January 1999

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CHAPTER 8

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DESCRIPTION OF THE PROBLEM

EVEN THOUGH acts of child abuse have been committed throughout history (Zigler & Hall, 1989), widespread concern over child abuse as a significant social problem began as recently as the 1960s. Maltreated children have been an increasing focus of protection efforts, which may be due to frequent and intense attention from the media, general public, legislators, and health, mental health, and social service professionals (Hansen, Conaway, & Christopher, 1990). Increased attention to child maltreatment is evident in the research literature, which has grown rapidly since the 1970s. Much of the initial focus was on identification and remediation of deficits in parental functioning, whereas current emphases seem to be on identification of the correlates and consequences of maltreatment (Hansen & MacMillan, 1990; Warner-Rogers, Hansen, & Hecht, 1999; Wolfe, 1988; Wolfe & McEachran, 1997).

Several excellent reviews have provided detailed summaries of the more established assessment procedures specifically for use with physically abusive parents and their children, including newly developed measures (e.g., Hansen & MacMillan, 1990; Lutzker, Van Hasselt, Bigelow, Greene, & Kessler, 1998; Milner, 1991; Wolfe & McEachran, 1997). The present chapter supplements the previous literature by providing additional evaluation of current procedures and issues, as well as further discussion of practical issues, legal and system considerations, and a case illustration. The chapter provides information relevant for identifying and preventing additional maltreatment, selecting and formulating treatment goals, and monitoring treatment effectiveness.

Prior to discussing specific assessment techniques, a brief description of the problem of physical abuse is needed.

DEFINITIONS

Operational, practical definitions of physical abuse have been difficult to develop because of problems in specifying what is excessive discipline or inappropriate treatment of children. Physical

abuse has commonly been defined as an act of commission by the parent and is characterized by presence of nonaccidental injury and infliction of overt physical violence (e.g., Kelly, 1983; National Center on Child Abuse and Neglect [NCCAN], 1988; Wolfe, 1988). Physical abuse usually occurs in discrete, lowfrequency episodes and is often accompanied by frustration and anger toward the child (Kelly, 1983). Physical abuse may include beating, squeezing, burning, lacerating, suffocating, binding, poisoning, exposing to excessive heat or cold, sensory overload (e.g., excessive light, sound, stench, aversive taste), and prevention of sleep. Although evidence of physical injury of the child has been a critical factor in identifying abusive behavior, especially for legal purposes, increasing emphasis is being placed on the circumstances and nature of the act, as opposed to the consequences on the child (Wolfe, 1988). There is not a clear distinction between acceptable forms of physical punishment and abuse.

Definitions of abuse in state statutes vary significantly in terms of specificity (Besharov, 1990; Kalichman, 1993), and information on state laws and procedures are available from local child protective services offices. Often the legal definitions are too vague to have applied research implications, but are sufficiently general to help prevent cases from slipping through the legal system on technicalities.

ETIOLOGY OF ABUSE

A brief discussion of potential causes of physical abuse is important for understanding the maltreating environment and the rationale for the various assessment procedures (for further information, see Ammerman, 1990; Wolfe, 1987; Wolfe & McEachran, 1997). The value of valid and objective assessment techniques stems from their ability to screen at-risk parents, identify suspected child abusers, and evaluate child abuse intervention and prevention efforts. Because a reliable diagnostic profile of the abusive parent has yet to be empirically validated beyond those that include concerns related to parenting role and stressful family circumstances, and the wide range of characteristics observed in abusive families, singular perspectives of etiology are discouraged. It is recommended that greater attention be placed on the bases of parenting and parent-child relationships and the environmental conditions that lead to extreme responses along a continuum of parenting experiences (Kolko, 1996).

Early conceptualizations proposed that child abuse results from severe parental psychopathology (Spinetta & Rigler, 1972). It is estimated, however, that few abusive parents are diagnosed with a psychiatric condition or exhibit significant psychopathology (Ammerman, 1990; Kelly, 1983). Etiological models have now emerged that attempt to integrate findings on the many variables correlated with abuse (Ammerman, 1990; Lutzker et al., 1998). Belsky (1980) proposed an ecological model of maltreatment with four levels of influence that bring about maltreatment: ontogenetic (personal characteristics), microsystem (family characteristics), ecosystem (community and social forces), and macrosystem (cultural determinants). Similarly, the transitional model proposed by Wolfe (1987) emphasized the importance of multiple causes and destabilizing and compensatory factors in physical abuse. There are three stages in the transition from milder to more harmful interactions: (1) reduced tolerance for stress and disinhibition of aggression, (2) poor management of acute crises and provocation, and (3) habitual patterns of arousal and aggression with family members.

The work of Cicchetti and colleagues builds on these models by focusing on the transactions among risk factors for the occurrence of maltreatment (Cicchetti & Lynch, 1993; Cicchetti &

Rizley, 1981). Under this model, risk factors are divided into two broad categories: potentiating and compensatory factors. Potentiating factors increase the probability *of* maltreatment and compensatory factors mitigate against the risk *of* maltreatment. Within these two broad categories, both short (Le., transient) and long-term (i.e., enduring) factors may be identified. Enduring vulnerability factors include relatively long-lasting factors, conditions, or attributes that serve to increase maltreatment risk (Cicchetti & Lynch, 1993). These include parental, child, or environmental characteristics. Such vulnerability factors may be biological, historical, psychological, and sociological. Short-term vulnerability factors include current life stressors or conditions such as loss *of* a job, loss *of* a loved one, physical injury or illness, legal difficulties, marital and family problems, and the child's reaching a new developmental stage. Enduring protective factors comprise stable conditions that protect against maltreatment risk (e.g., parent's history *of* good parenting, positive relationship between parent figures). Transient buffers (i.e., short-term protective factors) that may decrease maltreatment risk include sudden improvement in financial or living conditions, periods *of* marital harmony, and a child's successful resolution *of* a difficult developmental period.

In general, a behavioral, social-learning perspective, consistent with the ecological (Belsky, 1980), transitional (Wolfe, 1987, 1988), and developmental-transactional (Cicchetti & Lynch, 1993; Cicchetti & Rizley, 1981) models *of* physical abuse, is adopted for this chapter. Child abuse may be seen as the result *of* complex maladaptive interactions and/or lack *of* essential caretaking behaviors that are influenced by parental skill or knowledge deficits and other stress factors (Hansen et al., 1990; Hansen, Warner-Rogers, & Hecht, 1998; Kelly, 1983). Maltreatment may be related to the limited ability *of* parents to control their child's, as well as their own, behavior. Parental skill deficits may be found in areas such as child management and parent-child interaction, anger and stress control for child and non-child-related stressors, or problem solving for familial or other stressors. Maltreating parents may also have unrealistic expectations and distorted judgments *of* child behavior. In addition, a lack *of* motivation may interfere with adequate parenting behavior (e.g., due to personal values, cultural standards). Abuse is not usually the result *of* a specific event or single parent or child characteristic (Warner-Rogers et at, 1999; Wolfe & McEachran, 1997), but rather the product *of* multiple risk factors that interact or "potentiate" one another in the absence *of* protective factors or buffers (Cicchetti & Lynch, 1993; Cicchetti & Rizley, 1981; Wolfe & McEachran, 1997).

