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RELATION OF ABUSE AND PLACEMENT HISTORIES TO
PATHOLOGY DEVELOPMENT IN MIDDLE CHILDHOOD MALES

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
in
Psychology: Clinical Counseling Option

by
Clare Louise Herder
September 1999

RELATION OF ABUSE AND PLACEMENT HISTORIES TO
PATHOLOGY IN MIDDLE CHILDHOOD MALES

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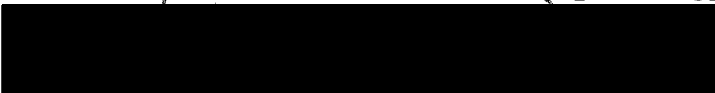
September 1999

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ABSTRACT

The present study investigated abuse/re-abuse and placement histories in middle childhood males as they relate to subsequent pathologies. Previous research has examined a relationship between abuse and pathology development; however, little research has looked specifically at different types of abuse/re-abuse experienced and placement histories outside of the biological parents' home in relation to the development of specific pathologies. It is hypothesized that there is a relationship between abuse histories and specific type of pathologies developed. It is further hypothesized that there is a relationship between the number of out-of-home placements and subsequent type of pathology developed. It is also hypothesized that re-abuse following removal from the biological parent's home will exacerbate pathology development and aggressive behaviors within this population of children. This study examined 104 archival records of male children aged 5-11 years placed in a treatment facility for severely emotionally disturbed children. Demographic information, abuse history (including re-abuse after removal from the biological parents home), and diagnosed pathologies were gathered from these archival records. A Pearson's Chi-square, with a significance level of .05, was utilized for all analyses. Significance was found for the first two hypotheses. Further understanding of the development of

specific pathologies related to abuse can assist in the development of improved intervention and prevention programs for these children and families.

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INTRODUCTION

Although there is an extensive body of research which examines the impact of child abuse on pathology development, less research has investigated the impact of specific types of abuse, re-abuse and placement histories (Bates, Bayles, Bennett, Ridge, & Brown, 1991; Ferleger, 1988). In order to better understand the impact of early childhood abuse on pathology development and the further impact of multiple placements, which take place in an attempt to keep these children safe, it is important to examine these factors collectively.

This paper focuses primarily on the type of abuse which initially occurred, re-abuse patterns, and multiple placement histories in middle childhood males. The type of initial abuse and consequential abuse after removal from the home is noted. The child's placement history and the abuse, if any, which occurred in these out of home placements is also examined. Finally, the type or types of pathology developed and diagnosed upon intake into the treatment facility are investigated.

In this thesis, abuse and its subtypes are first defined and then discussed in relation to pathology development. Current research on pathology development related to specific types of abuse will be reviewed. Following this, the issues of attachment, attachment disruption (in relation to pathology development), multiple

placement and re-abuse will be addressed. These four variables combined and separately have potentially long lasting negative consequences on the population being studied. Lastly, middle childhood developmental issues will be reviewed, emphasizing the crucial nature of this stage of development.

Abuse

According to the Crime Prevention Center (CPC) of the California Attorney General's Office (1993) and American Professional Society on the Abuse of Children (APSAC) (Reid, 1996), there are four categories of abuse considered when assessing a child's safety. These categories are physical abuse, sexual abuse, neglect, and emotional/psychological maltreatment. Abuse in general, according to the CPC (1993), can be defined as, "The act of inflicting injury or failure to act so that injury results." (p.1).

Specifically, physical abuse is described as "any act which results in non-accidental physical injury" (CPC, 1993, p. 3). These types of injuries are usually the result of some type of severe unjustified or corporal punishment. Use of an object such as a belt or wooden spoon to spank a child would be considered physical abuse. In very young children (i.e., less than 1 year old) abused children, the child is often shaken which causes severe brain damage and frequently death. This type of physical abuse has been named "SPS", i.e., shaken baby syndrome (Kolko, 1996). Fractures,

abrasions, bruises, lacerations, bite marks, cigarette burns and burns from scalding water, are also common injuries sustained by the physically abused child (CPC, 1993). The second type of abuse is sexual abuse. Simply stated, sexual abuse is any sexual activity in which a child's permission cannot be or is not given (Berlinger & Elliott, 1996). The parameters by which sexual abuse is defined vary depending on the state or country. For example, in the state of California it is a crime for a 19 year old to have sexual relations with a 16 year old. In other states this is not the case (CPC, 1993). Sexual abuse can range from exposing a child to sexually explicit materials to actual intercourse (Oates, 1996). The perpetrators of sexual abuse are more commonly people the victim knows. Berlinger and Elliott (1996) report that only 5-15% of sexual abuse is committed by a stranger. This statistic concurs with the CPC (1993) and Oates (1996).

The third type of abuse, i.e., neglect, has many different definitions depending on the source. For the purposes of this study, however, a general definition of neglect will be utilized. In the recently published book, The Spectrum of Child Abuse (Oates, 1996), neglect is defined in five separate sub-categories: emotional, educational, physical, safety and medical.

Emotional neglect is when the caregiver does not meet the child's emotional needs. An example of this would be a

parent who ignores his or her child's verbal or auditory requests for assistance or attention. This ignoring behavior can be intentional or due to the parent's physical inability to respond, as in the case of a person who abuses substances or is mentally ill. This intentional or unintentional type of neglect can also apply to educational neglect, according to Erickson and Egeland (1996).

