal consistency has been reported as between .46 and .80 for the 5 subscales with temporal stability ranging between .66 and .89 (Shelton, Frisk & Wootton).

Social Support Scale

As defined in previous research (Little & Girvin, 2005), social network size, was measured according to the number of friends and family members that the caregiver had contact with at least once each month. Social network support is assessed according to three domains: emotional support, practical assistance or advice. Each of these Subscales represents the proportion of support given in the specific area relative to total network size.

Interpersonal Reactivity Index

The IRI is a 28 item self-report scale designed to assess empathy. This index is based upon multidimensional theory suggesting that empathy is comprised of four different constructs: perspective taking (PT), empathic concern (EC), fantasy (FS) and personal distress (PD; Perez-Albeniz & de Paul, 2004). Perspective taking questions reflect the efforts the respondent makes regarding adopting another person's perspective. The Empathic Concern subscale provides an assessment of the individual's capacity to feel concern or compassion for other people. The Fantasy subscale measures the respondent's tendency towards identification with fictitious characters while the Personal Distress scale assesses the degree of anxiety or discomfort experienced when witnessing others in distress. Responses to the 28 items are measured according to a 5-point scale with potential scores for each subscale ranging between 0 and 28. Consistent with recent studies and the finding that personal distress decreases with age, this study with assess empathy according to a Total Empathy Score which excludes the Personal Distress scale (Perez-Albeniz & de Paul). Average scores for subscales in a female non-clinical population have been reported as being 18, 21.7, 12.3 and 18.75 for the PT, EC, PD and FS subscales respectfully (Davis, 1980 as cited in Guttman & Laporte, 2000). This instrument has been shown to demonstrate moderate internal

consistency with coefficients ranging from .63 to .73 across the four subscales (Perez-Albeniz & de Paul).

Inventory of Interpersonal Problems

The IIP is a 32 item self-report questionnaire, which is scored according to a 5-point scale. This inventory evaluates the nature and degree of an individual's interpersonal functioning via a Total Personal Problems Score (Horowitz, Alden, Wiggins & Pincus, 2000). Identification of the specific domains, which are contributing to this distress, can then be identified. These areas are assessed via eight subscales: a Domineering/Controlling Scale, Vindictive/Self-Centered Scale, Cold/Distant Scale, Socially Inhibited Scale, Nonassertive Scale, Overly Accommodating Scale, Self-sacrificing Scale and an Intrusive/Needy Scale. High levels of internal consistency regarding the individual subscales have been reported with Cronbach alpha coefficients ranging from .68 to .93 and subscale test-retest reliability ranging between .57 to .82 (Horowitz, Alden, Wiggins & Pincus). Moderate to strong correlations have been demonstrated between the Brief Symptom Inventory (r = .57 to .78) while the full scale has shown somewhat lower correlations with the Symptom Checklist-90-R (r = .02 to .40).

Findings

Data Analysis

Analyses were undertaken using SPSS 14.0 with missing data deemed to be 'missing at random'. Missing cells on the APQ were substituted with the mean score from items within the relevant subscale. Independent *t* test analyses were used to assess group differences regarding demographic variables. A series of univariate and multivariate analyses of variance (ANOVA and MANOVA[2]) were used to compare clinical and control cohorts while paired samples statistics were used to examine variables at the 3-month follow-up. Finally a series of multiple

[2] Statistical analysis procedures, which compare mean scores obtained by relevant groups on 1 (ANOVA) or more (MANOVA) dependent variables.

linear and hierarchical regression analyses [3] were used to examine the relationships between child and caregiver variables.

Descriptive Statistics

Differences between New and Existing Clinical Client Groups

Demographic differences between the two clinical groups (i.e., new and existing families) were explored. The children in the existing group were significantly older (*M* = 120.74 months, *SD* = 37.89) than the new children (*M* = 84.95 months, *SD* = 39.45), *t*(53.44) = .4.01, *p* < .001. However no group differences were found regarding the child's gender, family composition, the child's relationship to caregiver, caregiver age or gender. Likewise, no difference was found between groups regarding their SDQ total difficulties score. These two groups were thus merged for analysis so that the clinical group includes data from both the new and existing client families (*n* = 86).

Demographic Characteristics of Children Participants

The clinical and comparison group of children differed significantly regarding age, *t*(166) = 2.33, p = .02. The age of the children in the clinical group (*M* = 96.2 months, *SD* = 42.2) ranged between 2 and 17 years while the age of the children in the comparison group (*M* = 110.33 months, *SD* = 36.4) ranged between 3 and 14 years. No significant difference between groups was found regarding the gender distribution, *t*(166) = .48, p = .63 with each group having slightly more males than females. The children in both groups were similarly distributed regarding their attendance at educational facilities, *t*(166) = 1.87, p = .06. The children's demographic characteristics are presented in Table 2.

[3] Multiple Linear Regression is a statistical analysis which explores the prediction of 1 variable from several others which are often considered in ordered sets (hierarchical regression)

Table 2

Demographic Characteristics for Children in the Clinical and Comparison Groups

Characteristic	Clinical Group		Comparison Group	
	Number	Percent	Number	Percent
Age				
2 – 6 years	36	42	22	26
7 – 11 years	39	45	41	50
12 – 17 years	11	13	19	23
Gender				
Male	44	51	45	55
Female	42	49	37	45
Educational Attendance				
Nil	1	1	0	0
Daycare	19	22	8	10
Preschool	4	5	7	9
School	62	72	67	82

Note. Clinical children group $n = 83$, comparison children group $n = 82$.

Primary Caregiver Demographic Characteristics

Caregivers of children in the clinical group were significantly older than caregivers in the comparison sample, $t(85.6) = 2.54$, $p = .01$ (see Table 3 for further descriptive details). No gender difference was found between caregiver groups with the majority of caregivers in each being female. However, their relationship to the participating children in their care differed significantly, $t(133) = 5.87$, $p < .001$. All primary caregivers in the control group were parents of the participating children whereas children in the comparison group were cared for by parents, foster carers or relatives. The two groups were similar regarding their level of educational attainment, however, significantly more of the comparison community caregivers were currently employed, $t(132) = 2.76$, $p = .007$. Between group differences were evident regarding family composition with the majority of clinical families being classified as sole parent families while the majority of the comparison sample were living within nuclear family types, $t(133) = 5.20$, $p < .001$.

Table 3

Demographic Characteristics for Caregivers in the Clinical and Comparison Groups

Characteristic	Clinical Group Number	Clinical Group Percent	Comparison Group Number	Comparison Group Percent	*t*
Age					
20 – 30 years	6	11	13	16	
31 – 40 years	24	45	45	55	
41 – 50 years	13	25	24	29	
51 + years	10	19	0	0	**
Gender					
Female	50	94	75	92	
Male	3	6	7	8	
Relationship to Child					
Parent	31	59	82	100	
Foster Carer	14	26	0	0	
Relative	8	15	0	0	***
Educational Attainment					
Primary School	6	11	3	4	
Highschool grade10	15	28	23	28	
Highschool grade 12	4	8	26	32	
Training Course	17	32	16	20	
University Studies	11	20	22	17	
Employment Status					
Employed	12	23	37	46	
Not Employed	41	77	44	54	**
Family Composition					
Nuclear	16	30	59	72	
Sole Parent	26	50	19	23	
Extended Family	11	20	4	5	***

Note. Clinical caregiver group n = 53, comparison caregiver group n = 82. **$p < .01$, ***$p < .001$.

Abuse Characteristic for Children in the Clinical Group

The majority of the children (n = 64, 74%) were reported to have experienced multiple types of abuse with comorbid physical and emotional (21%) or comorbid physical, emotional and neglect (20%) being the most commonly experienced form of multiple abuse. Sexual abuse (13%) was the most common and physical abuse (2%) the least common forms of singularly occurring abuse types experienced. The severity of abuse and/or neglect received was rated subjectively by clinicians as being severe for 49% of the children. The abuse was most commonly perpetrated (35%) by the child's parent in combination with another person (e.g.,

the other biological parent, other relative or partner) or solely by the child's biological father (33%). In total, 83% of the abuse was perpetrated by at least one biological parent. Almost half of the children in the clinical group (49%) have had 2 or more prior child protection notifications documented. The abuse characteristics are presented in Table 4.

Table 4

Abuse Characteristics for the Clinical Group of Children

	Number	Percentage
Abuse types		
Physical	2	2
Sexual	11	13
Emotional	4	5
Neglect	5	6
Combination 1 (P, E)	18	21
Combination 2 (P,E,N)	17	20
Combination 3 (P,S)	3	4
Combination 4 (S, E)	3	4
Combination 5 (P, S, E)	1	1
Combination 6 (S, E, N)	2	2
Combination 7 (P, S, E, N)	12	14
Combination 8 (E, N)	8	9
Severity		
Mild	6	7
Moderate	38	44
Severe	42	49
Perpetrator		
Father	28	33
Mother	13	15
Parent and Another Person	30	35
Step-parent/partner	5	6
Other relative	4	5
Person known to family	6	7
Recorded Child Protection Notifications		
Nil	28	33
One	16	19
Two or more	42	49

Note in Combinations P = Physical, S = Sexual, E = Emotional, N = Neglect. Severity of abuse and/or Neglect was rated subjectively by the relevant case coordinator. n = 86.

Clinical Findings: The Psychological Adjustment of Children

Findings based upon the Strengths and Difficulties Questionnaire

Eight (10%) and 59 (71%) children within the clinical group compared to just 3 (4%) and 10 (12%) children within the comparison community sample, demonstrated global behaviour that bordered upon being problematic and fell within the clinically elevated range of behaviours respectively. Forty-eight clinical (58%) and 7 comparison children (9%) displayed emotional symptoms which exceeded the average range reported in normative data, 61 clinical (73%) and 20 comparison children (24%) demonstrated conduct behaviour which fell within the clinically significant range while 44 clinical children (53%) and 9 comparison children (11%) demonstrated clinically elevated levels of hyperactivity and/or inattention. Forty-two clinical (51%) and 12 comparison children (15%) experienced significant problems in the area of peer relationship while 19 children (23%) in the clinical group and none of the comparison children demonstrated abnormally low levels of pro-social behaviours. Mean total scores and subscales are displayed in Table 5.

According to the caregivers, 10 children (12%) did not experience any difficulties, 20 (24%) experienced minor difficulties, 40 (49%) experienced definite difficulties and 12 (15%) experienced severe difficulties. The majority of children (*N* = 46, 58%) were reported to have been experiencing difficulties for more than 1 year. Eleven caregivers (14%) did not believe that their child's difficulties placed a burden upon the family, while 23 (29%), 18 (23%) and 19 (24%) perceived the child's difficulties to place a little, quite a lot and a great deal of burden upon the family, respectively.

Table 5

Psychological Adjustment of Children on the Strengths and Difficulties Questionnaire

Scale	Clinical Group M	Clinical Group SD	Comparison Group M	Comparison Group SD
Total Difficulties Score	20.63	7.57	9.51	5.06
Emotional Symptoms	4.93	2.75	1.98	1.76
Conduct Problems	5.67	2.82	2.32	1.81
Hyperactivity/Inattention	6.39	2.97	2.44	2.41
Peer Problems	3.64	2.32	1.77	1.66
Prosocial Behaviour	6.53	2.58	8.35	1.53

Clinical group n = 83, comparison group n = 82

A one-way ANOVA was conducted to determine whether mean total difficulty scores were statistically different. The Levene's Test of Equality, $F(1,163) = 13.50$, p <.001, indicated a breech in the assumption of equal variance across groups[4]. Log 10 transformations[5] of variables were performed and run within a subsequent ANOVA. No statistically significant difference was noted and therefore the ANOVA results based upon original data are reported. Caregivers of the clinical children reported their children as having significantly higher levels of psychological difficulties, compared to the comparison sample, $F(1, 163) = 122.72$, $p < .001$. The effect size for this relationship was found to be large, $\eta^2 = .43$.