EPIDEMIOLOGY

The Third National Incidence Study *of* Child Abuse and Neglect (NIS-3) was recently completed by the National Center on Child Abuse and Neglect (NCCAN, 1996). The NIS3 surveyed a wide range *of* community professionals and agencies in a national probability sample *of* 42 counties. Abuse was defined according to two standards: (1) the Harm Standard, in which children were considered maltreated if they had already experienced harm (e.g., physical injury); and (2) the Endangerment Standard, a more inclusive standard in which children were considered maltreated if they experienced abuse that put them at risk *of* harm or if they had already experienced harm. Under the Harm Standard, 5.7 children per *1,000 (for* an estimated 381,700 children nationwide) experienced physical abuse in the United States in 1993. 'Under the less stringent Endangerment Standard, 9.1 children per *1,000 (for* an estimated 614,100 children nationwide) experienced

physical abuse. In 1993, an estimated 1,500 children died from maltreatment (NCCAN, 1996). The results likely underestimate the extent of the problem because they include only cases known to relevant agencies.

As child maltreatment definitions have evolved and changes in the identification and handling of cases taken place, estimates of the number of children physically abused in the United States have increased greatly over the past several years. According to the NIS-3 (NCCAN, 1996), from 1986 to 1993 the incident rate of physical abuse rose by 33% (from 4.3 to 5.7 per 1,000), while the total number of identified physically abused children increased by 42% (from 269,700 to 381,700). It is unclear whether the figures reflect an actual increase in incidence or an increase in reporting due to growing public awareness, or both.

Several demographic correlates of physical abuse were identified in the NIS-3 (NCCAN, 1996), including the following: boys showed a 24% higher risk for serious injury than girls; boys had higher incidence of fatal injuries than girls; disproportionate increases in the incidence of maltreatment among children under age 12 were seen, with children ages 6-8 having the highest incidence of physical abuse and the highest rate of moderate injuries from abuse and neglect; younger children (ages 0-2) had the lowest incidence rate of abuse; single-parent households, especially father-only households, appear to be at greater risk for physical abuse than dual-parent households; families with four or more children had marginally higher incidence rates of maltreatment in general; children from low-income families (less than $15,000 per year) are significantly more likely to be physically abused; and the majority of cases (72%) involved the natural parents as perpetrators of physical abuse, and the next largest group (21 %) consisted of other parents or parent substitutes (e.g., parent's boyfriend). No racial differences in maltreatment incidence were reported in the NIS-3. Other research has indicated that fathers are more likely to be reported for physical abuse, whereas mothers are more likely to be reported for neglect; that abusive parents are often younger than the average parent at the birth of their first child, with many being teenagers; and that parents with intellectual disabilities are at increased risk for being physically abusive (Ammerman, 1990; Lutzker, 1998; Walker, Bonner, & Kaufman, 1988; Wolfe, 1988). Although beyond the scope of this chapter, overlap exists among the forms of maltreatment within individual families, such that neglect, psychological maltreatment, and/or sexual abuse of children often are present in physically abusive families (Garbarino, Guttmann, & Seeley, 1986; Hansen et al., 1998).

CONSEQUENCES

Child physical abuse warrants clinical and empirical attention because of the risks to children's immediate safety and long-term developmental course and psychological adjustment. Several research studies have examined the characteristics of abused children. The literature often confuses correlates of maltreatment status with consequences of maltreatment (i.e., causation is inferred from correlational findings) (Conaway & Hansen, 1989; Malinosky-Rummell & Hansen, 1993). Little can be said confidently about the consequences of maltreatment; however, several correlates have been identified. Maltreated children have been found to evidence greater perceptual-motor deficits; lower scores on measures of general intellectual functioning; lower scores on academic achievement tests; insecure attachments; internalizing psychological problems, such as feelings of hopelessness, depression, and low self-esteem; and negative social behavior, such as more aggres-

sion with adults and peers (Ammerman, Cassisi, Hersen, & Van Hasselt, 1986; Conaway & Hansen, 1989; Fantuzzo, 1990; Kolko, 1996; Malinosky-Rummell & Hansen, 1993). Long-term correlates of a history of maltreatment include familial and nonfamilial violence, including abuse of their own children; conduct problems and criminal behaviors; substance abuse; self-injurious and suicidal behavior; emotional problems; and interpersonal problems (Kolko, 1996; Malinosky-Rummell & Hansen, 1993).

ASSESSMENT APPROACHES

There are unique aspects to the assessment of maltreating families, including that participation in services may be involuntary or under duress; the target behavior of abuse cannot be readily observed; and abusive families are a heterogeneous group of multiproblem families (Lundquist & Hansen, 1998; Lutzker et al., 1998; Wolfe, 1988). Assessment may include collecting information to validate the occurrence of maltreatment (e.g., *for* the judicial system), but is usually done to identify target areas *for* intervention and monitor progress throughout treatment. As child abuse is a multidetermined phenomenon, assessment of abusive situations and families should parallel such a perspective and occur across multiple domains. A scientist-practitioner approach to assessment and intervention is always important, but the empirical selection and evaluation of treatment procedures is especially beneficial when under the scrutiny of the court and child protective services.

A functional analytic perspective is helpful *for* conducting a complete, treatment-relevant assessment (Hansen et al., 1998; Hansen & MacMillan, 1990). Potential antecedents of maltreatment include child misbehavior, developmental problems, conflict between parents, unrealistic expectations or lack of knowledge regarding child development and behavior, substance abuse, and other stressors or interaction problems. There may be many positive consequences *for* abusive behavior. Maltreating behavior may remove an aversive event, such as noncompliance and tantruming. It may bring praise or approval to the maltreating parent *from* others who perceive the actions as appropriate child-rearing practices. Absence of negative consequences may also contribute to continued maltreatment.

The following sections discuss some of the most commonly used or promising measures *for* the assessment of target behaviors related to the occurrence of maltreatment and improved family functioning. Because of the extensive number of relevant measures, most are presented briefly. Unless otherwise noted, measures discussed have psychometric properties that support their use. Other reviews of the assessment of maltreating parents and their children (e.g., Hansen & MacMillan, 1990; Lutzker et al., 1998; Milner & Chilamkurti, 1991; Walker et al., 1988; Wolfe, 1988; Wolfe & McEachran, 1997) or more general assessment resources (e.g., Bellack & Hersen, 1998; Mash & Terdal, 1997) may be useful because of the wide variety of problems that occur in maltreating families.

HISTORY AND RISK OF ABUSE

Interviewing is an essential procedure *for* identifying circumstances associated with maltreatment and assessing risk. Interviews with a variety of individuals may be needed, including parents, children, and caseworkers. Wolfe and McEachran (1997) present a helpful Parent Interview and

Assessment Guide, which addresses identification of general problem areas and assessment of parental responses to child-rearing demands. Ammerman, Hersen, and Van Hasselt (1988) developed the Child Abuse and Neglect Interview Schedule, an extensive semistructured interview, to assess presence of maltreatment behaviors (e.g., corporal punishment, physically abusive behavior) and factors related to abuse and neglect (e.g., history of maltreatment). The whole interview is lengthy (approximately 45 minutes); however, a portion can be used to obtain information related to detection of abuse.