Educational neglect is when the child is not provided with adequate educational opportunities. For instance, a ten-year old child who is kept home from school to care for underage siblings would be an example of educational neglect. Physical neglect is when the child's basic needs, such as, food, shelter, and clothing are not met.

The last two types of neglect are more likely to cause physical harm. Safety neglect is generally related to a lack of proper supervision, which in turn leads to a child suffering from an injury. Lastly, medical neglect is when a child is not provided with adequate medical care. One example of medical neglect would be when a child who has the flu dies of dehydration because the parents did not seek medical attention or advice (Oates, 1996).

The fourth type of abuse is that of emotional/psychological abuse. Similar to emotional neglect, emotional abuse can involve ignoring a child's emotional needs, but it can also include hostile rejecting, belittling, and/or intentionally humiliating the child (Hart, Brassard, &

Karlson, 1996). Emotional abuse is generally more deliberate in nature than emotional neglect. Although emotional/psychological abuse is a distinctly different type of maltreatment, it is generally reported combined with some other type of abuse or separated from the other three types of abuse in research. This area of abuse is difficult to investigate due to the relative lack of physical evidence. A child's behavior can display the impact of this abuse, but generally some other type of abuse has occurred which made an assessment necessary (Hart et al., 1996; Oates, 1996). Due to the nature of the database in this study, emotional/psychological abuse will not be separated. The children in this database have all been neglected, physically and or sexually abused. It is assumed some degree of emotional abuse would be present when these types of abuses occur.

Pathology Development Related to Specific Types of Abuse

There is a large body of research which focuses on the impact of abuse on childhood pathologies, but the majority of these studies focus on the impact of abuse in general, not specific *types of abuse* and *re-abuse patterns*. It is indicated by several studies, however, that abuse can have a significant impact on development in general (Cicchetti, 1995; and Oates, 1996).

Many abused children have experienced more than one type of abuse (Oates, 1996). In a 1994 study, by Ney, Fung

and Wickett only 5% of those individual cases of abuse reviewed involved just a singular type of abuse. Most were victims of at least two types of the abuse described above. Nonetheless, some researchers have attempted to divide and compare outcomes of distinct types of abuse.

A study by Briere and Runtz (1990), for example, compared emotional, physical and sexual abuse among college populations and found that anger and aggression were significantly linked to those subjects who were physically abused. They also found that dysfunctional sexual behavior was highly correlated with childhood sexual abuse.

When researched separately, abuse has been found to have a negative impact on psychological development. One study which investigated family background and sexual abuse history related to the development of eating disorders found that there was a significant relationship between intensity of poor family functioning (including the presence of sexual abuse) and the development of eating disorders (Kinzel, Traweger, Guenther, and Biebl, 1994). Post-traumatic stress disorder is also common among sexual abuse victims (Berlinger and Elliott, 1996).

Another study which investigated adolescent perceived family functioning related to suicidal behavior found that negative family functioning was significantly related to suicidal behavior (Adams, Overholser and Lehnert, 1994). This same body of research attributes certain issues, such

as, youth violence, teen suicide and adult criminality to early family disruptions. Disruptions, such as, divorce, separation from family of origin due to parental incarceration and removal due to abuse can also cause stress and hence difficulties in functioning among children and adolescents (Adams & Horovitz, 1980; Bates et al., 1991).

One such study, conducted at the University of Illinois Institute of Juvenile Research, investigated prenatal stress and childhood psychopathology development. This study investigated 58 children aged 4-19 who were all categorized as severely emotionally disturbed. This study found that prenatal substance abuse, maternal stress during pregnancy and family problems during pregnancy (e.g., domestic violence) were highly correlated with children being hospitalized for treatment related to behavior disorders and other psychopathologies (Ward, 1991).

Recent studies, which have specifically looked at the impact of early childhood abuse, have demonstrated a link to later dysfunctional behavior (Cho, 1996; Cicchetti, 1995; and DHHS, 1996). A 1992 study, conducted by the National Institute of Justice (NIJ), found a 53% higher likelihood of being arrested as a juvenile if there was maltreatment in childhood. The same study also found that there is a 38% higher likelihood of being arrested as an adult and 38% higher likelihood of committing a violent crime as an adult

for those offenders who were maltreated in childhood (APA, 1998).

Research related to the development of pathologies in children has largely focused on those children before school age and those children in adolescence, but little has been conducted in the area of middle childhood aged children (6-11 years), with the exception of childhood depression and dysthymia. One study which investigated childhood depression found that boys in middle childhood tend to have higher rates of suicidal ideation when depressed (Wenar, 1994). It is also true that depression in children often manifests itself in hostile behavior, which can cause disruptions within the home and school settings. This would also include poor peer relationships and peer rejection which will be addressed later in this review (Rapoport & Ismond, 1996).

In an attempt to quantify specific behavior problems, specifically aggressive antisocial type behaviors, Lahey and Loeber (1994) developed a *hierarchy of behaviors* which tended to follow a developmental trend in those cases of conduct and oppositional defiant disorders they studied. Behaviors such as temper tantrums, irritability, defiance, anger and annoying others were more common during early development of behavior disorders. The next level of development was characterized as *intermediate conduct problems*, which includes lying, fighting, bullying,

firesetting and cruelty to animals. The last and most *advanced level* is indicated by behaviors such as running away, cruelty to others, truancy and stealing.

This hierarchy can be a reference source for those treating children that do not meet the criteria for a specific pathology, but have difficulties related to their behavior. For example, a child who was setting fires and hurting animals would be considered more severe than a child who was defiant and having temper tantrums.