A MANOVA was conducted to evaluate whether groups differed on the underlying behavioural domains assessed via the SDQ. The Box's Test of Covariance Matrices, $F(15,106940.7) = 3.79$, p = <.001, indicated a breech in the assumption of equal covariance across groups[6]. Log 10 transformations of analysis variables were conducted and no difference in significance was noted therefore the MANOVA was conducted using the original data. Significant differences were found between groups among the five subscales Wilks's $\Lambda = .55$, $F(5,159) = 26.38$, $p < .001$. The multivariate effect size based upon Wilks's Λ was large, $\eta^2 = .45$.

[4] The accuracy of ANOVA is reliant upon several assumptions regarding underlying data (e.g., that the scores attained on the dependent variable by all the groups are similarly distributed)

[5] A statistical method to transform data in order to proceed with further analyses.

[6] Similar to ANOVA, analysis is reliant upon scores obtained by both groups to be similarly distributed for all dependent variables.

Follow-up ANOVAs were conducted. The clinical group of children demonstrated significantly higher levels of emotional symptoms, $F(1,163) = 67.08$, $p < .001$, conduct problems, $F(1,163) = 81.94$, $p < .001$ and hyperactivity or inattention, $F(1,163) = 48.73$, $p < .001$. Children within the clinical group also were reported to have significantly more difficulties with peer relationships, $F(1,163) = 35.33$, $p < .001$ and lower levels of prosocial behaviour, $F(1,163) = 30.40$, $p < .001$. The children in the clinical group were significantly impaired in all assessed areas compared to the children in the community comparison group.

Findings based upon the Eyberg Behavior Inventory

Scores on the EBI, attained by the three children under two years of age in the clinical group, were examined. The mean Intensity of Behaviour Scale score of 101.67 (*SD* = 24.17) suggested that the intensity of assessed behaviour fell within the normal range (McGain & McKinzey, 1995) for these children. However, the mean score of 12 on the Problem Behaviour Scale (*SD* = 5.29) suggested that the caregivers perceived that these children demonstrated an abnormally high number of behavioural problems. The small sample size restricts further analysis of this data.

Clinical Findings: Caregiver Attributes and Level of Functioning

Caregiver scores attained on the psychometric instruments were examined and compared to normative data. Unless otherwise stated, data refers to the clinical group of caregivers. Where appropriate, statistical analyses were undertaken to compare scores obtained from the clinical and comparison groups. Table 6 displays the caregiver mean scores attained on the assessed attributes.

1. *Abuse Experiences Reported by Caregivers.* Twenty-eight (53%) caregivers within the clinical group reported experiencing abuse during their lifetime. Eight (15%) caregivers reported being abused during childhood, 11 (21%) reported experiencing abuse during adulthood, and 9 (17%) reported experiencing abuse during both childhood and adulthood.
2. *Parenting Stress. C*aregivers within the clinical group reported significant

levels of parenting stress (*M* = 101.67) with 69% of caregivers receiving total stress scores which fell within the problematic range (i.e., scores above 90 as reported by Abidin, 1995). In comparison, only 16 caregivers within the comparison group (20%) obtained scores indicating clinically elevated levels of parenting stress. An ANOVA was conducted to determine whether the mean total parenting stress score differed significantly. The clinical group of caregivers reported significantly higher levels of parenting stress compared to the control sample of caregivers $F(1,166) = 61.97$, $p < .001$. The effect size of this difference was shown to be large, $\eta^2 = .27$. A MANOVA was conducted to determine whether these two caregiver groups differed on the underlying parenting stress domains. Significant differences were found between groups among the three subscales Wilks's $\Lambda = .54$, $F(3,164) = 47.10$, $p < .001$ and the multivariate effect size based upon Wilks's Λ was large, $\eta^2 = .46$. Follow-up ANOVAs were conducted to explore between group differences on the three parenting stress domains. The clinical group of caregivers demonstrated significantly higher levels of parental distress, $F(1,166) = 5.13$, $p = .03$ and parent-child dysfunctional interaction, $F(1,166) = 53.49$, $p =< .001$ and greater perception of their child being difficult, $F(1, 166) = 119.25$, $p < .001$. The clinical group reported higher levels of distress in all three parenting stress domains compared to the caregivers from the community comparison group.

3. *Parenting Practices.* A MANOVA was undertaken to determine whether the caregiver groups differed with regards to their parenting practices. Significant differences were found between groups among the five behavioural practices Wilks's $\Lambda = .86$, $F(5,161) = 5.21$, $p < .001$. The multivariate effect size based upon Wilks's Λ was large, $\eta^2 =. 99$. Follow-up ANOVAs were conducted to explore group differences on each of the five underlying parenting practices. The clinical group of caregivers demonstrated significantly lower levels of parental involvement with their child, $F(1, 165) = 11.43$, $p = .001$, $\eta^2 = .07$ and less frequent usage of corporal punishment methods, $F(1,165) = 4.14$, $p = .04$. The groups did not differ regarding frequency of implementing positive parenting practices, poor monitoring and/or supervision or inconsistent discipline. However, caregivers of the abused and/or neglected children used

less corporal punishment methods and were less involved in their children's lives than caregivers in the community comparison group.

4. *Social Support.* The average caregiver in the clinical group reported having approximately 6 friends or family members with whom they have contact with at least once per month. Approximately 77% of these contacts provided the caregiver with emotional support, 62% provided practical support and 70% provided the caregiver with advice.

5. *Empathy.* The scores attained on the underlying 4 dimensions of the IRI suggest that the average caregiver within the clinical group falls within 2 standard deviations of means reported in previous research (e.g., Guttman & Laporte, 2000). Clinical caregivers appeared to report levels of empathy that is comparative with non-clinical populations.

6. *Interpersonal Problems.* The mean total interpersonal problem score attained by the clinical caregiver group fell within the normal ranges (i.e., 40th to 60th percentile as reported by Horowitz et al., 2000) suggesting that the clinical caregivers level of interpersonal functioning was equivalent to adults within the general population. The mean scores for all of the underlying subscales on the IPP also fell within the normal ranges, however a moderate degree of variability in scores was noted. Twenty-seven (31%) of the children had caregivers who reported clinically high levels (*T* score of 70 or higher) of difficulty regarding being overly accommodating, 23 (27%) experienced difficulties regarding being excessively self-sacrificing and 21 (24%) fell within the problematic ranges for intrusiveness or being needy. Ten (12%), 6 (7%), 7(8%), 14 (16%) and 14 (16%) children had caregivers who reported significant interpersonal problems regarding being domineering or controlling, vindictive or self-centered, cold or distant, socially inhibited and non-assertive respectfully

7. *Therapeutic Alliance.* According to the mean subscale scores attained on the WAI, caregivers in the clinical group reported that they often experienced an emotional bond with their clinician. Additionally, caregivers often agreed with the clinician regarding the tasks that were necessary in order to achieve the therapeutic goals. And caregivers reported that they very often agreed with

the overall therapeutic goals that were established in collaboration with their clinician. Caregivers in the clinical group appeared to rate their professional relationship with *Contact House* as highly satisfactory.

Table 6

Caregiver Attributes

Characteristic	Clinical Group M	Clinical Group SD	Comparison Group M	Comparison Group SD	
Parenting Stress (PSI)					
Parental Distress Subscale	30.42	7.61	27.46	9.25	*
Parent-Child Dysfunctional Interaction Subscale	30.40	8.42	21.38	7.51	***
Difficult child Subscale	40.86	8.65	26.27	8.66	***
Total Stress Score	101.67	21.54	75.11	22.18	***
Parenting Practices (APQ)					
Parental Involvement Scale	3.67	.56	3.94	.45	***
Positive Parenting Scale	4.23	.60	4.30	.50	
Poor Monitoring/Supervision Scale	1.36	.40	1.45	.54	
Inconsistent Discipline Scale	2.45	.63	2.33	.69	
Corporal Punishment Scale	1.58	.61	1.77	.61	*
Social Support					
Social Network Size	5.75	2.80			
Emotional Support Scale	.77	.31			
Practical Support Scale	.62	.34			
Advice Scale	.70	.34			
Empathy (IRI)					
Perspective Taking Subscale	17.78	5.50			
Empathetic Concern Subscale	19.10	4.25			
Fantasy Subscale	11.63	5.69			
Personal Distress Subscale	10.34	5.45			
Total Empathy Score	48.51	10.99			
Interpersonal Problems (IPP)					
Domineering/Controlling Scale	2.64	2.85			
Vindictive/Self-Centred Scale	2.67	3.34			
Cold/Distant Scale	3.00	4.01			
Socially Inhibited Scale	5.50	4.19			
Nonassertive Scale	6.65	4.75			
Overly Accommodating Scale	7.16	4.67			
Self-Sacrificing Scale	7.50	4.73			
Intrusive/Needy Scale	4.90	3.63			
Total Interpersonal Problem Score	40.02	23.40			
Working Alliance (WAI)					
Emotional Bond Subscale	5.37	1.02			
Task Collaboration Subscale	4.87	.68			
Goal Agreement Subscale	5.67	3.42			
Total Alliance Score	5.32	1.32			

Note. Caregiver attributes are reported for each child. n = 86. *p < .05, ***p < .001.

Interactions between Study Variables within the Clinical Sample

Relationship between Abuse Characteristics and Child Difficulties

The numbers of children experiencing each type of abuse varied considerably (see Table 4) preventing analysis of potential relationships such as the association between the type of abuse experienced and the child's psychological adjustment. The mean total difficulty scores attained by children within each category of abuse are displayed in Table 7. These scores suggest the presence of a general trend with children experiencing physical abuse (singular or in combination with other types) appearing to experience relatively high levels of global difficulties.

Table 7

Total Difficulties Score Achieved by Children within each Abuse Category

	M	SD
Physical	35.00	1.41
Sexual	22.73	7.75
Emotional	9.25	8.26
Neglect	21.60	5.59
Combination 1 (P, E)	18.00	6.99
Combination 2 (P, E, N)	21.36	6.90
Combination 3 (P, S)	25.00	2.65
Combination 4 (S, E)	15.33	7.57
Combination 5 (P, S, E)	27.00	-
Combination 6 (S, E, N)	19.50	.71
Combination 7 (P, S, E, N)	23.67	7.11
Combination 8 (E, N)	19.13	5.30

Note in Combinations P = Physical, S = Sexual, E = Emotional, N = Neglect. Severity of abuse and/or Neglect was rated subjectively by the relevant case coordinator. n = 83.

A series of ANOVAs were undertaken using research variables and the total level of child difficulties.

- An ANOVA was conducted to determine whether the child's total level of difficulties differed according to the comorbidity or number of abuse types experienced. Table 8 displays the mean total difficulties scores according to the number of abuse types experienced. The between group difference for level of total difficulties approached statistical

significance, $F(3,79) = 1.50$, $p = .05$. Follow-up tests conducted to determine which groups differed, revealed no significant differences after controlling for type 1 error using the Dunnett's C test[7].

Table 8

SDQ Total Difficulties Scores According to the Number of Abuse Types Experienced

Number of Abuse Categories	N	M	SD
1	22	21.14	9.54
2	32	18.89	6.52
3	12	20.67	7.63
4	23	23.63	7.57

$n = 83$.