A widely researched measure for detection of at-risk status is Milner's (1986) Child Abuse Potential Inventory (CAP Inventory). The Abuse Potential Scale can be divided into six factor scales: Distress, Rigidity, Unhappiness, Problems with Child and Self, Problems with Family, and Problems from Others. Distortion indexes of Fake-Good, Fake-Bad, and Random Responding are derived from the validity scales of Lie, Random Response, and Inconsistency. Two special scales, the Ego-Strength scale (Milner, 1988, 1990) and the Loneliness scale (Mazzuacco, Gordon, & Milner, 1989; Milner, 1990) have been developed from existing CAP Inventory items (Milner, 1991). The measure has substantial promise for screening, but it should not be used in isolation as a predictor of abuse because of the possibility of misclassification (Hansen & MacMillan, 1990; Kaufman & Walker, 1986).

Excellent resources are available for professionals who are seeking practical guidance in identifying and reporting child abuse (Lutzker, 1998; Milner, 1991; Wolfe & McEachran, 1997). Kalichman (1993) and Besharov (1990) have published books that can serve as practical guides to help professionals recognize and respond to suspicions of child maltreatment. The books examine important topics, including the child protection and legal systems, the various forms of maltreatment, signs or symptoms that may indicate maltreatment, and the reporting process.

PSYCHOPATHOLOGY AND SUBSTANCE ABUSE

In addition to clinical interviewing, other commonly used measures may be useful for screening for the presence of psychopathology and alcohol or drug abuse, as well as assessing their role in maltreatment and other family dysfunction. Because clients may not report honestly about substance use, it may also be helpful to get collateral information from caseworkers or family members.

The Symptom-Checklist-90-Revised (Derogatis, 1994) is a 90-item questionnaire that assesses self-report of a variety of problems. It has nine primary symptom scales (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, Psychoticism) and three global indices of stress (Global Severity, Positive Symptom Distress, Positive Symptom Total).

The Minnesota Multiphasic Personality Inventory-2 (MMPI-2) (J3utcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989; Butcher & Williams, 1992) may also be helpful. This update of the widely used MMPI has continued its predecessor's popularity with clinicians and the courts. The validity scales include Lie *(L),* Infrequency *(F),* and Correction *(K),* and the three new validity scales of Back Page Infrequency *(Fb),* which is for items in the latter part of the measure, Variable Response Inconsistency *(VRIN),* and True Response Inconsistency *(TRIN).* The basic clinical scales, essentially the same as the original MMPI, except for some new items, are Hypochondriasis *(Hs),* Depression *(D),* Conversion Hysteria *(Hy),* Psychopathic Deviate *(Pd),* Masculinity-

Femininity *(MF),* Paranoia *(Pa),* Psychasthenia *(Pt),* Schizophrenia *(Sc),* Hypomania *(Ma),* and Social Introversion *(Si).* Several of the available supplementary scales may also be useful, such as Anxiety, Repression, Ego Strength, MacAndrew Alcoholism Scale-Revised, Overcontrolled Hostility, Dominance, and Social Responsibility. The Content scales that seem particularly promising with maltreating parents include Anxiety, Fears, Obsessiveness, Depression, Health Concerns, Bizarre Mentation, Anger, Cynicism, Antisocial Practices, Low Self-Esteem, Social Discomfort, Family Problems, Work Interference, and Negative Treatment Indicators. As with the original MMPI, analysis of critical items and Harris-Lingoes Subscales may also prove important. The first 370 items must be administered for the basic scales, and all 567 items must be administered for the additional scales. An eighth-grade reading level is required to comprehend the content of all MMPI-2 items (Butcher et al., 1989).

More specific measures for screening for alcohol and drug abuse may also be necessary, and several instruments are available (Allen & Columbus, 1995; National Institute on Drug Abuse, 1994). Useful screening instruments for parents include the short version of the Michigan Alcohol Screening Test (SMAST; Selzer, Moskourtz, Schwartzman, & Ledingham, 1991) and the Drug Abuse Screening Test (DAST; Skinner, 1982).

KNOWLEDGE AND EXPECTATIONS REGARDING CHILD DEVELOPMENT AND BEHAVIOR

Parental knowledge and expectations about child development and behavior are particularly difficult areas of assessment because normative levels and timing of developmental milestones are so varied. The Parent Opinion Questionnaire (POQ; Azar & Rohrbeck, 1986) is an 80-item questionnaire that requires subjects to rate appropriateness of expecting a variety of child behaviors. In addition to the total score, six subscales are scored: Self-Care, Family Responsibility and Care of Siblings, Help and Affection to Parents, Leaving Children Alone, Proper Behavior and Feelings, and Punishment.

The Adult-Adolescent Parent Inventory (AAPI; Bavolek, 1984, 1989) is a 32-item self-report measure that assesses attitudes of adult and adolescent parents in four areas of parenting: (1) parental expectations of children, (2) empathetic awareness of children's needs, (3) belief in corporal punishment, and (4) view of parent-child roles. The content of the AAPI is specific to parenting expectations and attitudes toward child rearing and is particularly useful when these constructs are the target of intervention (Bavolek, 1984, 1989). Holden and Edwards (1989) provide a detailed review and discussion of approximately 100 measures of parental attitudes toward child rearing, although these measures have not been specifically developed or evaluated for use with abusive parents.

The Family Beliefs Inventory (Roehling & Robin, 1986) is a useful measure of adherence to unreasonable beliefs in parent-adolescent conflict. For parents, the beliefs measured are ruination, perfectionism, approval, obedience, self-blame, and malicious intent. For adolescents, the beliefs are ruination, unfairness, autonomy, and approval. Agreement with these beliefs is assessed for 10 vignettes of conflict.

CHILD MANAGEMENT AND PARENT-CHILD INTERACTION SKILLS

A variety of assessment approaches may be utilized for child management and parent-child interaction skills. Parent-report measures of child behavior problems are commonly used in clinical settings. Two of the most common and useful are the Child Behavior Checklist (CBCL; Achenbach, 1991) and the Eyberg Child Behavior Inventory (ECBI; Eyberg, 1992; Eyberg & Ross, 1978). The CBCL consists primarily of ratings of 118 items describing specific behavior problems. In addition, several questions are included to evaluate the child's social strengths. Behavior Problem scales of the CBCL vary according to the age and sex of the child, but may include Schizoid or Anxious, Depressed, Uncommunicative, Obsessive-Compulsive, Somatic Complaints, Social Withdrawal, Ineffective, Aggressive, and Delinquent. Social Competence scales include Activities, Social, and School.

The ECBI (Eyberg, 1992; Eyberg & Ross, 1978) is brief and can be readily used as a repeated measure for monitoring changes in child behavior. Thirty-six behavior problems are rated on a 7-point scale for frequency (or "intensity"). Parents are also asked to indicate which behaviors they consider a problem. Example behaviors include refusal to do chores when asked, temper tantrums, hitting parents, short attention span, and verbally or physically fighting with siblings or friends.

A measure developed to assess parental knowledge about child management is the Knowledge of Behavioral Principles as Applied to Children (KBPAC; O'Dell, Tarler-Benlolo, & Flynn, 1979). The KBPAC is a 50-item multiple-choice measure. Although it may be useful as a pre/post measure of parent training for some parents, its use is limited because substantial reading skills are apparently needed.