Although the precise etiology of specific pathology development is not clear, it is known that disruptions in attachment and inability to attach, have been found to be related (Rutter, 1997). This is particularly true for those pathologies related to behavior problems. Colin (1996) states that in middle childhood years poor/insecure attachment begins to manifest itself in acting-out, peer harassment and other disruptive behaviors. To further clarify these issues, attachment must be first explained and explored.

Attachment

Attachment has been defined as "...a reciprocal, enduring, emotional, and physical affiliation between a child and caregiver" (James, 1994, page 2). The caregiver in this instance is assumed to be the child's provider, guide, and most important, the child's protector (James,

1994). Attachment theory was first developed in 1969 by the psychoanalyst John Bowlby. Bowlby (1980) states that

Intimate attachments to other human beings are hub around which a person's life revolves, not only when he is an infant or a toddler or a schoolchild but throughout his adolescence and his years of maturity as well, and on to old age. From these intimate attachments a person draws his strength and enjoyment of life and, through what he contributes, he gives strength and enjoyment to others (Bowlby, 1980).

The impact of poor attachment early in life can have long-lasting effects as the person reaches adulthood. As Bowlby indicates in the above quote, early attachment is the foundation on which the remainder of life's relational experiences are based. With a weak early foundation, difficulties in relationships later in life are more likely (Bowlby, 1980).

Supporting Bowlby's beliefs in the importance of this early foundation is an article published in 1993 entitled "Children Without a Conscience" (Keogh, 1993). Keogh notes that children who are abused and neglected are unable to build strong attachment to others, and hence "...may grow up lacking empathy for other" (Keogh, 1993, p.53).

Another researcher pioneering to look at mother-child relationships was Dr. Harry Harlow, who in 1958 used rhesus

monkey's to investigate what aspects of mothering were the most important to infant monkeys. Harlow (1969) found that when the monkey's had a choice between food and nurturance, they chose nurturance. This work, although not directly related to human behavior, did begin to dispel the myth that a mother was merely depended upon as a source of food.

Rene Spitz followed Harlow's work and looked at orphaned children in foundling homes. He found that these children's basic needs were met, but no nurturance or emotional care was given. Spitz found, although these children were provided proper nutrition and basic needs, they did not grow and often died in this emotionally deprived environment. This phenomenon has been termed "failure to thrive" and is common among severely abused and neglected children (James, 1994).

Ainsworth (1982) also followed Harlow and further investigated the issue of attachment. Through her work with children and their mothers, using the "Strange Situation", she identified four distinct types of attachment. Her premise was that children need their mother/caretaker as a secure base to explore the world and feel safe. Ainsworth notes that a secure consistent base leads to a securely attached child. This child feels free to explore the world; if the base is unpredictable or inconsistent, however, the child may become anxiously, ambivalently or avoidantly

attached. Collectively, these three latter attachment styles are considered an insecure attachment (Ainsworth, 1981).

Dr. Robert Karen (1990) further explains the impact of poor attachment on development in his well-known article "Becoming Attached". In this article Karen supports Ainsworth's (1981) findings that a child who is insecurely attached can become aggressive or clinging in order to feel safe in their world.

Greenberg, DeKlyen, Speltz and Endriga (1997) found that 80% of the behaviorally disturbed children they studied were insecurely attached to their primary caregivers. The children in this clinical sample were diagnosed with behavioral disorders, Oppositional Defiant Disorder (ODD), Attention-Deficit/Hyperactivity disorder (ADHD) and Conduct Disorder (CD). In the same study, a relationship between early childhood attachment disruptions and later developed pathologies, such as ODD and CD, were found.

Greenberg et al. (1997) further explain that "...hostile or neglectful parenting" can be related to insecure attachment, which can be manifested by externalizing behaviors such as aggression toward peers and oppositional defiance (Crittenden & Ainsworth, 1989). This has been found to be especially true for males aged 5 and older (Rutter, 1996). Having said this, it is important to note that aggressive/externalizing behavior problems are a

key component in the pathologies found within the population of children to be studied within this research project.

Crittenden and Ainsworth (1989) conducted research which explored the issue of attachment among abused children. They found several telling characteristics within the population of abused children they studied. First, the majority of these children were anxiously or insecurely attached. These children tend to respond in an oppositional or clingy fashion with their biological parents.

Second, some differences in type of abuse and attachment were also observed by Ainsworth and Crittenden (1989). They found that children who were neglected often took over the role of parenting their own parents and siblings. The explanation for this, according to Ainsworth and Crittenden, is that the child who is ignored and unattended learns that the parents cannot care for them and thus they assume the role of caring for the parent. Physically abused children, however, tend to be more oppositional toward the abusive parent or caregiver.

Along with this relation of abuse on attachment, multiple placements can also have a negative impact on childhood attachments. Children may be removed from an out-of-home placement such as from the residence of a family member or foster parent, due to their behavior or may be removed due to re-abuse (Rutter, 1996). This issue of re-

abuse will be addressed further in a later section of this introduction.

The Issue of Multiple Placements

Until the 1980s, foster care was utilized as the primary resource in out-of-home placements (Rittner, 1995). At this time, the Adoption Assistance and Child Welfare Act (P.L. 96-272) was passed. This act, which was intended to protect children, gave much of the responsibility to protect the children to family service and family preservation agencies such as Child Protective Services (CPS) (Testa, 1992). Although foster care continued to be utilized after this law was passed, family members' homes and the returning of children back to the biological parents after treatment were the primary resources utilized. This was done in an attempt to maintain a "bond" for the child (Rittner, 1995).