- Several ANOVAs were conducted to explore potential group differences between categorical study variables and their relationship to the child's level of total difficulties. No differences were found between the child's level of total difficulties and the severity of the abuse or neglect as estimated by their clinician, $F(2,80) = 1.23$, $p = .28$, nor with the relationship of perpetrator to the child, $F(6,76) = .93$, $p = .48$.

Relationship between Caregiver Attributes and Functioning

Small sample size prohibited the statistical analysis of factors that may have been associated with the relationship of the caregiver to the child. The mean parenting stress scores and interpersonal difficulties scores (see Table 9) achieved by caregivers within each relationship category, suggests that there may be a trend for the biological parents of abused children to experience higher levels of parenting stress and interpersonal problems, compared to foster carers of abused children.

[7] The probability of finding a significant result when one doesn't really exist increases with the number of follow-up analyses. Dunnett's C test is one of the statistical procedures which controls for this type 1 error when groups are unequal.

Table 9

Caregiver Functioning According to their Relationship with the Abused and/or Neglected Child

Relationship with Child	Parenting Stress			Interpersonal Problems	
	N	M	SD	M	SD
Parent	31	104.55	21.88	46.10	25.81
Foster Carer	14	91.14	19.67	27.00	14.49
Grandparent/Other Relative	8	93.50	21.37	42.88	22.50

n = 53.

The small and unequal sample sizes regarding the caregivers abuse history contributed to the inability to statistically explore potential relationships between their abuse history and level of functioning. However, the mean scores and standard deviation for three areas of function as displayed in Table 10 suggest the existence of several trends. Caregivers who reported to have experienced abuse in both childhood and adulthood appeared to experience more stress than those caregivers without a history of abuse, or those who were abused only in adulthood. Similarly, those caregivers reporting experiencing abuse during both adulthood and childhood appeared to demonstrate higher levels of empathy. Caregivers in the clinical group who reported that they experienced abuse only in adulthood or at both life stages, appeared to experience higher levels of interpersonal difficulties, especially when compared to non-abused caregivers.

Table 10

Caregiver Functioning According to the Caregivers History of Abuse

		Parenting Stress		Empathy		Interpersonal Problems	
Timeframe	N	M	SD	M	SD	M	SD
No History	25	95.24	23.00	46.88	9.69	33.60	24.29
Childhood	8	101.63	22.92	46.88	9.14	42.50	21.25
Adulthood	11	96.18	14.79	50.82	12.51	48.64	25.26
Childhood and Adulthood	9	112.56	19.49	56.33	7.81	48.33	21.28

n = 53.

Relationship between Caregiver Attributes and Child Difficulties

1. *Family Factors.* A series of ANOVAs were undertaken to examine the relationship between caregiver or family factors and the level of child difficulties. The level of total difficulties experienced by the child did not differ according to either their family composition, $F(2,49) = .236$, $p = .79$, or their relationship with their caregiver (e.g., foster parent), $F(2,49) = .52$, $p = .60$.

2. *Caregiver Attributes and Functional Level.* A series of hierarchical regressions were conducted to explore the relationships between caregiver attributes or their level of functioning and the child's total difficulties score. Three regressions were found to create a conceptual pathway which accounts for some of the variability in children's level of functioning and assists in understanding the inter-relationships between study variables.

    - A hierarchical regression was conducted to determine whether the child's demographical variables (i.e., age and gender), the comorbidity of abuse types and the level of parenting stress reported by caregivers were able to predict the total level of difficulty experienced by the child. The bivariate correlations are displayed in Table 11. The results of the analysis indicated that the linear combination of age, gender and number of abuse types experienced failed to significantly predict variability in the child's level of difficulties, $R^2 = .03$, adjusted $R^2 = .01$, $F(3,79) = .67$, $p = .57$. However, the linear combination of these variables combined with parenting stress significantly predicted total difficulties level after controlling for the effects of the first set of predictors, R^2 change = .20, $F(1,78) = 19.84$, $p < .001$. The level of parenting stress reported by the caregiver uniquely accounted for 20% of the variability in the level of total difficulties, $t(79) = 4.45$, $p < .001$, $sr = .445$. The results from this regression suggest that caregivers reporting high levels of parenting stress are more likely to care for a child who demonstrates high levels of total difficulties.

Table 11

Bivariate Correlations amongst variables within the Total Difficulty Hierarchical Regression

	Child Age	Child Gender	Abuse Number	Parenting Stress
Child's Gender	-.18 *			
Abuse Number	-.13	.09		
Parenting Stress	.00	.01	.02	
Total Difficulties Score	.01	.09	.13	.45 ***

*$p < .05$. ***$p < .001$

- A hierarchical regression was conducted to determine whether social support and parenting practices predict the level of parenting stress experienced by the caregiver. Bivariate correlations are displayed in Table 12. The first set of predictors assessing social support included social network size, the proportion of emotional support received, the proportion of practical support received, and the proportion of advice received from family and friends. The results indicated that the level of social support significantly predicted the level of parenting stress, $R^2 = .16$, adjusted $R^2 = .11$, $F(4,71) = 3.38$, $p = .01$. The second set of predictors, which included five parenting practices measured by the APQ, predicted parenting stress significantly over and above the social measures, R^2 change = .16, $F(5,56) = 3.11$, $p = .01$, explaining a further 16% of variance in parenting stress. The individual contributions of variables within each set were examined. Within the social support variable set, social network size appeared as a significant predictor, uniquely accounting for 7% of parenting stress variability, $t(74) = -2.35$, $p = .02$ $sr = -.26$. Within the parenting practices subscales, positive parenting and poor monitoring or supervision appeared to be the main contributors. Positive parenting uniquely accounted for 6% of the parenting stress variability $t(74) = -2.35$, $p = .02$ $sr = -.24$, while poor monitoring and supervision uniquely accounted for 5% of the variability in parenting stress, $t(74) = 2.18$, $p = .03$ $sr = .22$. Social support and

parenting practices did not directly predict the child's total difficulties after controlling for gender, age and abuse type comorbidity, suggesting that parenting stress mediates the relationship between these factors and the child's level of distress. Caregivers reporting high levels of parenting stress tend to have low levels of support and use different parenting practices with their children particularly with regards to the less frequent use of positive parenting methods and the tendency to not adequately supervise or monitor their child.

Table 12

Bivariate Correlations amongst variables within the Parenting Stress Hierarchical Regression

	Network Size	Emotional Support	Practical Support	Advice	PI	PP	PM	ID	CP
Emotional Support	.24								
Practical Support	.27**	.44***							
Advice	-.04	-.02	.22*						
PI	.26*	.22*	.36**	.18					
PP	.11	.40***	.57***	.07	.52***				
PM	-.00	.01	-.04	-.07	-.10	-.23*			
ID	-.01	-.08	-.04	-.12	-.17	-.17	.22*		
CP	.02	-.15	-.00	.12	-.27**	-.20*	.13	.25*	
Parenting Stress	-.31**	-.22*	-.23*	-.18	-.17	-.37**	.32**	.11	.13

Note. PI = parental involvement, PP = positive parenting, PM = poor monitoring, ID = inconsistent discipline, CP = corporal punishment. *$p < .05$. **$p < .01$. ***$p < .001$.

- A hierarchical regression was carried out to determine whether social support, caregiver empathy and caregiver interpersonal problems predict the use of positive parenting practices. The bivariate correlations are displayed in Table 13. The linear combination of variables within the social support set of predictors was found to account for a significant amount (36%) of variance in positive parenting practices, $R^2 = .36$, adjusted $R^2 = .32$, $F(4,71) = 9.78$, $p < .001$. The inclusion of caregiver empathy into the linear combination at step two, significantly explained a small amount of variability (4%) in the use of positive parenting above that of the first set of predictors, R^2 change = .04, $F(1,70) = 4.11$, $p = .05$. The addition of the total interpersonal problems in the third step

of the model, significantly explained variability in the use of positive parenting above the previous steps, R^2 change = .06, $F(1,69) = 7.46$, $p = .008$, accounting for a further 6% of positive parenting variability. The primary contributor to the relationship with the first set of predictors appeared to be the level of practical support offered to the caregiver, $t(74) = 4.51$, $p < .001$, $sr = .43$, uniquely explaining 18% of the variability in positive parenting methods. The level of empathy reported by the caregiver in step two uniquely accounted for 6% of the variability in positive parenting. The level of interpersonal difficulties experienced by the caregiver, was found to uniquely explain 6% of the variability in positive parenting, $t(74) = -2.73$, $p = .008$ $sr = -.25$. However, when considering the bivariate correlations as displayed in Table 13, there does not appear to be a direct relationship between positive parenting and interpersonal problems. Therefore, the finding that interpersonal problems predict the frequency of positive parenting methods, may be explained by the significant relationship between interpersonal problems and empathy and emotional support. The findings from this analysis suggest that primary caregivers who receive limited support, particularly with regards to practical support, have low levels of empathy and/or experience high levels of interpersonal difficulties, are less likely to implement positive parenting practices with their abused child. No study variables were found to predict the caregivers' level of monitoring or supervision regarding their child.

Table 13

Bivariate Correlations amongst variables within the Positive Parenting Hierarchical Regression

	Network Size	Emotional Support	Practical Support	Advice	Empathy	Interpersonal Problems
Emotional Support	.24*					
Practical Support	.27**	.44***				
Advice	-.04	-.02	.22*			
Empathy	.43***	.14	.14	-.03		
Interpersonal problems	.11	.27**	.01	.02	.27**	
Positive Parenting	-.11	.40***	.57***	.07	.26*	-.14

*$p < .05$. **$p < .01$. ***$p < .001$.

The reported findings from the three previous hierarchical regressions has enabled the creation of a conceptual pathway which assists in explaining inter-relationships regarding caregiver attributes and accounts for some of the variability in the level of difficulties experienced by abused and neglected children (see Figure 1).

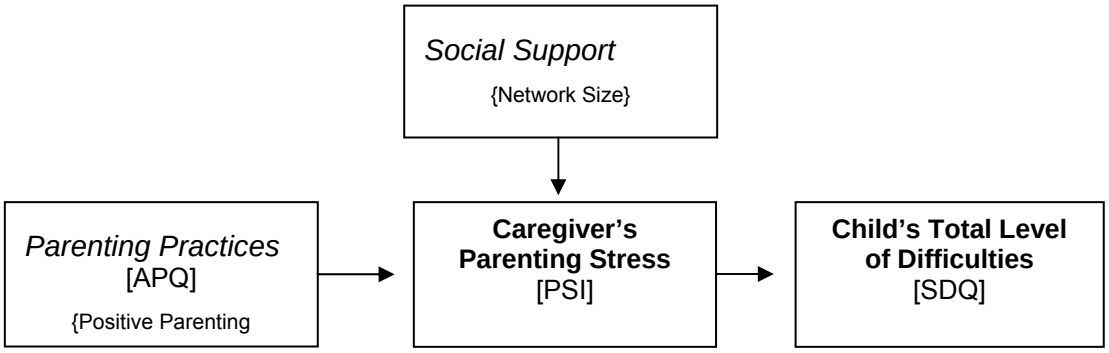

Figure 1

Proposed Pathway Explaining Variability in Children's Total Level of Difficulties

Preliminary Findings for Children at Three Month Follow-up

A series of paired-samples *t* tests were conducted to evaluate the differences between initial SDQ scores recorded for the 13 children who had completed a 3-month follow-up assessment. Attention is drawn to the low number of children in

this sample which restricts generalisation of findings to the larger population of children who have experienced abuse and/or neglect. Table 14 displays the mean score recorded at both periods in time.