Direct observations of parent-child interactions and parenting behavior are essential for a complete assessment. Videotaping can be an informative, integral part of assessment, especially given the availability and portability of video recording equipment. Several direct observation codes have been developed for assessing the quality and content of parent-child interactions (McMahon & Estes, 1997), such as the Dyadic Parent-Child Interaction Coding System II (DPICS-II; Eyberg, Bessmer, Newcomb, Edwards, & Robinson, 1994; Eyberg, Edwards, Bessmer, & Litwins, 1994), the Interpersonal Process Code (Rusby, Estes, & Dishion, 1991), or the Behavioral Coding System (Forehand & McMahon, 1981). The DPICS-II, for example, has 26 specific behaviors in five categories for comprehensive assessment of parent-child interactions. The five categories and example behaviors are (1) verbalizations (e.g., labeled praise, direct or indirect command, criticism), (2) vocalizations (e.g., laugh, whine), (3) physical behaviors (e.g., physical positive or negative, destructive), (4) responses following commands (e.g., compliance, noncompliance), and (5) responses following commands (e.g., answer, no answer). The behaviors may be coded for both parents and children. The DPICS-II is flexible in that fewer categories can be used for clinical purposes or specific research questions (Eyberg, Bessmer, et al., 1994; Eyberg, Edwards, et al., 1994).

The Behavioral Coding System (Forehand & McMahon, 1981) has fewer categories, and is particularly useful in the context of parent training (McMahon & Estes, 1997). The appropriateness of child behavior is recorded, as well as the parental antecedents (command, warning, question, attend, reward), child responses (compliance, noncompliance), and parental consequences (attend, reward).

Tuteur, Ewigman, Peterson, and Hosokawa (1995) developed two clinic-based observational screening instruments that focus on the qualitative aspects of parent-child interactions. The first instrument, the Maternal Observation Matrix (MOM) takes approximately 10 minutes to complete and can be used in a clinic setting. Mother-child interactions are coded along 11 behavior catego-

ries (description of child, description of child's behavior, request, affect, nonphysical promise, tone, intense head touch, intense body touch, uncharged head touch, uncharged body touch and control) in 20 intervals of 30-second duration.

The Mother-Child Interaction Scale (MCIS; Tuteur et al., 1995) is an observer rated checklist consisting of eight qualitative categories for which each dyad is rated along a 3point scale ranging from *negative* (1) to *positive* (3). These categories include degree of positive or negative parental direction of child, names mother called child, maternal touch, maternal observation of child, maternal expression, manner in which child approached mother, quality of control and manner in which mother physically moved child. Preliminary analyses support the instruments' discriminant utility in correctly classifying abusers and nonabusers. The useful features of the MOM and MCIS measures are that they are cost-effective, may be used by nonclinically trained observers, and may be used as a preliminary screening device after which more intensive instruments, interviews or home visits could be used to perform further assessment of the possibility of risk of abuse (Tuteur et al., 1995).

While behavioral coding approaches possess more objectivity, reliability, and descriptive power, major drawbacks include that they can be time-consuming and training-intensive (King, Rogers, Walters, & Oldershaw, 1994). A "judgment observation approach," in which an observer encodes and interprets information in terms of a given categorization system, may provide greater generalizability to opinions and judgments of others and is less expensive and time-consuming (King et al., 1994). King and colleagues have used the judgment observation approach in establishing preliminary evidence of the reliability and validity of a series of rating scales for assessing abusive maternal behavior. Observers rate videotaped mother-child interactions along the following categories of maternal behavior: approval, intrusiveness, responsiveness, humiliation; negative physical, and cooperation. The instrument does not require resources for full scale direct observation and coding, and may be useful for tailoring interventions to the specific needs of particular mothers (King et al., 1994).

In terms of variables associated with physical child abuse, cognitive and affective factors are an important domain. Recently, a factor that includes both cognitive and affective components, parental empathy, has drawn attention in risk assessment for child abuse. The small amount of research performed to date suggests that physically abusive parents are less able to empathize with their children than their nonabusive counterparts (Rosenstein, 1995). Empathy (both cognitive and affective) has also been found to predict two risk factors of abuse-perceived loss of control and parental depression. Rosenstein found a negative correlation between empathy and stress in the parent-child relationship (Le., higher levels of stress associated with lower levels of empathy) to be predictive of child abuse. Thus, empathy seems to be a potential mediating variable between stress and physical abuse. While this area is in need of further exploration with sound empirical studies (e.g., use of larger sample sizes, detailed examination of constructs, etc.), Rosenstein states that a complete assessment of the risk of child physical abuse must include a measure of parental empathy. Although relatively few standardized, objective measures of empathy exist, the following measures seem to be appropriate: the Mehrabian and Epstein Emotional Empathy Scale (Letourneau, 1981; Mehrabian & Epstein, 1972), which consists of 33 items that measure emotional responsiveness to various situations; and the Parent/Partner Empathy Scale (Feshbach, 1989), a 40-item self-report inventory designed to specifically assess a parent's empathy toward his/her child and his/her spouse or partner. The Parent/Partner Empathy Scale is based on Feshbach's con-

ceptual model of empathy and provides information across the following factors: cognitive, affective, spouse/partner empathy, and empathic distress (Feshbach, 1989). Additionally, one of the four constructs on the AAPI (Bavolek, 1984, 1989) discussed in a previous section relates to parental empathy and has been used in abusive parenting research (e.g., East, Matthews, & Felice, 1994; Rosenstein, 1995).

Situations in which discipline is attempted are high risk for physical abuse and should be an assessment priority (Hansen & MacMillan, 1990). Because directly observing actual discipline is often difficult (Lutzker et al., 1998), an assessment utilizing an adult actor to present deviant child behavior was developed by MacMillan, Olson, and Hansen (1991). The Home Simulation Assessment (HSA) measures parent ability to apply child management skills in realistic problem situations. During the assessment, parents are provided with 10 tasks (e.g., dry the dishes) and asked to "do their best" at prompting the actor to complete the tasks. "Deviant" scripted behaviors are exhibited by the actor in response to each of four types of control or parental discipline efforts: instructions, prediscipline warnings, initiation of timeout, and maintenance of timeout (i.e., efforts to keep the actor in a timeout chair). A high-deviance segment of the HSA can also be utilized to examine anger and stress responses to child behaviors. The high-deviance assessment uses an additional actor and increases the frequency of deviant actor behaviors. Following the 10 tasks, parent ratings of stress, anger, and anxiousness are also collected. The assessment introduces costs of time, equipment, and human resources, but may be especially useful when children are not available to participate in assessment of parent-child interactions.

The quality of stimulation and affection provided within parent-infant interactions may also be a focus of assessment. For example, Dietrich, Starr, and Kaplan (1980) coded tactile, auditory, vestibular, and visual stimulation provided by abusive parents. In a maltreatment prevention project, Lutzker, Lutzker, Braunling-McMorrow, and Eddleman (1987) assessed and trained several parent-infant affection behaviors, including smiling, affectionate words, eye-to-face behavior, affectionate physical, passive physical, leveling (i.e., putting parent on same plane as infant), speech, guided play, and vocalizations.

STRESS AND ANGER CONTROL

General measures of stress may be helpful in examining recent stressful experiences of maltreating families. Such measures include the Life Experiences Survey (Sarason, Johnson, & Siegel, 1978), which assesses occurrence and impact of major life events, and the Hassles Scale (Kanner, Coyne, Schaefer, & Lazarus, 1981), which assesses occurrence and impact of minor, commonly occurring stressors.