According to Rittner (1995), the same dysfunctional parenting styles tend to occur in familial homes of the abusing parents. For example, the child may be placed with their aunt or uncle who has learned the same dysfunctional parenting style as their abusive sibling. Removal from a familial placement, as mentioned previously, may be due to the inability of the caretaker to adequately care for the child. This inability may be an adult sibling whose parenting style is also abusive or an elderly grandparent who cannot manage behavior problems. When this inability to

care for and protect the child occurs, the child is placed in another out-of-home placement. This additional placement may be another family member's or foster care.

A foster home is intended to be a "family like" setting which provides temporary care for a child (Schor, 1988). If the foster home is "short-term" the child may be removed merely because the time limit has run out. In this case a child can potentially have over 5 placements in a one year period (Schor, 1988). Even if this child had no pathology upon removal from the biological home, this instability in living situations could potentially lead to feelings of worthlessness and not being wanted. These feelings, if left untreated, may lead to later developed pathology such as suicide, aggression or self-endangering behaviors (Greenberg et al., 1997; Schor, 1988). Also, each disruption to the child's living situation can potentially exacerbate attachment difficulties and increase the potential for physical harm (Rittner, 1995).

Crittenden and Ainsworth (1989) researched abused children and their attachment patterns. From their work they reported several observations with regard to abused children and their parents. One observation was that abused children who are anxiously or insecurely attached to their caregivers tend to display greater amounts of anger toward their parents, but are also clingy. This combination of behaviors cannot only lead to further rejection from the

abusive parent, but also may cause difficulties in parenting for the chosen caregiver if the child is removed from the home. Another observation Crittenden and Ainsworth made was that some abused children who are insecurely attached tend to develop a manipulative behavior style in an attempt to seek the care they need from their parent. This style may include superficial compliance and or *inhibited anger*. In both of these cases, the developed behavior makes parenting this child for an out-of-home caregiver difficult.

Having discussed implications and issues related to multiple placements, it is also important to explore re-abuse which can occur in out-of-home placements. A child may be initially placed in a foster home upon removal from the abusive biological parents, and then later removed from this home due to re-abuse. These continual disruptions can be harmful to a child; however, equally as harmful is abuse which may occur in these out-of-home placements.

Re-abuse

This issue of re-abuse and its potentially lethal implications has recently been addressed in Riverside County, California. According to a report in the local newspaper, a four-year-old child died after being tortured and physically abused for two days by his un-licensed foster mother (Nissenbaum, 1999, August 5). The child had been removed from his biological mother when she was

arrested on drug charges. In a follow-up article (Nissenbaum 1999, August 8) it was reported that within a year's time this child was placed with a family member, two foster homes and then the third and final un-licensed foster home, where he was consequently tortured and killed. Ironically, there were no reports of physical abuse in the biological home. The child's safety was in question due to substance abuse by the parent (Thurston, 1999).

Most current studies of re-abuse have focused on biological parents' patterns re-abuse, but few have looked at re-abuse of a child which occurs in different placement settings after the child is removed from the biological parents' home. One study, which looked at patterns of biological parents re-abuse in a court sample, found that of the 203 cases of returned children followed, over 50% were re-abused and 10% were eventually permanently removed from the biological parent's homes (Murphy, Bishop, Jellinek, Quinn and Poitras, 1992).

An earlier study conducted by Ferleger et al. (1988) examined correlates of re-abuse in biological parents after treatment and rehabilitation. They found that length of parents treatment and parents own history of abuse were highly correlated to re-abuse patterns. Although these type of re-abuse studies have contributed to this area of research, investigating re-abuse which may occur while in

out-of-home care is also important. This includes familial placements, as well as foster care.

Consider the earlier study by Murphy et al. (1992). They found high percentages of re-abuse and permanent removal for this population of children. These removed and re-abused children will be placed out-of-home at least temporarily. As mentioned earlier, potential re-abuse which occurs in out-of-home placements, may be equally as harmful, if not more so to this population of children (Schor, 1988; Rittner, 1995; Greenberg et al., 1997). Addressing this gap in the research is one function of this research project. Abuse statistics do indicate, however, that re-abuse may be as under-reported as initial abuse (CPC, 1993). If this is the case findings may not be fully reflective of the potential enormity of this issue.

When looking at different stages of development related to later problems in functioning, middle childhood is often overlooked. Considering this is the developmental stage when social skills first begin to be developed, pathology during this stage can have far reaching consequences (Cole & Cole, 1996). Specific issues related to the population of middle childhood aged boys to be studied within this project, should be examined.

Middle Childhood

Middle childhood (ages 5-11) is a period when children begin to spend less time with their parents and more time

with peers. Although, compared to early childhood and adolescence, physical growth is slight in middle childhood, cognitive development is quite notable.

During middle childhood, children move from preoperational thought to concrete operational thought. In preoperational thought a child is unable to take another person's perspective or to better understand causation. In concrete operational thought, however, the child begins to understand another's perspective and understand causation (Cole & Cole, 1996).

Coie and Antonius (1993) found that peer rejection in middle childhood is frequently due to a child's inability to understand rules and be able to compromise. These are both functions of concrete operational thought. Behaviorally, these inability are manifested as bossiness, aggression, intrusiveness and hyperactivity.