The mean total difficulties score was significantly lower at the 3-month follow-up assessment and a large standardised effect size was demonstrated, $t(12) = 3.65$, $p = .003$, $d = 1.01$. Comparisons over time were also made regarding the mean scores recorded on the 5 underlying subscales. A significant reduction was found regarding emotional symptoms, $t(12) = 4.03$, $p = .002$, $d = 1.12$ and hyperactivity or inattention, $t(12) = 3.57$, $p = .004$, $d = .99$.

Despite finding that the total level of difficulties had reduced significantly, the mean score remained in the clinically problematic range, suggesting that the average child continued to exhibit behaviour that was within the clinical range. However, clinically significant decreases in problematic behaviour were evident in this small group of children. The mean score on both the emotional symptoms and hyperactivity means, which had previously been within the clinically elevated range, fell within the average ranges at the 3-month follow-up assessment. The average child in this group experienced a return to normal functioning levels in the areas of emotional symptoms and hyperactivity or inattention.

Table 14

Change in SDQ at Three Month Follow-up

	Time 1		Time 2		
Scale	M	SD	M	SD	
Total Difficulties Score	25.15	7.03	19.62	6.50	**
Emotional Symptoms	6.23	3.14	3.34	3.45	**
Conduct Problems	7.54	2.73	7.31	2.78	
Hyperactivity/ Inattention	6.69	2.56	4.84	3.18	**
Peer Problems	4.69	2.25	4.08	1.71	
Prosocial Behaviour	4.92	3.20	5.38	3.43	

n = 13. **p < .01.

Preliminary Findings at Termination of Contact House Services

The small sample size prohibits statistical analysis of score changes between

initial assessment and at the time of ceasing interventions. Examination of factors relating to attrition was not appropriate as the three families leaving the treatment program prior to completion did so because of extraneous reasons (e.g., legal proceedings or moving out of the physical boundaries covered by *Contact House).* Nevertheless, descriptive data can be presented to illustrate trends regarding child and caregiver functioning.

Children's Psychological Adjustment

The level of total difficulties demonstrated by these 7 children appears to have been relatively stable as does their functioning on underlying behavioural domains over the period since their initial assessment (see Table 15). The pre and post scores achieved by each child across the assessed areas are displayed in Appendix B.

Table 15

Change in SDQ on Termination of Interventions

	Initial Assessment		**Termination**	
Scale	M	SD	M	SD
Total Difficulties Score	22.71	7.87	18.57	7.02
Emotional Symptoms	5.4	4.08	4.14	4.14
Conduct Problems	6.29	3.20	5.86	3.02
Hyperactivity	6.43	2.50	4.71	2.75
Peer Problems	4.57	2.23	3.86	.90
Prosocial Behaviour	5.57	3.05	6.12	2.97

Note. Children completing therapy $n = 4$. Children who have not completed therapy $n = 3$.

Caregiver Attributes

Table 16 presents mean scores for level of parenting stress and parenting practices reported by the 3 caregivers who volunteered information at the cessation of their treatment program. The pre and post scores attained by the caregivers across the assessed domains are displayed in Appendix C. There appeared to be a general reduction in the total level of parenting stress and underlying domains reported by these 3 caregivers since their initial assessment. The parenting practices of these caregivers appear to have remained relatively

stable over time.

Table 16

Change in PSI on Termination of Interventions

Scale	Initial Assessment M	Initial Assessment SD	Termination M	Termination SD
Parenting Stress Index				
Parental Distress Subscale	32.17	2.48	27.00	4.38
Parent-Child Dysfunctional Interaction Subscale	27.33	2.34	25.00	1.55
Difficult child Subscale	46.67	1.63	39.50	4.28
Total Stress Score	106.17	5.23	91.50	7.45
Alabama Parenting Questionnaire				
Parental Involvement Scale	3.40	.77	3.50	.89
Positive Parenting Scale	4.53	.53	3.72	1.16
Poor Monitoring/Supervision Scale	1.20	.00	1.58	.47
Inconsistent Discipline Scale	1.78	.14	1.75	.09
Corporal Punishment Scale	1.56	.50	1.50	.41

$n = 3$

Discussion

Psychological Adjustment of Abused Children

The majority of children receiving services through *Contact House* facilities during 2005, experienced multiple types of abuse. Approximately half of the children in the clinical group experienced severe abuse and/or neglect and had two or more recorded child protection notifications. Similar to figures released by the AIHW (2005), 83% of children within the clinical group were abused by at least one biological parent. In the clinical group of children, no relationship was found between the child's age or gender and short-term psychological distress. Neither was any relationship found between the child's level of difficulties and either the abuse type or the child's relationship to the perpetrator.

Previous research has found an association between types of abuse and differential or more severe psychological pain (e.g., Moran et al., 2004).

Unfortunately, the combination of small sample size and considerable variability in the number of children who experienced each type of abuse restricted capacity to explore this relationship further. The current findings, however, replicate previous research (e.g., Ackerman et al., 1998) finding an association between the number of abuse types and the child's level of difficulties. Therefore, considering the large proportion of children who experienced multiple types of abuse, it was not surprising to find that a large proportion of abused children displayed problematic behaviour which fell within clinical ranges in assessed areas: emotional symptoms, conduct, hyperactivity or inattention, peer relationship problems and to a lesser degree, pro-social behaviour. The psychological adjustment of the children who had experienced abuse and/or neglect was significantly impaired compared to children in the general community.

The Australian Mental Health Outcomes and Classification Network (AMHOCN, 2005) has published data regarding the SDQ admission scores attained by children aged between 4 and 10 years receiving interventions through national mental health service settings: emotional symptoms (*M*= 5.8, *SD* = 2.5), conduct problems (*M*= 5.9, *SD* = 2.7), hyperactivity (*M*= 7.3, *SD* = 2.5), peer problems (*M*= 4.6, *SD* = 2.2) and prosocial behaviour (*M*= 5.4, *SD* = 2.5). Comparison between these norms and the scores attained by the clinical group of children (see Table 5) suggests that the functioning of children referred to *Contact House* is comparable in terms of pathology, to children referred to government mental health services in Australia. Findings confirm previous empirical studies attesting to the diverse negative consequences associated with abuse and neglect. The current findings also highlight the level of distress evident in the immediate period following abuse and/or neglect and provide substantial justification towards the initiation of early intervention.

Scores obtained on the SDQ subscales suggest that children who had experienced child abuse and/or neglect were particularly vulnerable in the area of conduct problems. These children with clearly observable, often externalising behaviour problems may be more easily brought to the attention of child protection authorities such as the Department of Child Safety. These children may be perceived as posing greater difficulties for parents, or staff in schools and

childcare prompting referrals for treatment (e.g. Gracia, 1995). The finding that pro-social behaviour was a relative strength in these children is less readily explained, as previous observational studies have found young maltreated children to demonstrate low levels of empathetic concern towards peers and inappropriate responses (e.g., Main & George, 1985; Klimes-Dougan & Kistner, 1990). As the assessment of child behaviour was reliant upon caregiver reports, such a result may reflect a social bias wherein the caregiver has portrayed the child and, perhaps, indirectly themselves, in a favourable way. This reasoning finds some support with the current findings that only 12 of the children were rated by their caregiver as having severe difficulties. Assuming that caregiver reports regarding pro-social behaviour were accurate, it may be speculated that these families differ from other populations of families affected by abuse and/or neglect, as these caregivers were willing, and in the case of self-referrals, eager to engage with clinicians in seeking therapeutic assistance.

Primary Caregiver Attributes and Level of Functioning

The large proportion of primary caregivers disclosing their own experiences of abuse reflects the long-term pervasive and damaging consequences of child abuse and neglect. In this study, the majority of caregivers were not the perpetrators of abuse. Therefore it is speculated that adults who have experienced abuse during childhood and/or adulthood, may indirectly place their children at risk of abuse via their choice of partner(s) and exposure to domestic violence. They may also experience difficulty protecting their children by providing age appropriate monitoring and supervision.

Parenting Stress

Of primary concern was the finding that the majority of the clinical group caregivers reported clinically high levels of parenting stress, which was significantly higher than levels reported by parents within the general community. Although small sample size restricted analyses, the current findings suggest a relationship between caregivers' own abuse history and increased levels of parenting stress. Such findings appear consistent with research demonstrating an

association between abuse during childhood and later adjustment difficulties associated with parenting their children (e.g., Roberts, O'Connor, Dunn & Golding, 2004). Consistent with social learning and trauma theory, adults who were abused during childhood may have had limited opportunities to observe and learn optimal parenting practices early in life, and may relive their own adverse experiences when parenting their child. Further, they may have been entrenched in social systems offering little social support and intervention for these issues.

Parenting stress was a strong predictor of the level of total difficulties experienced by the child. Caregivers with high levels of parenting stress tended to be caring for abused children demonstrating high levels of behavioural difficulties. Importantly, this relationship was not causal and the association may be bidirectional. That is, caring for a child who demonstrates clinically elevated symptoms and difficult behaviours may contribute to parental stress and perceptions of the child as being 'difficult'. Regardless of whether a stressed parent contributes to their child's difficulties or vice versa, the fact that a relationship exists and that high levels of parenting stress was prevalent in the clinical group, further highlights the importance of intervening early to address parenting stress in primary, secondary and tertiary prevention efforts.

Parenting Practices

The caregivers of abused and neglected children reported similar parenting practices to those used by parents within the general community. In fact, caregivers in the clinical group reported less frequent use of corporal punishment techniques. This finding was not unexpected. Foster carers (representing 26% of the caregivers in the clinical group) are prohibited from using corporal punishment methods. Additionally, as approximately half the children had at least two documented child protection notifications, it is hypothesised that the majority of caregivers would have been reluctant to use, or at least report using corporal punishment. The caregivers of abused children, whether biological parents or foster parents, were less likely to be involved in their child's life (for example to participate in school activities) than parents within the community. The fact that caregivers were less involved may be related to high parenting stress, diminished parenting skills and/or the possibility that parent-child interactions and involvement

may be more difficult to accomplish when the child is exhibiting problematic behaviour.

Interestingly, while none of the study variables predicted the caregiver's level of monitoring or supervision, several factors predicted the use of positive parenting. Caregivers with high levels of empathy, low levels of interpersonal problems and strong social support networks particularly regarding practical assistance, appear to be more able to use positive parenting techniques with their children. The interaction of these factors reflects the ecological model whereby caregiver behaviour is influenced by their own attributes in combination with influences from their wider social community.

Based upon previous conduct disorder research (e.g., Frick et al., 1999), it was anticipated that there would be a direct relationship between the parenting practices and the child's level of functioning. The fact that no such association was found may be explained by postulating that behavioural difficulties demonstrated by the children were a consequence of their abuse experiences and, therefore, not amenable to the parenting practices used by the caregivers. An alternative explanation, based upon the current findings, is that parenting stress influences parenting style mediating the relationship between parenting and the child's level of difficulties.

Relationship between Parenting Stress and Parenting Practices

Current findings support previous research (e.g., Wind & Silvern, 1994), regarding the association between high levels of family stress and less optimal parenting. Parenting stress was found to be negatively associated with the use of adaptive parenting practices. Not surprisingly, caregivers experiencing high levels of parenting stress report less frequent usage of positive parenting practices (e.g., rewarding good behaviour) and more frequently fail to supervise or monitor their child.