The Parenting Stress Index (Abidin, 1995) was developed specifically for assessing dysfunctional parent-child relationships and stress associated with parenting. The Child Domain scales (based on 47 items) are Adaptability, Acceptability, Demandingness, Mood, Distractibility/Hyperactivity, and Reinforces Parent. The Parent Domain scales (based on 54 items) are Parent Health, Depression, Attachment, Restrictions of Role, Sense of Competence, Social Isolation, and Relationship with Spouse. Life Stress is an optional 19item scale. A 36-item short form of the PSI (Abidin, 1995) has subscales of Total Stress, Parental Distress, Parent-Child Dysfunctional Interaction, Difficult Child.

Anger specifically related to child behavior should be an assessment priority with abusive parents. The Parental Anger Inventory (PAI; Hansen & Sedlar, 1998; MacMillan, Olson & Hansen, 1988) was developed to assess anger experienced by maltreating parents in response to child misbehavior and other child-related situations. For a child between 2 and 12 years of age, parents rate 50 child-related situations (e.g., child refuses to go to bed, child throws food) as problematic or nonproblematic and rate the degree of anger evoked by each situation. It may be used for identifying anger control problems and evaluating the effects of treatment. Research has supported the internal consistency, temporal stability, content, and construct validity of the measure; however, like many self-report measures, it may be influenced by socially desirable response patterns (Sedlar, Hecht, & Hansen, 1997). Research efforts are underway to further document the psychometric and evaluative properties of the PAI.

The Issues Checklist (IC) (Robin & Foster, 1989) is valuable for assessment of anger specifically related to parent-adolescent conflict. The IC is a 44-item self-report measure of conflict issues and intensity of anger during interactions about these issues. Example issues are telephone calls, doing homework, cleaning up bedroom, cursing, lying, and sex. A brief 17-item version of the IC has also been developed (e.g., Fuhrman & Holmbeck, 1995). Other, more general measures of adult anger may also be useful, such as the State-Trait Anger Scale (STAS; Spielberger, Jacobs, Russel, & Crane, 1983) or the Multidimensional Anger Inventory (Siegel, 1986).

A disadvantage of utilizing self-report ratings of negative affect with maltreating parents is that these parents might underreport negative responses (Hansen & MacMillan, 1990; Warner-Rogers et al., in press). Although not often practical, it may be of value to record physiological measurements of arousal (e.g., heart rate, electromyographic activity, galvanic skin response, blood pressure, and peripheral temperature) during exposure to audiorecorded or videorecorded stimuli (e.g., child-deviant behavior) or in vivo exposure to child deviance warranting discipline (Hansen & MacMillan, 1990; Wolfe, 1988).

Self-report procedures, such as monitoring of responses associated with arousing events, are also useful for assessing stress and anger-control deficits. The parent may be instructed to record a description of each incident that led to feelings of anger, frustration, or tension, the manner in which he or she dealt with the problems, the way it was resolved, and the feelings he or she had afterward.

PROBLEM-SOLVING AND COPING SKILLS

An area of assessment receiving increasing attention is the problem-solving skill of abusive parents (Azar, Robinson, Hekimian, & Twentyman, 1984; Hansen et al., 1998). The Parental Problem-Solving Measure (PPSM) (Hansen, Pallotta, Christopher, Conaway, & Lundquist, 1995; Hansen, Pallotta, Tishelman, Conaway, & MacMillan, 1989) measures problem-solving skill for child-related as well as non-child-related areas. Problem situations for the PPSM are classified into one of five problem areas: (1) child behavior and child management, (2) anger and stress control, (3) finances, (4) child care resources, and (5) interpersonal problems. Responses are rated for the number of solutions generated and effectiveness of the chosen solution. An initial 25-item version (Hansen et al., 1989) and a subsequent 15-item version (Hansen et al., 1995) have been evaluated. Although such measures assess skill levels based on parent verbal report, it is not yet clear to what degree such reports are related to in vivo behavior.

Self-report problem-solving measures that have shown promise with other populations may also be helpful (Hansen & MacMillan, 1990). For example, the Social Problem-Solving Inventory (D'Zurilla & Nezu, 1988) is a measure of multiple components of problem-solving ability, and the Problem-Solving Self-Monitoring Form (D'Zurilla, 1986) is a measure of handling of problems that occur in the natural environment.

Assessment of coping styles may also be evaluated (Hansen & MacMillan, 1990). As coping skills deficits may be detected in several areas (e.g., anger control, general life stressors), multimodal measures that assess a broad range of functioning should be utilized (Kolko, 1996). The Ways of Coping Checklist-Revised (Lazarus & Folkman, 1984) is a 66-item inventory comprising of eight scales (problem-focused coping, wishful thinking, detachment, seeking social support, focusing on the positive, self-blame, tension reduction, keeping to self). It is completed for a particular, single stressor, and has been used with adult populations (Hansen & MacMillan, 1990; Lazarus & Folkman, 1984). Another measure that has utility with maltreating parents is the Parental Locus of Control Scale (Campis, Lyman, & Prentice-Dunn, 1986), a 47-item self-report scale that provides an overall score and five sub scale scores (parental efficacy, parental responsibility, child control of parents, parental belief in fate/chance, parental control of child behavior).

ADAPTIVE SOCIAL CONTACTS AND SOCIAL SUPPORT

Presence and quality of social contacts and social support may be assessed through interview and self-monitoring. The Community Interaction Checklist (Dumas & Wahler, 1983; Wahler, Leske, & Rogers, 1979) is an easy-to-use semistructured interview that examines the frequency and nature of social contacts. Availability and use of types of social support such as guidance and advising, emotional support, socializing, tangible assistance, self-disclosure, and support related to child problems (e.g., advice on how to handle tantrums, emotional support for handling child-related stressors) should also be evaluated.

Measures developed with nonmaltreating adults may prove useful. Cohen, Mermelstein, Kamarck, and Hoberman (1985) developed the Interpersonal Support Evaluation List, a 40-item inventory to assess the degree to which social support fulfills the following functions: tangible support (i.e., concrete or material aid), appraisal support (i.e., opportunities to assess or evaluate the problem), self-esteem support (i.e., positive evaluation), and belonging support (i.e., opportunities to socialize with others). The Perceived Social Support Questionnaire (Procidano & Heller, 1983) is a 40-item measure of the extent to which needs for support, information, and feedback are fulfilled by friends and family. If social support and social interaction measures reveal deficits, then social skill inventories and role-play measures should also be considered for use (Kelly, 1982, 1983).

MARITAL FUNCTIONING AND PARENTING COOPERATION

Assessment of marital interaction, including conflict, aggression, and cooperation in child-rearing efforts can be valuable. Self-report measures commonly used in the assessment of marital problems include the Marital Adjustment Scale (MAS; Kimmel & van der Veen, 1974; Locke & Wallace, 1959) and the Dyadic Adjustment Scale (DAS; Spanier, 1976). The DAS, which is similar to the MAS, is a 32-item questionnaire using primarily Likertstyle rating scales to assess the quality

of dyadic relationships. The DAS yields a standard score that represents the degree of dissatisfaction in the relationship, which can be compared with distressed and nondistressed norms.