The above mentioned negative behaviors are all components of pathologies related to abuse which were discussed earlier (Bates et al., 1991). This is important when considering the importance of social skills not only in childhood, but also in adolescence and into adulthood. Coie and Antonius (1993) also found that once a child was seen as rejected, other children also rejected them. A consequence of this rejection was a decrease in self-esteem, which in turn perpetuated feelings of depression. This depression is

generally manifested in an increase in aggressive behavior (Rapoport & Ismond, 1996).

The negative impact of multiple placements and re-abuse also increases in middle childhood due to a greater understanding of consequences (Cole & Cole, 1996). The child attempts to find a relationship between their abuse and not being wanted in a home. The child frequently comes to the conclusion that it is because there is something wrong with them (James, 1994; Oates, 1996 & Greenberg et al., 1997).

The Present Study

The focus of this study is an examination of factors, which may lead to or influence pathology development in abused male children. These factors include type or types of abuse initially experienced by the child, the number of placements the child experienced after removal from the biological parents home and if re-abuse occurred in these out-of-home placements. Also, if re-abuse did occur, the type of abuse experienced and who did the re-abusing was considered. The re-abusers were divided into two categories, familial and other. Familial re-abusers are relatives with whom the children are placed and others can include foster parents, group home caretakers, or any non-familial caretaker.

This study will first explore the relationship between the type of abuse initially experienced and primary

pathology diagnosed upon intake into a residential treatment facility. Then the relationship between number of out-of-home placements and primary diagnosed pathology upon intake will be analyzed. Next the relationship between those children who have been reported re-abused in their placement information and those that have not been reported re-abused with primary pathology diagnosed is addressed. This is followed by a more in-depth exploration of this sub-set of reported re-abuse cases. First, among those re-abused, the relationship between type of re-abuse sustained and the primary pathology diagnosis is investigated. Last, within the same sub-set of re-abused cases, the individual committing the abuse (familial or other) and pathology is explored.

Although attachment is not directly analyzed in this research project, related implications surrounding the findings are addressed in the discussion section. The issue of insecure attachment, as related to the variables addressed in this study, is important due to its potentially far reaching affects on the population of children explored.

Hypotheses

It is hypothesized that there is a significant relationship between type of initial abuse and diagnosed pathology/behaviors. Second, it is hypothesized that there is a significant relationship between number of placements and the type of pathology developed/behaviors displayed in

this population of middle childhood aged males. Third, it is hypothesized that there is a significant relationship between those cases of re-abuse and no re-abuse with type of pathology diagnosed. Fourth, it is also hypothesized that there is a significant relationship, in the sub-set of those re-abused (N=48), between type of re-abuse experienced and primary Axis I pathology diagnosed. Lastly, it is hypothesized that there will be a difference, in the sub-set of those re-abused, between who the re-abuser (familial, other or both) was and primary Axis I diagnosed.

METHODS

Data Base

This study used 104 archival records as the data base. These records were provided by an in-patient treatment facility in Riverside County for children classified as Severely Emotionally Disturbed (SED). The classification of SED is utilized by special education programs and treatment facilities to identify children who have difficulties interacting in social situations (James, 1994). Those in treatment facilities have difficulties severe enough to warrant residential treatment. This type of facility is generally a last resort for children who cannot function in a foster care or group home setting.

The records used for this study are of middle childhood males aged 5-11 years. Only those males who fell into this age range upon date of placement within this facility were

utilized. Most of the children placed at this facility were victims of some type of abuse. A majority had been placed with extended family members, in hospitals, or in group and/or foster homes, prior to placement in the facility. Based on past research in the areas addressed in this study approximately 100-125 client files (one per child) were determined necessary for this study.

All participant records include a narrative and an historical statement (which contains information regarding placement, abuse, re-abuse, and family histories). Also included in these records are diagnostic reports including a initial Multi-Axial Diagnoses. Only those primary Axis I pathologies diagnosed upon intake were utilized for this study in to order avoid possible treatment influences.

The DSM-IV is comprised of five different axes of diagnosis (APA, 1994). Axis I is used for reporting all the various pathologies (with the exception of personality disorders and mental retardation) or conditions which may be a primary focus of treatment. Axis II includes personality disorders which are not generally diagnosed in childhood and will not be addressed in this study. Axis III is used to specify any medical conditions, which may be related to the diagnosed problem. For the purposes of this study the diagnosed pathological disorder from this axis will be noted. Axis IV is used to specify environmental and psychosocial problems, such as physical abuse, poverty,

family conflict and malnutrition. Axis V is an assessment rating that indicates the person's social level of functioning (see DSM-IV, page 32).

All cases reviewed contain diagnoses which were determined utilizing the criteria provided in the DSM-IV. Any files found to have diagnoses which utilized earlier versions of the DSM (i.e. DSM-III-R, etc.) were eliminated from the database to avoid confounds related to differences in diagnostic criteria. While hypothesis-blind data collection would help prevent bias only the researcher collected the data, due to the sensitive nature of these files, (at the request of the Clinical Director and Executive Board of Directors). The collection process yielded 104 client files that met the criteria for this study.