The relationship between parenting stress and parenting practices appears obvious as caregivers experiencing high levels of stress because they are caring for a child with problematic behaviours, may be less able to implement positive parenting techniques. For example, a caregiver with high stress levels may have

difficulty noticing and rewarding good behaviour and may be more attentive to the child's negative behaviour. Similarly, an overwhelmed caregiver may be incapable of consistently supervising a child who appears hyperactive, inattentive, and displays conduct problems.

The relationship between parenting stress and parenting practices has practical implications for treatment. Findings from conduct behaviour research (Frick et al., 1999) suggests that poor parenting practices may contribute to or exacerbate the level of maladaptive behaviour experienced by the child. Additionally, failure to supervise the child may place them at increased risk for further abuse or exposure to adverse circumstances (e.g., substance use).

Considering the association between parenting stress and child functioning, it is proposed that interventions aimed at reducing parenting stress combined with appropriate parenting education and connectivity to community supports, offers potential benefits to both the caregiver and child. Individualising abuse and neglect treatment to focus upon multiple influences in the child's environment is consistent with ecological model (i.e., abuse occurs within, and consequences are affected by, a system of interacting factors with belong to the child, family and wider contextual environment). The effectiveness of such broad-reaching interventions, which target and encompass multiple factors: the child, caregiver and community warrants further empirical investigation.

Caregiver Empathy and Interpersonal Functioning

The caregivers' levels of empathy and interpersonal functioning were consistent with average ranges reported in normative data. However, it was interesting to find that between one quarter and one third of caregivers within the clinical group experienced interpersonal difficulties in three main areas: being overly accommodating, excessively self-sacrificing and needy or intrusive. Consistent with previous research which found that interpersonal difficulties are long-term consequences of abuse during childhood (e.g., Herman, 1981), there is an association between caregivers own abuse experiences and interpersonal functioning. For example, a woman or man who is overly accommodating or needy may be more accepting of an aggressive partner and less emotionally equipped to

protect their child or end a relationship that involves domestic violence and/or child abuse.

Although restricted by a small sample size, there was a trend towards the biological parents of abused children experiencing higher levels of interpersonal problems and parenting stress. Pithers et al. (1998) also found that biological parents of abused children experienced higher levels of interpersonal difficulties compared to foster carers. Biological parents, particularly those who have experienced abuse themselves, may therefore be more at risk regarding parenting stress and difficulties with maintaining relationships which may inadvertently further negate their ability to access support.

Interestingly, the current findings suggest that caregivers who experienced abuse during both childhood and adulthood were more empathetic compared to non-abused caregivers or those experiencing abuse only in childhood. Although a diminished capacity for empathy has been shown to be associated with childhood abuse, finding that caregivers who were abused in both childhood and adulthood were more empathetic compared to non-abused caregivers is less readily explained. Perhaps caregivers who themselves have recently been the victim of abuse are more able to understand the abusive experiences from the child's perspective and, in the case of domestic violence, may have directly witnessed the child's abuse.

Social Support

Consistent with previous research highlighting the positive effects of direct support to abuse victims (e.g., Murthi & Espelage, 2005) the level of support given to the caregiver appears to fulfil a protective role within the child's contextual environment. The level of social support given to the caregiver directly impacted upon their parenting stress levels and their parenting practices. Caregivers receiving support from large numbers of friends and relatives experienced lower levels of parenting stress**.** Rather than finding that social support mediated the relationship between stress and parenting practices (Rogers, 1998), current findings suggest that different types of support may influence parenting stress levels and practices. For example, while the numbers of friends and relatives

providing support appeared to be critical to the caregivers level of parenting stress, the level of practical support received appeared more directly related to the caregivers parenting practices. Those caregivers receiving high levels of practical support were found to be more likely to use positive parenting practices. This has implications for tertiary prevention services and indicates that wider support networks must also be considered in provision of interventions.

Interaction between Caregiver Functioning and the Psychological Adjustment of Abused Children

The complex relationship between study variables appears consistent with the ecological model. This study focused upon potential proximal influences associated with the caregiver such as their level of interpersonal difficulties and more distal influences such as the support given to the caregivers from their larger community or extended family. As previously reported, the level of parenting stress appears to be a critical factor which is closely related to the child's level of functioning. Factors such as parenting practices and social support have been shown to provide a significant, yet more distal influence upon child functioning.

The current findings have implications towards informing abuse and neglect policy and service provision, particularly in the development and delivery of intervention services. For example, it appears that caregiver support in the general community plays an important role that potentially influences child outcomes. Assisting families to connect with their community may facilitate a reduction in parenting stress levels and improved parenting practices. Additionally the prevalence of parenting stress and its role in influencing parenting practices and child functioning provides further evidence for the need to incorporate interventions aimed at caregiver functioning and parenting education.

Preliminary Findings Regarding Treatment Outcomes

Although the evaluation of children's outcomes during their treatment via *Contact House* was not included within the main aims of this project, data was gathered and provides preliminary findings in this area. Given the small sample size of children completing the 3-month follow-up reassessment, it was surprising to find

such a significant reduction in the child's level of difficulties within a 3-month period of therapy. Implications for these results are two-fold. First, the SDQ is not only a brief and easy to administer assessment tool, but it appears sensitive to the measurement of change and a suitable outcome measure for children who have been abused and/or neglected. Second, while results must be treated cautiously, the reduction in problematic behaviour for this small group of children over time, offers tentative support towards the effectiveness of the individualised multi-disciplinary therapy implemented through *Contact House* in achieving symptom reduction and in some cases a return to functioning within normal ranges. To substantiate effectiveness claims, particularly in view of recent program changes, future longitudinal research utilising a large sample is warranted to ensure *Contact House* continues to provide an evidence base to inform its therapeutic practices.

Study Limitations

Findings are based upon self-reported measures and therefore subject to associated limitations such as social bias. The assessment of children's level of functioning was reliant upon caregiver reports. Future research should consider using multi-informant ratings of child behaviour (e.g., self-report by child and teacher ratings) to assess the reliability of self-reported data.

Preliminary findings regarding treatment gains must be considered cautiously within the context of the small sample size. Additionally, the children who were reassessed at the 3-month interval were not randomly selected and therefore may not representative of the clinical children in general.

It is further noted that children within the clinical group had been referred for treatment and families had agreed to engage with the *Contact House* service. It cannot be assumed that these families represent the broader population of children experiencing abuse and/or neglect. Therefore generalisation of findings must be treated with caution.

Conclusion

“Child abuse is an evil to which no child should be exposed” (Mullen et al., 1996, p. 20).

Abused and neglected children have demonstrated significant levels of difficulty regarding global behaviour and in the areas of emotional symptomatology, conduct, hyperactivity and/or inattention, peer relations and prosocial behaviour. However, the variability in outcomes and associations with caregiver functioning demonstrated in this study, confirms the important role that the child’s family and community contexts fulfil regarding influencing the impact of abuse.

Research within the area of child abuse and neglect remains a significant challenge due to the interplay of multiple variables operating at the level of the child, family and contextual environment. This study has provided a body of evidence regarding the distress experienced by caregivers (who were in the majority of cases not responsible for the abuse) when parenting children with histories of abuse or neglect. Additionally, findings have contributed to existing knowledge and exposed several factors, directly and indirectly influencing the abused child’s level of functioning. Consistent with the ecological paradigm, the child’s behaviour was influenced by proximal and distal agents: caregiver functioning and community support. The level of parenting stress experienced by the caregiver appeared to be a particularly critical factor along with parenting practices and social support. Other caregiver factors, which appeared to play a more indirect role within this complex framework, include: their abuse history, level of empathy and interpersonal difficulties.

This study provides further evidence of the need to extend abuse treatment beyond interventions for the children to include contextual influences. At the time of this study, the intervention program offered by *Contact House* was consistent with such an approach. *Contact House* treatment was individualised according to the family need and potentially included child therapy, family therapy, parenting support, health assessment and education and at one facility, an early childhood

educational unit. *Contact House* is further refining their intervention program to facilitate the connectivity of clients to community resources and support groups.

Preliminary findings based upon a small group of children with repeated assessments provided tentative support towards the effectiveness of the current *Contact House* intervention program. However, to evaluate the effectiveness of such broad interventions and importantly, the sustainability of treatment gains, further longitudinal research based upon more substantial numbers of children is required.

Recommendations

This project has enabled the establishment of a database containing a significant amount of information on both children and their families. It is strongly recommended that further research is undertaken with these families and extended to new clients in order to assess the effectiveness of therapeutic interventions and the sustainability of outcome gains.

In view of the statistical exploration of several variables (such as abuse types or caregivers abuse history) being restricted by the small sample size, it may be advantageous to include these factors within further studies to improve statistical power. Future research may explore additional caregiver factors associated with the child's distress to further develop and refine the conceptual model offered within this study. Such research holds potential for furthering the understanding of abuse outcomes within an ecological framework and importantly, provides an evidenced-based framework to better inform the refinement of intervention strategies towards more effective and sustainable outcomes for child victims.

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Appendix A

INSTRUCTIONS FOR THE COMPLETION OF THIS DOCUMENT

Thank you for participating in this research. Please answer the questions as honestly as possible. Your responses are treated in confidence as explained in the attached information sheet.

Family Information

The following questions refer to you and your family. Mark the box that is the best answer for you.

1. Are you the child's primary caregiver?

- Yes
- No

2. What is your relationship to the child?

- Parent
- Step-parent
- Foster parent
- Grandparent
- Other Relation
- Other _____
  (Please Specify)

3. How long has the child been in your care?

- 0-3months
- 3-6 months
- 6-12 years
- 1-3 years
- More than 3 years

4. How old are you?

- Less than 20 years old
- 20-30 years old
- 30-40 years old
- 40-50 years old
- 50 +

5. Are you female or male?

- Female
- Male

6. Which statement best describes your living situation?

- I live with my partner and child/children
- It's just me and the kids at home
- We live with extended family

7. Who does your child live with? (Tick all that apply)

- mother
- father

- step-mother
- step-father
- grandparents/great grandparents
- siblings/other children

8. What is/are the gender/s of your children receiving Contact House services.
(When more than 1 child please put the number of each gender in each box).

- Female/s
- Male/s

9. Please list the ages of Child/children receiving Contact House services:

_____years _____months
_____years _____months
_____years _____months
_____years _____months
_____years _____months
_____years _____months

10. Does your child or children mentioned above attend:
(please fill in the appropriate number when more than 1 child)

- day care
- pre-school
- play group
- school

11. Is your child subject to any court orders?

- Yes
- No

12. What is your ethnic background?

- Aboriginal/Islander
- Australian
- Other ethnic backgrounds

13. Within the last year what has been your main source of income?

- paid employment
- unemployment benefits
- disability pension
- sole parenting allowance
- other

14. What is your highest level of education?

- primary school
- high school up to & including grade 10
- high school year 11 &/or 12
- training course eg. Tafe
- some university education
- completed university studies

15. What is or has been your main occupation?

- no occupation – never worked
- labourer

- ☐ skilled worker (ie. trained in a job)
- ☐ professional/manager
- ☐ domestic duties

16. Are you currently working?

- ☐ Yes
- ☐ No

17. Do you have / care for <u>other</u> children?

- ☐ Yes
- ☐ No

18. Please complete the following details for all the children in your care:

Child 1: Indicate Age in years_____ Please circle Gender: M/F

Child 2: Indicate Age in years_____ Please circle Gender: M/F

Child 3: Indcate Age in years_____ Please circle Gender: M/F

Child 4: Indicate Age in years_____ Please circle Gender: M/F

Child 5: Indicate Age in years_____ Please circle Gender: M/F

Child 6: Indicate Age in years_____ Please circle Gender: M/F

19. Please complete the table to indicate how much alcohol you drink by writing the number of each drink consumed in the appropriate frequency box.