The Conflict Tactics Scale (Straus, 1979) is a 19-item measure designed to assess individual responses to situations involving conflict within the family. It can be used to assess conflict resolution tactics between adults or between a parent and a child, and can be administered in interview or questionnaire fashion. Subscales are Reasoning, Verbal Aggression, Minor Violence, and Severe Violence. Items assess a wide range of tactics, from "discussed the issue calmly" to "kicked, bit, or hit with a fist." Respondents are asked to report on their own and their significant other's behavior. The more thorough Revised Conflict Tactics Scales (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) has 39 items that are designed to be asked about both the participant and the partner, for a total of 78 questions. The CTS2 has a simplified format, increased clarity and specificity of items, better distinction between minor and severe levels of psychological and physical aggression, replacement of the Reasoning scale by an improved Negotiation scale, and addition of new scales to address sexual coercion and physical injury.

Direct observation coding procedures are available, such as versions of the Marital Interaction Coding System (MICS; Heyman, Weiss, & Eddy, 1995; Weiss & Summers, 1983; Weiss & Tolman, 1990). The MICS-III includes 32 behavior codes that assess functions including problem description, blame, proposal for change, validation, invalidation, and facilitation (Weiss & Summers, 1983). The MICS-IV (Heyman et al., 1995) includes 36 behavior codes and addresses more nonverbal affect during interactions than the MICS-III. The MICS-IV hierarchical rules for creating sequences produce stronger negative codes (e.g., blame) and more subtle positive codes (e.g., facilitation) than the MICS-Ill. There is also a MICS-G (Weiss & Tolman, 1990), a global rating system based on the MICS-III. The MICS-G consists of six global rating categories, five of which are derived from the MICS-III summary categories: Conflict, Problem Solving, Validation, Invalidation, and Facilitation. A sixth category, Withdrawal, was included because it is considered a potential mediating factor in spouse abuse and a predictor of marital satisfaction. Thus, the MICS-G has the advantages of being derived from the empirically valid and widely used MICS, a microanalytic coding system, but is less costly in training and time required for making ratings (Weiss & Tolman, 1990).

Specific measurement of parenting-related conflict can also be valuable (McMahon & Estes, 1997). The 20-item Parenting Alliance Inventory (Abidin & Brunner, 1995) is designed to measure the degree of parental collaboration in child rearing. Each partner is asked to rate the other parent's involvement with the child and parenting competence, as well as the degree of agreement-discord between parents over child-rearing issues. Extensive discussions of assessment of marital interaction in the context of the family (e.g., Grotevant & Carlson, 1989; Touliatos, Perlmutter, & Straus, 1990), and more specifically as it relates to parenting (e.g., McMahon & Estes, 1997) and marital violence (e.g., Holtzworth-Munroe, Beatty, & Anglin, 1995), are available for interested readers.

PRACTICAL ISSUES IN THE ASSESSMENT OF ABUSIVE FAMILIES

Practical issues arise in the assessment of maltreating families, and a few warrant discussion here. Interacting with child protective services (CPS) workers is important for a coordinated, multidisciplinary effort. Prompt initial contact with the relevant CPS worker, followed by regular contact

by phone or periodic written updates, may facilitate communication. It is also important to clarify the goals of all parties (i.e., therapists, client, CPS workers) and to clarify with the client the distinction from and relationship with CPS.

Although most states have mandatory reporting laws requiring physicians, psychologists, teachers, and other professionals to report suspected instances of child maltreatment, as many as one-third of possible child physical abuse cases remain unidentified or unreported (NCCAN, 1988, 1996). Much research attention has been directed toward factors that influence or bias judgments of the presence, severity, and reporting of child abuse (e.g., Hansen, Bumby, Lundquist, Chandler, Le, & Futa, 1997; Howe, Herzberger, & Tennen, 1988; Kalichman & Brosig, 1993; Warner-Rogers, Hansen, & Spieth, 1996). Factors that may influence judgments about whether an event is abusive and should be reported, include the gender of the child victim, the perpetrator, or the person making the judgment; one's own personal history of maltreatment; the age of the victim; socioeconomic status and race of the perpetrator; the severity of the abuse; and familiarity with reporting laws and procedures. The impact of such factors is complex and still not well understood, as their influence varies across professional groups (e.g., psychologists, social workers) and types of maltreatment (Hansen et al., 1997). Reviews of the influence of such variables on the ability to recognize and willingness to report abuse are available (e.g., Kalichman, 1993; Warner & Hansen, 1994).

An issue in need of further evaluation is to inform parents of a decision to report them for child maltreatment (Lundquist & Hansen, 1998). Indeed, some argue that not informing parents of suspicion or intent to report is deceptive and may be unethical (Racusin & Felsman, 1986). The impact of such actions on the assessment and treatment process likely varies with different parents, but little is known at this time.

Significant attention has been directed toward acceptability of treatment procedures by abusive parents (e.g., Kelley, Grace, & Elliott, 1990; Lundquist & Hansen, 1998); however, the acceptability of assessment procedures has been neglected (Hansen & McMillan, 1990). Maltreating parents, often mandated and reluctant to participate in therapy, may be hypersensitive to negative evaluation and prone to make inaccurate interpretations of assessment procedures if they are not explained thoroughly (e.g., videotaping parent-child play behavior may be viewed as an attempt to show that the child does not like the parent). Research is needed that examines acceptability of various assessment procedures for maltreating parents and the conditions that may make procedures more or else acceptable (Hansen & McMillan, 1990; Lundquist & Hansen, 1998).

Maltreating parents often do not identify themselves as having a problem and are usually not self-referred for evaluation or treatment (Kelly, 1983; Wolfe, 1988). It is not surprising, then, that research indicates that session attendance and homework completion are problems with maltreating families (e.g., Hansen & Warner, 1994; Warner, Rummell, Ellis, & Hansen, 1990). Use of strategies to improve attendance, as well as participation within and after the session (e.g., homework), may be essential and should begin in the early phases of contact. Professionals must be sensitive to the factors that may contribute to noncompliance, such as inadequate instructions, lack of skills or motivation to perform the assignment, and competing contingencies that may reinforce noncompliance or punish compliance (Lundquist & Hansen, 1998; Hansen & Warner, 1994). Antecedent, prompting strategies include establishing attendance policies, providing additional stim-

uli (e.g., reminders), getting written commitments, and training parents in tasks assigned. Consequent strategies include reinforcement (e.g., praise), tangibles (e.g., clothing, movie tickets, money), and attention to nonadherence responses (e.g., open discussion). Combined antecedent and consequent strategies include contingency contracting and involving significant others (e.g., children, partners) in assignments to be carried out in the home. Results on the effectiveness of court orders, which mayor may not specify positive or negative consequences (e.g., return child to home or remove child from home) for participation in assessment or therapy, have been inconclusive (Lundquist & Hansen, 1998). In addition to antecedent and consequent strategies, it can be valuable to address contextual or environmental factors that may impact compliance, such as providing stress-management training or intervention for other problems that interfere, such as substance abuse, emotional problems, or marital difficulties (Hansen et al., 1998; Kolko, 1996). Although many of these procedures are used in clinical and research endeavors with maltreating families, the effectiveness of these and other procedures to enhance compliance of abusive parents has not specifically evaluated (Lundquist & Hansen, 1998).