Procedure/Scoring

An information/data sheet was developed for this study based on a preliminary survey of retired client files at the treatment facility. For the purposes of this study the information gathered was 1) date of birth, 2) age, 3) race/ethnicity, 4) reason child was initially removed from biological parents (i.e. type of abuse), 5) age of child upon removal from biological home, 6) who abused in biological parents home (i.e. mother, father, mother's boyfriend, etc.), 7) age upon placement into the treatment facility, 8) total number of out-of-home placement's, 9) type of

placements, 10) reason(s) for removal from each placement (i.e. abuse or child's behavior), 11) if re-abuse occurred in placement, who the abuser was (foster mother, familial member, etc.), 12) multi-axial diagnosis, 13) externalizing or internalizing behaviors(i.e., aggression toward others, suicidal ideation, etc.) displayed by the child prior to intake, which were in placement history, but not included on multi-axial diagnosis (see Appendix A). It is important to note that all of the data gathered was not analyzed for this study. However, they were included to provide a clearer picture of this population and potentially may be utilized for future research investigations.

Client files to be used for this study were requested by the researcher from the above mentioned facility prior to the design of this experiment. A letter was written and then submitted to the Clinical Director of the facility and then to the Executive Board of Directors. Again, due to the sensitive nature of these client files, only retired files were evaluated. Pertinent information was recorded in accordance with the items specified on the initial data sheet (see Appendix A). Initial intake multi-axial diagnoses was utilized for all information sheets to maintain consistency of data collection. A separate data sheet was used for each individual case file.

This study is exploratory in nature, in that little research of this type has been done in the past. This being

the case, knowing the specific type of pathologies to be examined was impossible until the data was gathered and examined. The majority of the disorders to be addressed for this study were ascertained based on a brief pilot exploration of 30 sample cases and were found to be behaviorally, mood or anxiety related (e.g., Oppositional Defiant Disorder, Dysthymia, Attention Deficit Hyperactivity Disorder and Intermittent Explosive Disorder). This preliminary information gathering was felt necessary to provide information for the research design and investigating relevant literature.

All cases reviewed contain diagnoses which were determined utilizing the criteria provided in the DSM-IV. Any files found to have diagnoses which utilized earlier versions of the DSM (i.e. DSM-III-R, etc.) were eliminated from the database to avoid confounds related to differences in diagnostic criteria.

Due to the categorical nature of the data, information regarding each independent variable was placed in categories. Dummy values were assigned; these values are reported in parenthesis. First, type of abuse initially inflicted was indicated as neglect(1), physical(2), sexual(3), some combination with sexual abuse(4), and a combination without sexual abuse(5) in order to capture all of the diverse abuse histories.

The next variable was number of out-of-home placements. This independent variable had three categories: The categories are those with 0-1 out-of-home placements(1), 2-4 out-of-home-placements(2), and 5-9+ out-of-home placements(3).

The third independent variable was children who were re-abused once removed from the biological parents home. This dichotomous variable (yes=1, no=0) was created in order to isolate the population of children who were re-abused and investigate differences. As mentioned earlier, the issue of re-abuse is difficult to absolutely determine due to under reporting. For this thesis, only those with substantiated reports of re-abuse were placed in the "yes" category.

The next two independent variables pertained only to the sub-set of this population that were re-abused (N=48): the type of re-abuse that occurred and who the abuser was, regarding the type of abuse. The same categories used to clarify initial abuse were also used for this variable. The type of re-abuse sustained (e.g., neglect, physical, etc.) was dummy coded the same way as the initial abuse. The last independent variable is who the re-abuser was, either a familial member(1), a nonfamilial caregiver(2) or a combination of both(3). Many cases in which re-abuse occurred were re-abused by different caregiver types in different placements.

The dependent variable for the set of analyses was the pathology diagnosed upon initial intake into the treatment facility. This diagnosis was taken from the Axis I diagnosis given closest to the child's intake date in order to attempt to control current treatment as a confound. From the number of individual diagnoses provided by this data, five categories of pathologies have been developed. The first is ADHD(1). The next are Anxiety Disorders (2) (i.e., PTSD) and Mood Disorders(3) (i.e., Dysthymia). The last two categories are that of Behavior Disorders(4) (i.e., Conduct Disorder) and Adjustment Disorders(5).

Design/Analysis

In this study, five separate Pearson's chi-square analyses were conducted to test the five hypotheses. The first chi-square tested the relationship between type of initial abuse and pathology diagnosed at intake into treatment. The second analysis tested the relationship between number of out-of-home placements and pathology developed. Third, an analysis of the relationship between those re-abused out-of-home and those not re-abused with Axis I diagnosed pathology were analyzed.

The last two Pearson Chi-square's were designed to look specifically at the sub-set of children who were re-bused (N=48). The first of these two investigated the relationship between type of re-abuse in out-of-home placement and primary Axis I pathology diagnosed. The second investigated

who the re-abuser was in the out-of-home placement (i.e. familial, other or both) and pathology development.

The data gathered for this research project was analyzed using SPSS for Windows Statistical Software (version 9.0). A significance level of $p < .05$ was adopted to determine statistical significance of the results found. Tables will be presented for significant findings.

RESULTS

There is a overall significant difference between type of initial abuse (i.e., physical, sexual, neglect, a combination with sexual abuse and a combination without sexual abuse) and type of primary Axis I diagnosis, $\chi^2(12, N=104)=23.216, p < .05$. The highest frequency of initial type of abuse found was the category comprised of a combination of types including sexual abuse(37%). The primary diagnoses most seen for this group($n=52$) were Anxiety Disorders(27%), ADHD(21%) and Behavior Disorders (21%). The next highest abuse category was a combination of neglect and physical abuse($n=30$). ADHD(33%) and Anxiety Disorders(33%) were the most frequently diagnosed primary Axis I disorders in this combination abuse category(see Table 1).

Table 1.