Drink Type	Not at all	Socially or less than once per week	On 1-2 occasions each week	On 3-4 occasions each week	On 5-7 occasions each week	On more than 7 occasions each week
Beer (stubby)						
Wine (standard glass)						
Spirit (standard glass)						

20. Have you taken any drugs/unprescribed substances over the past month?

- ☐ Yes
- ☐ No

21. If you answered yes please indicate how often you use this substance

- ☐ Less than once per week
- ☐ Once per week
- ☐ 2-3 times per week
- ☐ 4-5 times per week
- ☐ 5-7 times per week
- ☐ More than 7 times per week

Therapy Details

1. **Location of sessions:** (Please mark all that apply)
   - □ Home
   - □ Contact House
   - □ School
   - □ Other

2. In your own words please explain why you use the contact house services?

_____
_____
_____
_____

3. How do you feel about what has happened to your child/children and family?

_____
_____
_____
_____

4. Has your child received any of the following services over the past 6 months?

(Please tick all that apply).

- □ None of the following services
- □ Counselling
- □ Speech therapy
- □ Occupational therapy
- □ Health services
- □ Early childhood education
- □ Family aide programme
- □ Other (please specify)_____

5. What would you like Contact House staff to do for you and your child/children?

_____
_____
_____
_____

Working Alliance Inventory – Client Form

Below is a list of statements about your relationship with your therapist. Consider each item carefully and indicate your level of agreement for each of the following items.

Please score accordingly on a scale from 1 = Never
2 = Rarely
3 = Occasionally
4 = Sometimes
5 = Often
6 = Very often
7 = Always

1. My therapist and I agree about the things I will need to do in counselling to help improve my situation.	1	2	3	4	5	6	7
2. What I am doing in therapy gives me new ways of looking at my problem.	1	2	3	4	5	6	7
3. I believe that my therapist likes me.	1	2	3	4	5	6	7
4. My therapist does not understand what I am trying to accomplish in therapy	1	2	3	4	5	6	7
5. I am confident in my therapist's ability to help me.	1	2	3	4	5	6	7
6. My therapist and I are working towards mutually agreed upon goals.	1	2	3	4	5	6	7
7. I feel that my therapist appreciates me.	1	2	3	4	5	6	7
8. We agree on what is important for me to work on.	1	2	3	4	5	6	7
9. My therapist and I trust each other.	1	2	3	4	5	6	7
10. My therapist and I have different ideas on what my problems are.	1	2	3	4	5	6	7
11. We have a good understanding of the kind of changes that would be good for me.	1	2	3	4	5	6	7
12. I believe the way we are working with my problem is correct.	1	2	3	4	5	6	7

Strengths and Difficulties Questionnaire

Below are a series of phrases that describe children's behaviour. Please mark to what extent each of the items is true for your child based on their behaviour ***over the last six months*.**

	Not true	Somewhat true	Certainly true
1. Considerate of other people's feelings	○	○	○
2. Restless, overactive, cannot stay still for long	○	○	○
3. Often complains of headaches, stomach-aches or sickness	○	○	○
4. Shares readily with other children (treats, toys, pencils etc.)	○	○	○
5. Often has temper tantrums or hot tempers	○	○	○
6. Rather solitary, tends to play alone	○	○	○
7. Generally obedient, usually does what adults request	○	○	○
8. Many worries, often seems worried	○	○	○
9. Helpful if someone is hurt, upset or feeling ill	○	○	○
10. Constantly fidgeting or squirming	○	○	○
11. Has at least one good friend	○	○	○
12. Often fights with other children or bullies them	○	○	○
13. Often unhappy, down-hearted or tearful	○	○	○
14. Generally liked by other children	○	○	○
15. Easily distracted, concentration wanders	○	○	○
16. Nervous or clingy in new situations, easily loses confidence	○	○	○
17. Kind to younger children	○	○	○
18. Often argumentative with adults	○	○	○
19. Picked on or bullied by other children	○	○	○
20. Often volunteers to help others (parents, teachers, other children)	○	○	○
21. Can stop and thinks things over before acting	○	○	○
22. Can be spiteful to others	○	○	○
23. Gets on better with adults than with other children	○	○	○
24. Many fears, easily scared	○	○	○
25. Sees tasks through to the end, good attention span	○	○	○

26. Overall do you think your child has difficulties in one or more of the following areas: Emotions, concentration, behaviour or being able to get on with other people?

- No
- Yes minor difficulties
- Yes definite difficulties
- Yes severe difficulties

If you have answered "Yes", please answer the following questions about these difficulties:

27. How long have these difficulties been present?

- Not applicable
- Less than 1 month
- 1 – 5 months
- 6 – 12 months
- Over a year

28. Do the difficulties upset or distress your child?

- Not applicable
- Not at all
- Only a little
- Quite a lot
- A great deal

29. Do the difficulties interfere with your child's everyday life in the following areas?

Area	Not Applicable	Not at all	Only a little	Quite a lot	A great deal
Home Life					
Friendships					
Classroom Learning					
Leisure Activities					

30. Do the difficulties put a burden on you or the family as a whole?

- Not applicable
- Not at all
- Only a little
- Quite a lot
- A great deal

Parenting Stress Index (short form)

Directions:
In answering the following questions, please think about ***the child you are most concerned about.***

The questions on the following pages ask you to mark an answer which best describes your feelings. While you may not find an answer which exactly states your feelings, please mark the answer which comes closest to describing how you feel.

Your first reaction to each question should be your answer.

Please mark the degree to which you agree or disagree with the following statements by crossing the number which matches how you agree with the statement. If you are not sure, please choose "not sure".

1 Strongly agree | 2 Agree | 3 Not Sure | 4 Disagree | 5 Strongly Disagree

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
1. I often have the feeling that I cannot handle things very well.	O	O	O	O	O
2. I find myself giving up more of my life to meet my children's needs than I ever expected.	O	O	O	O	O
3. I feel trapped by my responsibilities as a parent.	O	O	O	O	O
4. Since having this child I have been unable to do new and different things.	O	O	O	O	O
5. Since having a child I feel that I am almost never able to do things that I like to do.	O	O	O	O	O
6. I am unhappy with the last purchase of clothing I made for myself.	O	O	O	O	O
7. There are quite a few things that bother me about my life.	O	O	O	O	O
8. Having a child has caused more problems than I expected in my relationship with my spouse (male / female friend).	O	O	O	O	O
9. I feel alone and without friends.	O	O	O	O	O
10. When I go to a party I usually expect not to enjoy myself.	O	O	O	O	O
11. I am not as interested in people as I used to be.	O	O	O	O	O
12. I don't enjoy things as I used to.	O	O	O	O	O
13. My child rarely does things for me that make me feel good.	O	O	O	O	O
14. Most times I feel that my child does not like me and does not want to be close to me.	O	O	O	O	O
15. My child smiles at me much less than I expected.	O	O	O	O	O
16. When I do things for my child I get the feeling that my efforts are not appreciated very much.	O	O	O	O	O
17. When playing, my child doesn't often giggle or laugh.	O	O	O	O	O
18. My child doesn't seem to learn as quickly as most children.	O	O	O	O	O

19. My child doesn't seem to smile as much as most children.		O	O	O	O	O
20. My child is not able to do as much as I expected.		O	O	O	O	O
21. It takes a long time and it is very hard for my child to get used to new things.		O	O	O	O	O
22. I feel that I am: Not very good at being a parent	O	Fill in one				
A person who has some trouble being a parent	O					
An average parent	O					
A better than average parent	O					
A very good parent	O					
		Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
23. I expected to have closer and warmer feelings for my child than I do and this bothers me.		O	O	O	O	O
24. Sometimes my child does things that bother me just to be mean.		O	O	O	O	O
25. My child seems to cry or fuss more often than most children.		O	O	O	O	O
26. My child generally wakes up in a bad mood.		O	O	O	O	O
27. I feel that my child is very moody and easily upset.		O	O	O	O	O
28. My child does a few things which bother me a great deal.		O	O	O	O	O
29. My child reacts very strongly when something happens that my child doesn't like.		O	O	O	O	O
30. My child gets upset easily over the smallest things.		O	O	O	O	O
31. My child's sleeping or eating schedule was much harder to establish than I expected.		O	O	O	O	O

32. I have found that getting my child to do something or stop doing something is: Much harder than I expected	O
Somewhat harder than I expected	O
About as hard as I expected	O
Somewhat easier than I expected	O
Much easier than I expected	O
33. Think carefully and count the number of things, which your child does that bother you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc. Please circle the number which includes the number of things you counted. 10 or more	O
8-9	O
6-7	O
4-5	O
1-3	O

Fill in one

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
34. There are some things my child does that really bother me a lot.	O	O	O	O	O
35. My child turned out to be more of a problem than I expected.	O	O	O	O	O
36. My child makes more demands on me than most children.	O	O	O	O	O

Support Scale

Please think of all of the family members and friends that you have had contact with **at least once per month**. List them all by name/role or relationship (eg. mum, girlfriend) and then tick whether they give you emotional support, practical assistance or advice.

Name/Role	Emotional Support	Practical Support	Advice	None of the previously noted support
1.				
2.				
3.				
4.				
5.				
6.				
. 7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

Interpersonal Reactivity Index

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D or E. When you have decided on your answer, fill in the letter in the answer space following the item**.**

READ EACH ITEM CAREFULLY BEFORE RESPONDING.

Answer as honestly and accurately as you can.

A	B	C	D	E
Does Not Describe Me Well				Describes Me Very Well

1. I daydream and fantasize with some regularity about things that might happen to me.	A	B	C	D	E
2. I often have tender, concerned feelings for people less fortunate than me.	A	B	C	D	E
3. I sometimes find it difficult to see things from the "other guys" point of view.	A	B	C	D	E
4. Sometimes I don't feel very sorry for other people when they are having problems.	A	B	C	D	E
5. I really get involved with the feeling of the characters in a novel.	A	B	C	D	E
6. In emergency situations, I feel apprehensive and ill-at-ease.	A	B	C	D	E
7. I am usually objective when I watch a movie or play and I don't often get completely caught up in it.	A	B	C	D	E
8. I try to look at everybody's side of a disagreement before I make a decision.	A	B	C	D	E
9. When I see someone being taken advantage of, I feel kind of protective towards them.	A	B	C	D	E
10. I sometimes feel helpless when I am in the middle of a very emotional situation.	A	B	C	D	E
11. I sometimes try to understand my friends better by imagining how things look from their perspective.	A	B	C	D	E
12. Becoming extremely involved in a good book or movie is somewhat rare for me.	A	B	C	D	E
13. When I see someone get hurt, I tend to remain calm.	A	B	C	D	E

14. Other people' misfortunes do not usually disturb me a great deal	A	B	C	D	E
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.	A	B	C	D	E
16. After seeing a play or movie, I have felt as though I were one of the characters.	A	B	C	D	E
17. Being in a tense emotional situation scares me.	A	B	C	D	E
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.	A	B	C	D	E
19. I am usually pretty effective in dealing with emergencies	A	B	C	D	E
20. I am often quite touched by things that I see happen	A	B	C	D	E
21. I believe that there are two sides to every question and try to look at them both.	A	B	C	D	E
22. I would describe myself as a fairly soft-hearted person.	A	B	C	D	E
23. When I watch a good movie, I can very easily put myself in the place of a leading character.	A	B	C	D	E
24. I tend to lose control during emergencies.	A	B	C	D	E
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.	A	B	C	D	E
26. When I am reading an interesting story or novel, I imagine how I would feel in the events in the story were happening to me.	A	B	C	D	E
27. When I see someone who badly needs help in an emergency, I go to pieces.	A	B	C	D	E
28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.	A	B	C	D	E

Inventory of Interpersonal Problems

People have reported having the following problems in relating to other people. For each item below, please consider whether it has been a problem for you *with respect to any significant person in your life.* Then fill in the number that describes how distressing that problem has been.