An in-depth discussion of the role of cultural and ethnic factors extends beyond the scope of this chapter, but some general considerations warrant attention. Just as parental acts and child-rearing practices should be evaluated within the context of the immediate family and community environment as well as the developmental stages of the child, such behavior should also be examined from the perspective of the culture in which they happen. Evaluators and practitioners should possess an awareness and sensitivity about another culture's attitudes, beliefs and values which in turn may influence child-rearing practices. For example, a traditional value of the Hispanic *culture, familism,* strongly emphasizes family unity and encourages a sense of familial obligation among members (Zayas, 1992). Without such sensitivity and understanding, misinterpretation of events or decision making based on personal biases rather than on empirical information about the effect of specific parent behaviors is possible (Sternberg, 1993). Additionally, when professionals target areas for intervention and monitor progress of those interventions, they should consider culturally relevant factors throughout the process. These cultural factors may interact with child abuse risk factors such as distress, social isolation, family conflict, and stressful life events (Derezotes & Snowden, 1990; Rubin, 1992). Clinicians have been found to be more successful at engaging minority families by demonstrating cultural sensitivity (Sue & Sue, 1977; Tsui & Schultz, 1985). Miscommunication and language barriers between English-speaking professionals and families who speak another language may present obstacles to providing needed and most appropriate services. Finally assessment and intervention should include an individualized evaluation of the family's strengths as well as weaknesses (Rubin, 1992).

LEGAL AND SYSTEMS CONSIDERATIONS

LEGAL AND CHILD PROTECTION ISSUES

Professionals who work with physically abusive families can expect to have interactions with the legal system. These interactions can be with the local child protective services agency, law enforcement officials, lawyers, or the judicial system. Although most states and Washington, DC, have laws requiring certain professionals (e.g., psychologists, physicians, teachers) to report sus-

pected child maltreatment, these laws vary from state to state (Besharov, 1990; Kalichman, 1993). Many professionals are reluctant to report, possibly due to fear of getting involved in the legal system, as well as concern about harming a therapeutic relationship (Besharov, 1990; Wolfe, 1988). As noted previously, many professionals may also fail to report abuse because they do not recognize the abuse or because they make a judgment that reporting is not appropriate or necessary for a particular situation (Kalichman, 1993; Hansen et al., 1997; Warner & Hansen, 1994). Not reporting is a crime, usually a misdemeanor, and civil liability is also possible. Those who report are immune from criminal and civil liability.

There are two general areas of legal involvement regarding child maltreatment. The first, the protection of children, is typically addressed through civil procedures. The second, the criminal prosecution of the child abuser, occurs when abuse is severe. Thus, professionals must be aware of the current laws and practices in their state as to definitions of abusive and neglectful acts, as well as reporting procedures and requirements. In addition, they should be cognizant of the local and national norms for appropriate parenting behavior.

In most cases, reports of suspected maltreatment reach the local child protective services (CPS) office for substantiation. Practitioners may be asked by CPS to assist in any of the ensuing procedures: report taking, screening, investigation, initial risk assessment, crisis intervention, report disposition, case planning and implementation, and eventually case closure (Besharov, 1990). If maltreatment is substantiated, the legal system may become involved more formally. Examples of more formal involvement include mandating the family to participate in therapy, temporary removal of the child from the home and, in rare cases, termination of parental rights or criminal prosecution of the perpetrator. Clinicians may participate in courtroom proceedings, giving expert testimony or preparing children for testimony.

When working with a family, it is important for practitioners to confine their part in the legal process to either investigator, evaluator, or therapist (Melton & Limber, 1989; Melton, Petrila, Poythress, & Slobogin, 1997). Adoption of more than one role may result in conflict of interest or require a breach of confidentiality that could be detrimental to the therapeutic relationship. The clinician should be clear about the nature of his or her role at the outset of any legal case. To offset any potential misunderstanding by individuals being evaluated, professionals should explicitly state their roles, the scope and nature of the services, who requested the services, who will have access to assessment information, and limits of confidentiality.

ADDITIONAL SYSTEM CONSIDERATIONS

Cicchettti, Toth, and Hennessy (1993) note that, given federal legislative efforts that allocate money for demonstration and service programs which work in conjunction with preschool, elementary and secondary schools, "educators and other professionals are being called upon to become more active in efforts to identify and treat victims of child abuse" (p. 304). These federal efforts point to a recognition that abuse must be dealt with through an integration of social service, health, mental health, education, and substance abuse agencies (Cicchetti et al., 1993). Such recognition necessitates a strong working alliance between the school system, health and mental health practitioners, and social service agencies regarding the assessment of child physical abuse.

Americas' educators and school personnel spend a significant amount of time with children and consequently are able to witness patterns of behavior across time. Not surprisingly, more reports are provided from schools than any other systems (e.g., hospitals, day-care centers, mental health systems) (NCAAN, 1988, 1996). Maltreating families may fail to provide proper or consistent health care (e.g., medical, dental, mental health) for their children, and therefore many possible instances of abuse may escape observation by medical and other professionals. Thus, teachers are a primary source for reports of frequent or suspect injuries. These facts carry important implications for school systems with regards to identifying and assessing children who may have experienced physical abuse. Educators are in a prime position to encourage timely and suitable assessment and intervention services for these children and their families. In addition, teachers are important sources of information pertaining to a child or family that may warrant attention in the assessment of abuse, including the child's academic, behavioral, emotional, and social functioning. Comprehensive and integrative assessments in school settings can be valuable for identification of intervention goals for the child and family, especially when assessment across the multiple domains of development is conducted (e.g., cognitive, socioemotional, and linguistic/representational) (Cicchetti et al., 1993).

In recognition of the presence of child abuse across various systems (e.g., health, education, social services, legal), many states have developed multidisciplinary teams for investigation, assessment, and intervention (Melton et al., 1997). These teams consist of professionals from settings such as health, judicial, mental health, and social service systems. Here the clinician serves as a team member, often serving an advisory role concerning decisions about legal issues. The clinician may be looked on as an expert in interviewing and evaluating the allegedly abused child or abusive parent. When the clinician is obtaining information that may be used in prosecution of a case, however, the potential exists for confusion regarding the clinician's role by both the clinician and the child or parent being interviewed.

CONSIDERATIONS AT VARIOUS STAGES OF ASSESSMENT

The goal of mandatory reporting laws is to promote child protection, not to punish the perpetrators. After a report of suspected maltreatment is received, the child protection system may request an assessment of the likelihood that the child is in danger of being maltreated. Any assessment conducted during this disposition phase must focus on ensuring the safety and welfare of the children, as well as determining the parent's need and willingness to participate in intervention. Historically, clinicians have rarely been involved in the validation of abuse; however, this trend is changing (Melton & Limber, 1989). Mental health professionals are not only becoming more involved in addressing forensic issues in child abuse cases, they are getting involved at earlier stages (e.g., prior to adjudication) as well (Melton et al., 1997). Clinicians may become involved at any of the following phases of a child maltreatment case: investigation, emergency decision making, adjudication, disposition and post-dispositional review, and mediation and other alternative processes.

Typically, answers to two questions are sought in abuse investigations: (1) whether abuse occurred and (2) if so, what can be done to mediate its harmful effects in the immediate and long term (which may involve prevention and intervention decisions). Because clinicians may assume the roles of decision maker, initiator, and objective expert for one case, there is increasing oppor-

tunity for confusion to arise concerning professional roles and boundaries. It is important for the professional to be aware of the constraints of their role within the legal system. Mental health practitioners should avoid dispensing ultimate issue opinions concerning disposition (e.g., whether risk is so great that the child requires out-of-home placement) (Melton et al., 1997).