Percentages of Specific Primary Axis I Disorder Diagnosed
Related to Type of Initial Abuse Experienced

	ADHD	Anxiety	Mood	Behavior	Adjustment	Total N
Ne	23%(5)	18%(4)	41%(9)	18%(4)	0%(0)	1%(22)
Ph	20%(2)	30%(3)	20%(2)	30%(3)	0%(0)	7%(10)
Ne+Ph	33%(10)	33%(10)	3%(1)	20%(6)	10%(3)	21%(30)
Ne+Ph +S	21%(11)	27%(14)	4%(2)	21%(11)	8%(4)	37%(52)
Total N	27%(28)	30%(31)	13%(14)	23%(24)	7%(7)	100%(104)

Note. Ne= Neglect Abuse; Ph= Physical Abuse; S= Sexual Abuse. Frequencies are reported in parentheses.

There were also significant differences between numbers of out-of-home placements and primary Axis I diagnoses, $\chi^2(12, N=104)=21.40, p<.05$. The highest occurrence of placements for the total population ($N=104$) was in the 2-4 placements category ($n=62$). Within this category ADHD(32%) was the highest primary Axis I disorder diagnosed, followed by Anxiety(19%) and Mood Disorders(19%). The 5-9 placements category ($n=32$) was found to occur in 31% of the overall

population. In this 5-9+ category Anxiety Disorders(38%) were found to have the highest prevalence of 31%, followed by Behavior Disorders(31%) and ADHD(22%) (see Table 2).

Table 2.

Percentages of Specific Primary Axis I Disorder Diagnosed Related to Number of Out-of-Home Placements Experienced

	ADHD	Anxiety	Mood	Behavior	Adjustment	Total N
0-1	10%(1)	30%(3)	0%(0)	40%(4)	20%(2)	10%(10)
2-4	32%(20)	26%(16)	19%(12)	16%(10)	6%(4)	60%(62)
5-9+	22%(7)	38%(12)	6%(2)	31%(10)	3%(1)	31%(32)
Total N	27%(28)	30%(31)	13%(14)	23%(24)	7%(7)	100%(104)

Note. Frequencies are reported in parentheses.

There was not a significant difference found between those not re-abused(n=56) and re-abused(n=48) with regard to primary Axis I diagnosis found. The most frequently diagnosed disorder in the re-abused group was ADHD(35%) and Anxiety Disorders(32%) in the not re-abused group. The second most frequent diagnosis for those in the not re-abused group(n=56) were Behavior Disorders(23%) and for

those is the re-abused group ($n=48$) were Anxiety Disorders (27%).

Similarly, no significance difference was found between type of abuse experienced among those children re-abused ($N=48$) and type of primary Axis I pathology diagnosed. Although not significant, some findings were notable. For example, within this re-abused population ($N=48$) a combination of types of abuse with sexual abuse ($n=16$) was the most commonly reported category (33%). Furthermore, within this category of children who suffered a combination of abuse including sexual abuse, Mood Disorders (66.7%) were the most frequently diagnosed primary Axis I diagnosis.

Also, ADHD ($n=17$) was the most frequently found primary Axis I diagnosis (35.4%) within the overall population of re-abused children ($N=48$). ADHD (45%) is also the most frequently diagnosed primary Axis I disorder within the physical abuse only category ($n=11$). The second highest overall primary Axis I diagnosis was Anxiety Disorders (27.1%) for those children who were re-abused. Within those diagnosed with Anxiety Disorders ($n=13$), those in the combination of types of abuse with sexual abuse were most prevalent (38.3%) for this population.

Last, no significant difference was found in the population of those re-abused regarding who committed the re-abuse (familial, other or both) and primary Axis I diagnosis. However, 58% ($n=28$) of the re-abuse occurred at

the hand of a familial caretaker only. This was followed by 31% ($n=15$) experiencing re-abuse from non-familial caretakers and lastly a 10% ($n=5$) at the hands of a combination of both (familial and other). In total, this accounted for over 69% ($n=33$) of the sample being re-abused at the hands of familial members at some point in their placement histories.

Along with the above analytical findings, several important demographic trends were observed in the sample gathered. The first was the potential impact of substance abuse on this population of children. From the 104 children's files reviewed for this study, 38% were confirmed in utero drug exposed, while another 33% were suspected cases. In addition, 74% ($n=77$) of mothers were reported to be substance abusers, with an additional 5% ($n=5$) having a diagnosed Axis II diagnosis (e.g., Schizophrenia) along with documented substance abuse. Also, 6% of the mothers were diagnosed with a Axis II pathology without substance abuse. One child was adopted at birth from another country and birth parent information was unknown.

The second notable trend was age of initial removal (from the biological parents) patterns for this population. Thirty-eight percent ($n=39$) of the children were reported initially removed from the biological parents after the age of 1 and before the age of 3, with an additional 8% ($n=8$) being removed at birth or before 1 year of age. These

demographic issues will be addressed more fully in the discussion section of this paper.