0 = Not at all 1 = A little bit. 2 = Moderately. 3 = Quite a bit. 4 = Extremely

THE FOLLOWING ARE THINGS YOU FIND HARD TO DO WITH OTHR PEOPLE. IT IS HARD FRO ME TO:					
1. Say “no” to other people	0	1	2	3	4
2. Join in on groups	0	1	2	3	4
3. Keep things private from other people	0	1	2	3	4
4. Tell a person to stop bothering me	0	1	2	3	4
5. Introduce myself to new people	0	1	2	3	4
6. Confront people with problems that come up	0	1	2	3	4
7. Be assertive with another person	0	1	2	3	4
8. Let other people know when I an angry	0	1	2	3	4
9. Socialize with other people	0	1	2	3	4
10. Show affection to people	0	1	2	3	4
11. Get along with people	0	1	2	3	4
12. Be firm when I need to be	0	1	2	3	4
13. Experience a feeling of love for another person	0	1	2	3	4
14. Be supportive of another person’s goals in life	0	1	2	3	4
15. Feel close to other people	0	1	2	3	4
16. Really care about other people’s problems	0	1	2	3	4
17. Put somebody else’s needs before my own	0	1	2	3	4
18. Feel good about another person’s happiness	0	1	2	3	4
19. Ask other people to get together socially with me	0	1	2	3	4
20. Be assertive without worrying about hurting the other person’s feelings	0	1	2	3	4

THE FOLLOWING ARE THINGS THAT YOU DO TOO MUCH					
21. I open up to people too much	0	1	2	3	4
22. I am too aggressive toward other people	0	1	2	3	4
23. I try to please other people too much	0	1	2	3	4
24. I want to be noticed too much	0	1	2	3	4
25. I try to control other people too much	0	1	2	3	4
26. I put other people's needs before my own too much	0	1	2	3	4
27. I am overly generous to other people	0	1	2	3	4
28. I manipulate other people too much to get what I want	0	1	2	3	4
29. I tell personal things to other people too much	0	1	2	3	4
30. I argue with other people too much	0	1	2	3	4
31. I let other people take advantage of me too much	0	1	2	3	4
32. I am affected by another person's misery too much	0	1	2	3	4

Alabama Parenting Questionnaire –Parent Form

The following are a number of statements about your family. Please rate each item as to how often it **TYPICALLY** occurs in you home.

The possible answers are 1 = Never
2 = Almost never
3 = Sometimes
4 = Often
5 = Always

1. You have a friendly talk with your child.	1	2	3	4	5
2. You let your child know when he/she is doing a good job with something.	1	2	3	4	5
3. You threaten to punish your child and then do not actually punish him/her.	1	2	3	4	5
4. You volunteer to help with special activities that your child is involved in such as sports, boy/girl scouts, church youth groups).	1	2	3	4	5
5. You reward or give something extra to your child for obeying you or behaving well.	1	2	3	4	5
6. Your child fails to leave a note or to let you know where he/she is going.	1	2	3	4	5
7. You play games or do other fun things with your child.	1	2	3	4	5
8. Your child talks you out of being punished after he/she has done something wrong.	1	2	3	4	5
9. You ask your child about his/her day in school.	1	2	3	4	5
10. Your child stays out in the evening past the time he/she is supposed to be home.	1	2	3	4	5
11. You help your child with his/her homework.	1	2	3	4	5
12. You feel that getting your child to obey you is more trouble than it's worth.	1	2	3	4	5
13. You compliment your child when he/she does something well.	1	2	3	4	5
14. You ask your child what his/her plans are for the coming day.	1	2	3	4	5

15. You drive your child to a special activity.	1	2	3	4	5
16. You praise your child if he/she behaves well.	1	2	3	4	5
17. Your child is out with friends you don't know.	1	2	3	4	5
18. You hug or kiss your child when he/she has done something well.	1	2	3	4	5
19. Your child goes out without a set time to be home.	1	2	3	4	5
20. You talk to your child about his/her friends.	1	2	3	4	5
21. Your child is out after dark without an adult with him/her.	1	2	3	4	5
22. You let your child out of a punishment early (like lift restrictions earlier than you originally said).	1	2	3	4	5
23. Your child helps plan family activities.	1	2	3	4	5
24. You get so busy that you forget where your child is and what he/she is doing.	1	2	3	4	5
25. Your child is not punished when he/she has done something wrong.	1	2	3	4	5
26. You attend P&C meetings, parent/teacher conferences, or other meetings at you child's school.	1	2	3	4	5
27. You tell your child that you like it when he/she helps out around the house.	1	2	3	4	5
28. You don't check that your child comes home at the time she/he was supposed to.	1	2	3	4	5
29. You don't tell your child where you are going.	1	2	3	4	5
30. Your child comes home from school more than an hour past the time you expect him/her.	1	2	3	4	5
31. The punishment you give your child depends on your mood.	1	2	3	4	5
32. Your child is at home without adult supervision.	1	2	3	4	5
33. You spank your child with your hand when he/she has done something wrong.	1	2	3	4	5
34. You ignore your child when he/she is misbehaving.	1	2	3	4	5

35. You slap your child when he/she has done something wrong.	1	2	3	4	5
36. You take away privileges or money from your child as a punishment.	1	2	3	4	5
37. You send your child to his/her room as a punishment.	1	2	3	4	5
38. You hit your child with a belt, or other object when he/she has done something wrong.	1	2	3	4	5
39. You yell or scream at your child when he/she has done something wrong.	1	2	3	4	5
40. You calmly explain to your child why his/her behaviour was wrong when he/she misbehaves.	1	2	3	4	5
41. You use time out (make him/her sit or stand in a corner) as a punishment.	1	2	3	4	5
42. You give your child extra chores as a punishment.	1	2	3	4	5

THANK YOU VERY MUCH FOR YOUR ASSISTANCE IN THIS VALUABLE RESEARCH PROJECT

Section completed by the Case Coordinator

Type and Degree of Abuse

1. Who is suspected of being the perpetrator of the abuse: (please mark all that apply)

- Father
- Mother
- Step-parent/ parent's partner
- Other relative
- Person known to the family
- Stranger
- Unknown

2. Type of abuse: (please mark all that apply)

- Physical
- Sexual
- Emotional
- Neglect

3. Was this abuse a single case?

- Yes
- No
- Unknown

4. Estimation of severity of abuse:

- Mild
- Moderate
- Severe

5. Recidivism of maltreatment :

- No child protection notification recorded prior to current case
- One prior child protection notification
- Two or more prior child protection notifications

6. Status of intervention:

- Mandatory (e.g. subject to conditions such as removal of child)
- Voluntary (e.g. referred by government departments, agencies, schools etc.)
- Self-referred

7. Description of treatment type: Please tick all that apply

- Child

- Parent
- Family
- Health
- Other

8. Has the primary caregiver experienced abuse?

- No
- Yes
- Unknown

9. If answered "yes" to above, when was this experienced?

- As a child
- As an adult
- As both a child and adult

10. Please tick the appropriate box for this family regarding the period they have received Contact House services:

- have received CH services in the past and is now returning for further intervention
- just commencing to receive or on waiting list
- have received CH services for a period less than 3 months
- have received CH services for a period of 3 – 6 month
- have received CH services for a period of 6 – 12 months
- have received CH services for a period of 12 – 18 months
- have received CH services for a period of more than 18 months

Section to be completed at the End of Therapy

Strengths and Difficulties Questionnaire

Below are a series of phrases that describe children's behaviour. Please mark to what extent each of the items is true for your child based on their behaviour ***over the last month.***

	Not true	Somewhat true	Certainly true
1. Considerate of other people's feelings	○	○	○
2. Restless, overactive, cannot stay still for long	○	○	○
3. Often complains of headaches, stomach-aches or sickness	○	○	○
4. Shares readily with other children (treats, toys, pencils etc.)	○	○	○
5. Often has temper tantrums or hot tempers	○	○	○
6. Rather solitary, tends to play alone	○	○	○
7. Generally obedient, usually does what adults request	○	○	○
8. Many worries, often seems worried	○	○	○
9. Helpful if someone is hurt, upset or feeling ill	○	○	○
10. Constantly fidgeting or squirming	○	○	○
11. Has at least one good friend	○	○	○
12. Often fights with other children or bullies them	○	○	○
13. Often unhappy, down-hearted or tearful	○	○	○
14. Generally liked by other children	○	○	○
15. Easily distracted, concentration wanders	○	○	○
16. Nervous or clingy in new situations, easily loses confidence	○	○	○
17. Kind to younger children	○	○	○
18. Often argumentative with adults	○	○	○
19. Picked on or bullied by other children	○	○	○
20. Often volunteers to help others (parents, teachers, other children)	○	○	○
21. Can stop and thinks things over before acting	○	○	○
22. Can be spiteful to others	○	○	○

23. Gets on better with adults than with other children	○	○	○
24. Many fears, easily scared	○	○	○
25. Sees tasks through to the end, good attention span	○	○	○

26. Overall do you think your child has difficulties in one or more of the following areas: Emotions, concentration, behaviour or being able to get on with other people?

- □ No
- □ Yes minor difficulties
- □ Yes definite difficulties
- □ Yes severe difficulties

If you have answered "Yes", please answer the following questions about these difficulties:

27. How long have these difficulties been present?

- □ Not applicable
- □ Less than 1 month
- □ 1 – 5 months
- □ 6 – 12 months
- □ Over a year

28. Do the difficulties upset or distress your child?

- □ Not applicable
- □ Not at all
- □ Only a little
- □ Quite a lot
- □ A great deal

29. Do the difficulties interfere with your child's everyday life in the following areas?

Area	Not Applicable	Not at all	Only a little	Quite a lot	A great deal
Home Life					
Friendships					
Classroom Learning					
Leisure Activities					

30. Do the difficulties put a burden on you or the family as a whole?

- □ Not applicable
- □ Not at all
- □ Only a little
- □ Quite a lot
- □ A great deal

31. Do you have any other comments or concerns?

_____
_____
_____
_____

32. Since coming to the service, are your child's problems

- Much worse
- A bit worse
- About the same
- A bit better
- Much better

33. Has coming to the service been helpful in other ways eg. providing information or making the problem more bearable?

- Not at all
- A little bit
- A medium amount
- A great deal

Inventory of Interpersonal Problems

People have reported having the following problems in relating to other people. For each item below, please consider whether it has been a problem for you with respect to *any significant person in your life.* Then fill in the number that describes how distressing that problem has been.

0 = Not at all 1 = A little bit. 2 = Moderately. 3 = Quite a bit. 4 = Extremely

THE FOLLOWING ARE THINGS YOU FIND HARD TO DO WITH OTHR PEOPLE. IT IS HARD FRO ME TO:					
1. Say “no” to other people	0	1	2	3	4
2. Join in on groups	0	1	2	3	4
3. Keep things private from other people	0	1	2	3	4
4. Tell a person to stop bothering me	0	1	2	3	4
5. Introduce myself to new people	0	1	2	3	4
6. Confront people with problems that come up	0	1	2	3	4
7. Be assertive with another person	0	1	2	3	4
8. let other people know when I an angry	0	1	2	3	4
9. Socialize with other people	0	1	2	3	4
10. Show affection to people	0	1	2	3	4
11. Get along with people	0	1	2	3	4
12. Be firm when I need to be	0	1	2	3	4
13. Experience a feeling of love for another person	0	1	2	3	4
14. Be supportive of another person’s goals in life	0	1	2	3	4
15. Feel close to other people	0	1	2	3	4
16. Really care about other people’s problems	0	1	2	3	4
17. Put somebody else’s needs before my own	0	1	2	3	4

18. Feel good about another person's happiness	0	1	2	3	4
19. Ask other people to get together socially with me	0	1	2	3	4
20. Be assertive without worrying about hurting the other person's feelings	0	1	2	3	4
THE FOLLOWING ARE THINGS THAT YOU DO TOO MUCH					
21. I open up to people too much	0	1	2	3	4
22. I am too aggressive toward other people	0	1	2	3	4
23. I try to please other people too much	0	1	2	3	4
24. I want to be noticed too much	0	1	2	3	4
25. I try to control other people too much	0	1	2	3	4
26. I put other people's needs before my own too much	0	1	2	3	4
27. I am overly generous to other people	0	1	2	3	4
28. I manipulate other people too much to get what I want	0	1	2	3	4
29. I tell personal things to other people too much	0	1	2	3	4
30. I argue with other people too much	0	1	2	3	4
31. I let other people take advantage of me too much	0	1	2	3	4
32. I am affected by another person's misery too much	0	1	2	3	4

Parenting Stress Index (short form)

Directions:
In answering the following questions, please think about ***the child you are most concerned about.***
The questions on the following pages ask you to mark an answer which best describes your feelings. While you may not find an answer which exactly states your feelings, please mark the answer which comes closest to describing how you feel.

Your first reaction to each question should be your answer.

Please mark the degree to which you agree or disagree with the following statements by crossing the number which matches how you agree with the statement. If you are not sure, please choose "not sure".

1	2	3	4	5
Strongly agree	Agree	Not Sure	Disagree	Strongly Disagree

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
1. I often have the feeling that I cannot handle things very well.	O	O	O	O	O
2. I find myself giving up more of my life to meet my children's needs than I ever expected.	O	O	O	O	O
3. I feel trapped by my responsibilities as a parent.	O	O	O	O	O
4. Since having this child I have been unable to do new and different things.	O	O	O	O	O
5. Since having a child I feel that I am almost never able to do things that I like to do.	O	O	O	O	O
6. I am unhappy with the last purchase of clothing I made for myself.	O	O	O	O	O
7. There are quite a few things that bother me about my life.	O	O	O	O	O
8. Having a child has caused more problems than I expected in my relationship with my spouse (male / female friend).	O	O	O	O	O
9. I feel alone and without friends.	O	O	O	O	O
10. When I go to a party I usually expect not to enjoy myself.	O	O	O	O	O
11. I am not as interested in people as I used to be.	O	O	O	O	O
12. I don't enjoy things as I used to.	O	O	O	O	O
13. My child rarely does things for me that make me feel good.	O	O	O	O	O
14. Most times I feel that my child does not like me and does not want to be close to me.	O	O	O	O	O
15. My child smiles at me much less than I expected.	O	O	O	O	O
16. When I do things for my child I get the feeling that my efforts are not	O	O	O	O	O

appreciated very much.						
17. When playing, my child doesn't often giggle or laugh.		O	O	O	O	O
18. My child doesn't seem to learn as quickly as most children.		O	O	O	O	O
19. My child doesn't seem to smile as much as most children.		O	O	O	O	O
20. My child is not able to do as much as I expected.		O	O	O	O	O
21. It takes a long time and it is very hard for my child to get used to new things.		O	O	O	O	O
22. I feel that I am:	Not very good at being a parent	O	Fill in one			
	A person who has some trouble being a parent	O				
	An average parent	O				
	A better than average parent	O				
	A very good parent	O				

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
23. I expected to have a closer and warmer feelings for my child than I do and this bothers me.	O	O	O	O	O
24. Sometimes my child does things that bother me just to be mean.	O	O	O	O	O
25. My child seems to cry or fuss more often than most children.	O	O	O	O	O
26. My child generally wakes up in a bad mood.	O	O	O	O	O
27. I feel that my child is very moody and easily upset.	O	O	O	O	O
28. My child does a few things which bother me a great deal.	O	O	O	O	O
29. My child reacts very strongly when something happens that my child doesn't like.	O	O	O	O	O
30. My child gets upset easily over the smallest things.	O	O	O	O	O
31. My child's sleeping or eating schedule was much harder to establish	O	O	O	O	O

than I expected.					

32. I have found that getting my child to do something or stop doing something is: Much harder than I expected	O
Somewhat harder than I expected	O
About as hard as I expected	O
Somewhat easier than I expected	O
Much easier than I expected	O
33. Think carefully and count the number of things, which your child does that bother you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc. Please circle the number which includes the number of things you counted. 10 or more	O
8-9	O
6-7	O
4-5	O
1-3	O

Fill in one

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
34. There are some things my child does that really bother me a lot.	O	O	O	O	O
35. My child turned out to be more of a problem than I expected.	O	O	O	O	O
36. My child makes more demands on me than most children.	O	O	O	O	O

Alabama Parenting Questionnaire –Parent Form

The following are a number of statements about your family. Please rate each item as to how often it **TYPICALLY** occurs in you home.

The possible answers are 1 = Never
2 = Almost never
3 = Sometimes
4 = Often
5 = Always

1. You have a friendly talk with your child.	1	2	3	4	5
2. You let your child know when he/she is doing a good job with something.	1	2	3	4	5
3. You threaten to punish your child and then do not actually punish him/her.	1	2	3	4	5
4. You volunteer to help with special activities that your child is involved in such as sports, boy/girl scouts, church youth groups).	1	2	3	4	5
5. You reward or give something extra to your child for obeying you or behaving well.	1	2	3	4	5
6. Your child fails to leave a note or to let you know where he/she is going.	1	2	3	4	5
7. You play games or do other fun things with your child.	1	2	3	4	5
8. Your child talks you out of being punished after he/she has done something wrong.	1	2	3	4	5
9. You ask your child about his/her day in school.	1	2	3	4	5
10. Your child stays out in the evening past the time he/she is supposed to be home.	1	2	3	4	5
11. You help your child with his/her homework.	1	2	3	4	5
12. You feel that getting your child to obey you is more trouble than it's worth.	1	2	3	4	5
13. You compliment your child when he/she does something well.	1	2	3	4	5
14. You ask your child what his/her plans are for the coming day.	1	2	3	4	5
15. You drive your child to a special activity.	1	2	3	4	5
16. You praise your child if he/she behaves well.	1	2	3	4	5

17. Your child is out with friends you don't know.	1	2	3	4	5
18. You hug or kiss your child when he/she has done something well.	1	2	3	4	5
19. Your child goes out without a set time to be home.	1	2	3	4	5
20. You talk to your child about his/her friends.	1	2	3	4	5
21. Your child is out after dark without an adult with him/her.	1	2	3	4	5
22. You let your child out of a punishment early (like lift restrictions earlier than you originally said).	1	2	3	4	5
23. Your child helps plan family activities.	1	2	3	4	5
24. You get so busy that you forget where your child is and what he/she is doing.	1	2	3	4	5
25. Your child is not punished when he/she has done something wrong.	1	2	3	4	5
26. You attend P&C meetings, parent/teacher conferences, or other meetings at you child's school.	1	2	3	4	5
27. You tell your child that you like it when he/she helps out around the house.	1	2	3	4	5
28. You don't check that your child comes home at the time she/he was supposed to.	1	2	3	4	5
29. You don't tell your child where you are going.	1	2	3	4	5
30. Your child comes home from school more than an hour past the time you expect him/her.	1	2	3	4	5
31. The punishment you give your child depends on your mood.	1	2	3	4	5
32. Your child is at home without adult supervision.	1	2	3	4	5
33. You spank your child with your hand when he/she has done something wrong.	1	2	3	4	5
34. You ignore your child when he/she is misbehaving.	1	2	3	4	5
35. You slap your child when he/she has done something wrong.	1	2	3	4	5
36. You take away privileges or money from your child as a punishment.	1	2	3	4	5
37. You send your child to his/her room as a punishment.	1	2	3	4	5
38. You hit your child with a belt, or other object when he/she has done	1	2	3	4	5

something wrong.					
39. You yell or scream at your child when he/she has done something wrong.	1	2	3	4	5
40. You calmly explain to your child why his/her behaviour was wrong when he/she misbehaves.	1	2	3	4	5
41. You use time out (make him/her sit or stand in a corner) as a punishment.	1	2	3	4	5
42. You give your child extra chores as a punishment.	1	2	3	4	5

THANK YOU VERY MUCH FOR YOUR ASSISTANCE IN THIS VALUABLE RESEARCH PROJECT

To be completed by the case coordinator

End of Therapy Details

1. Reason for the cessation of therapy

- ☐ the client decided to finish therapy prematurely
- ☐ premature cessation by therapist (eg. due to client failing to engage, notification)
- ☐ therapy completed
- ☐ moved out of Contact House area
- ☐ legal proceedings (eg. child giving evidence)

2. Estimated degree of engagement by the primary caregiver

- ☐ not at all
- ☐ a little bit
- ☐ a satisfactory amount
- ☐ a very high level

3. Estimated level of progress made by the child

- ☐ not at all
- ☐ poor
- ☐ satisfactory
- ☐ good progress

4. Estimated level of progress made by the primary caregiver and/or family

- ☐ not at all
- ☐ poor
- ☐ satisfactory
- ☐ good progress

Appendix B

SDQ Score Changes for Children Completing Therapy

	TOTAL DIFFICULTIIES		EMOTIONAL SYMPTOMS		CONDUCT		HYPERACTIVITY INATTENTION		PEER PROBLEMS		PRO-SOCIAL BEHAVIOUR	
	Time1	Time2	Time1	Time2	Time1	Time2	Time1	Time2	Time1	Time2	Time1	Time2
CHILD 1	27	24	2	0	10	10	10	10	5	4	2	1
CHILD 2	27	17	4	2	8	6	7	4	8	5	2	6
CHILD 3	24	30	10	10	3	10	6	6	5	4	8	4
CHILD 4	28	20	9	9	6	3	7	4	6	4	4	8
CHILD 5	27	16	10	6	8	4	5	2	4	4	7	8
CHILD 6	6	8	2	1	1	3	2	2	1	2	10	10
CHILD 7	20	15	1	1	8	5	8	5	3	4	6	6

Note. Time one refers to the initial assessment and Time two refers to the assessment at completion of therapy. $n = 7$

Appendix C

APQ and PSI Score Changes for Caregivers at Therapy Closure

	Caregiver 1		Caregiver 2		Caregiver 3	
	Time1	Time2	Time1	Time2	Time1	Time2
Alabama Parenting Questionnaire						
Parental Involvement	2.1	2.44	4.2	4.6	3.3	3.11
Positive Parenting	3.8	5	4.17	4.67	5	2.67
Poor Monitoring	1.2	1.25	1.2	1.10	1.2	2
Inconsistent Discipline	2	1.67	1.83	1.67	1.67	1.83
Corporal Punishment	2.3	2	1	1	1.67	1.67
Parenting Stress Index						
Parental Distress	60	31	35	31	30	23
Dysfunctional Interaction	55	22	27	25	26	26
Difficult Child	48	36	46	45	46	37
Total Parenting Stress	136	89	108	101	102	86

Note. Time one refers to the initial assessment and Time two refers to the assessment at completion of therapy.