DISCUSSION

The results in this study offer support for two of the five hypotheses. Although causality cannot be inferred by the significant differences found between initial types of abuse and primary Axis I diagnoses, these findings are both logical and consistent with the literature. As mentioned in the results section, "a combination of abuse with sexual abuse" was most common in those children with Anxiety Disorders, ADHD and other Behavioral Disorder respectively. Anger is a common theme in all three of these disorders. It is important to note that anxiety in young children can often be manifested by negative behaviors rather than just internalizing behaviors. These findings are consistent with the research which addresses factors leading to re-abuse in those parents who have received treatment for abusing their children (Ferleger, et al., 1988). Generally, children who display negative externalizing characteristics are more likely to be the victims of physical re-abuse (Oates, 1996). Significant differences were also found between numbers of placements and primary Axis I diagnoses. When reviewing this data, children with two or more placements were more likely to be diagnosed with ADHD and Anxiety disorders. Those children with ADHD may be more difficult to handle and thus, are probably more likely to experience more

placements. Also, those children with multiple placements may develop anxiety due to the many changes in living situations. In the sub-set of the population which experienced 5 or more placements, Anxiety Disorders were most frequently found. Again, it is difficult to imply causality, however, a high number of placements may bring about higher levels of instability and thus anxiety.

Although no significant difference was found among re-abusers (i.e., familial, other or both) and primary Axis I diagnoses, it was noted that a high percentage (68%) were familial members. These findings are disturbing in light of The Adoption Assistance and Child Welfare Act (Rittner, 1995) discussed earlier. The Act advocates for family placements, but familial placements may perpetuate potential harm due to similar learned parenting styles. This may not be the case for all familial placements, but assessment of harm risk needs to be addressed.

Some related demographic findings were also noted in the Results section. The high number of substance abusing parents and in utero drug exposure are the first two. When addressing this in relation to intervention and prevention programs several factors seem important to note. What can be done to help these families who are abusing children due to substance abuse at some level? Could some type of early screening and intervention program be instituted which includes an "in home" component; a component which may

include a treatment team to address the substance abuse along with the parenting issues? This may be especially useful in those families where neglect was the primary form of abuse, as was the case in the four-year-old who was killed by the unlicensed foster mother, previously discussed.

The age of initial removal is also a concern when considering implications for attachment. Many of these children are removed and then experience multiple placements well before their third birthday. These disruptions would make future attachment to a primary caregiver tenuous at best, according to Bowlby (1981) and Ainsworth (1982). This inability to attach may be another factor leading to later developed pathologies in this population of children. This disruption of attachment, if there was any attachment to begin with, may have long lasting effects. Bowlby (1981) noted that secure attachment is the basis by which we develop all of our life relationships, these children then, are at considerable risk for negative social courses.

Training of foster parents (or lack thereof) also came to light when looking at the number of re-abuse cases which occurred outside of a familial setting. Again, there was a high instance of re-abuse in children with ADHD and Behavior Disorders, which may lead to more difficult parenting of the child and possible abuse. By increasing understanding of these disorders, risk of re-abuse in a foster home may be

decreased. If, for example, a child with ADHD is more likely to be re-abused, an assessment of a foster parent's knowledge of this disorder and what it entails could be useful. Specialized training and certification to care for these children may be necessary. This may potentially reduce the number of placements and therefore possibly reduce the incidences of re-abuse.

Limitations

The issue of control was a serious concern in this study. Steps were taken to reduce confounds by limiting the population investigated, limiting the age range investigated and by maintaining consistency in diagnostic criteria utilized (i.e., only DSM-IV diagnoses were considered). This issue of control could be greatly reduced if a similar study were conducted longitudinally with live subjects. Limitations, which may occur in the use of archival data, are also an issue. Using this data base made the information gathered second or third hand which may have distorted or caused omissions in some of the historical placement reports. Lastly, the small number of subjects was of concern. With further data collection this could be remedied. It is also likely that the inclusion of females to the data base would be useful.

Implications

When researching the area of childhood pathology development, as mentioned prior in the introduction, it is

important to develop a full body of literature relating to all areas of pathology and at all developmental stages.

Similarly, middle childhood in abused populations is an area of development which deserves future research interest. This is due to the potential negative impact of poor social skills acquired at this stage by this population on later relationships. This is also true for the impact of re-abuse on this population of children (Adams, et al., 1994; Cichetti, et al., 1995; Curry, 1995). This information could further aid in the development of future prevention and intervention programs. Along with this issue, it may bring to light aspects of current methods of child abuse prevention and intervention which need to be reformed.

Also, this particular population of children, those in treatment facilities, are a virtually untapped resource of information. This resource can potentially further aid researchers in establishing more sophisticated understanding of pathology development in children. Better understanding of these developments would lend support to programs which promote intervention and early prevention for those families considered "at risk" for abuse and thus developed pathologies.

APPENDIX A

Initial Data Sheet

- 1) DOB: ___-___-___ 2) Age: _____
- 3) Race: ___ African American ___ Asian ___ Native American
 ___ Latino ___ Caucasian ___ Other _____
- 4) Reason for Removal from bio parents home: _____
- 5) Age of child when initially removed from home: _____
- 6) Who abused in bio-parents: _____
- 7) Age upon intake (or DOP): _____
- 8) Placement History (# of out-of-bio-home placements): _____
- 9) Type of Placements: _____
- _____
- _____

10) Reason for Removal from out-of-home placement (a1= placement #1, etc. for each placement:

Abuse:	Child's Behavior
a1)	b1)
a2)	b2)
a3)	b3)
a4)	b4)

11) Who abused in placement(s)/ if abuse occurred:

- a1) _____
- a2) _____
- a3) _____
- a4) _____

PATHOLOGIES DIAGNOSED: Date Of Diagnosis: _____

- 12) AXIS I _____ AXIS II _____ AXIS III _____ AXIS IV _____ AXIS V _____
- _____
- _____

13) Behaviors:

- 1) Externalizing: _____
- _____
- 2) Internalizing: _____
- _____

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