Assessment information may be used in a court hearing or trial. Especially in cases where criminal charges are pending, practitioners must ensure that the parents had an opportunity to consult with their counsel prior to the onset of assessment (Melton & Limber, 1989). Legal proceedings are adversarial in nature; thus, cross-examination, including questioning of professional credibility or choice of assessment devices, can be expected. Practitioners must be extremely familiar with any assessment devices they used, including its psychometric properties. They should formulate opinions and judgments on clear, well-defined databases and make cautious use of clinical observations (Guyer & Ash, 1985). The reliability of subjective opinions may be questioned rather easily in the courtroom.

Those involved in the evaluation of maltreatment may have more information concerning use and interpretation of assessment procedures than the legal and other professionals. Thus, it is important to confirm that the assessment procedures and their results are neither misconstrued nor misused (Melton & Limber, 1989). While mental health practitioners should avoid answering ultimate opinion issues or making legal determinations, they can provide valuable assistance to the court by focusing clinical assessments on prevention of further abuse and amelioration of the psychological harm that may already be present (Melton et al., 1997). The purposes and appropriate uses of formal assessment instruments are often delineated clearly in accompanying manuals. For example, the Child Abuse Potential Inventory (Milner, 1986) was designed to assess maltreatment potential by comparing characteristics of the parent with those of known abusers; practitioners must prevent its use as a determining measure of whether the parent did or did not maltreat a child.

Assessment throughout intervention is critical for monitoring treatment effectiveness. This information may be required for hearings, or relayed to the CPS workers and used for decisions regarding case closure. At these times, evaluation of changes in the home environment and the impact of services received by the family are of primary interest (Melton & Limber, 1989). In many cases, following an initial hearing, families will be granted an improvement period. Several states require clear documentation that the state has tried repeatedly to provide assistance to the family (Melton et al., 1997). If this assistance has not proved beneficial, there may be grounds for more intense legal involvement (e.g., court mandation for services, removal of children, termination of parental rights).

GENERAL CAVEATS REGARDING ASSESSMENT

Some general concerns must be considered at every point in the legal process. At all times, it is critical that everyone involved is knowledgeable about who will be receiving the results of the assessments (Guyer & Ash, 1985; Melton & Limber, 1989). In addition, during any assessment procedure, parental rights, as well as the child's welfare, must be protected. Unless there is a court order stating otherwise, information gathered during assessment is confidential. The parents control their own records, as well as those of children in their legal custody. Nevertheless, these cli-

ents should be warned that their records may be subpoenaed by the court and that the clinician cannot guarantee unconditional confidentiality (Guyer & Ash, 1985).

If the assessment is ordered by the court, assessment material is not considered privileged, even initially. All data acquired throughout assessment will be given to the court and the attorneys. Clients, when assessed in this context, must be informed of this lack of confidentiality. Records should document that information about confidentiality has been related to the clients (Guyer & Ash, 1985). It must be clear that all parties understand their role in the process prior to the onset of assessment (Melton & Limber, 1989).

In many cases, information gathered during these assessment phases eventually will be included in reports to CPS and possibly to the courts or other members of the legal community. At the minimum, these reports should include the dates of assessment, pertinent background information regarding the clients, the reason and source for the referral to the clinician, the names of all assessment devices used, the scores on the devices as appropriate, interpretation of scores and other assessment data, and a summary and recommendations. These reports should be as free as possible from psychological jargon and readable by other professionals involved in the case. A lawyer, for example, may not understand or appreciate the meaning of an elevated T-score on the Rigidity Scale of the CAPI.

An important caveat about assessment is that conclusions and recommendations should be based on relevant, objective data and not on unfounded speculation. In addition, it is important that professionals avoid reliance on anyone measure and look for converging evidence across various measures when attempting to understand parental behavior. Practitioners must also be careful not to overstep their professional roles or training and make decisions best made by others (Melton & Limber, 1989; Melton et al., 1997). Although they may be more knowledgeable about the etiology and epidemiology of maltreatment, and more familiar with the tools of assessment, they are probably less familiar with the legal issues and proceedings.

The growing involvement of mental health professionals in the legal system has not been without controversy or problems (Melton & Limber, 1989; Melton et al., 1997). Faust and Ziskin (1988), in a controversial article, noted, "Studies show that professionals often fail to reach reliable or valid conclusions and that their accuracy does not necessarily surpass that of laypersons, thus raising substantial doubt that psychologists or psychiatrists meet legal standards for expertise" (p. 31). However, research on the collaboration of child welfare, mental health, and judicial systems suggests a good working relationship among the systems, with placement recommendations and decisions being highly correlated (Butler, Atkinson, Magnatta, & Hood, 1995).

CASE ILLUSTRATION

As illustrated in the following case description, evaluation and treatment planning for a physically abusive parent can be a lengthy and challenging process.

BACKGROUND INFORMATION

Sharon Reed was referred to a university-based treatment program for physically abusive and neglectful parents by her CPS caseworker. On a referral checklist, her caseworker identified the following as "highly important" targets for treatment: child management skills, knowledge of

child development, anger control, financial management, social isolation, emotional neglect, and medical care.

Ms. Reed was a 21-year-old woman who described herself as a "recovering alcoholic" with a "horrible temper." She reported a history of three hospitalizations for depression and substance abuse. Ms. Reed indicated that she left two of these hospitalizations against medical advice. She was not currently on any medications and denied all use of alcohol and drugs. She denied current suicidal ideation, though she reported that she attempted suicide by overdosing on prescribed medication approximately 11 months earlier, which resulted in her most recent hospitalization.

Her daughter, Samantha, was 26 months old at the time of the referral. Ms. Reed reported that she had no current contact with Samantha's biological father. Ms. Reed indicated that she voluntarily placed Samantha in foster care approximately 19 months earlier because the child was suffering from "failure-to-thrive." Samantha was returned to her mother approximately 2 months later after gaining weight at the foster placement.

Ms. Reed was referred for the current assessment by CPS for suspected physical abuse of Samantha. The CPS investigation and concerns about possible physical abuse were initiated when Ms. Reed brought Samantha to the University hospital emergency room for a high fever, and at that time medical personnel reported to CPS that Samantha had "unexplainable bruises" on her face and "apparent burn marks" on the palms of her hands. CPS also reported concerns about Ms. Reed leaving her daughter with various caregivers over extended periods of time (e.g., several weeks) without contact from Ms. Reed.

CPS requested a psychological evaluation of Ms. Reed to determine her capacity to care for Samantha and her potential for abuse. They also requested that Ms. Reed receive parent training and other interventions as needed (e.g., anger control). At the time of referral, Samantha had been in foster care for approximately 3 months, and Ms. Reed had weekly 48- to 72-hour visits with her daughter.

Ms. Reed and Samantha lived in a rented house with Ms. Reed's boyfriend, Tony Blake. Mr. Blake was 29 years old. They were engaged and had plans to marry following Ms. Reed's divorce from her previous husband. Because Mr. Blake planned to take an active role in parenting Samantha and he was a source of financial and emotional support for Ms. Reed and Samantha, he was included in assessment and subsequent treatment as much as possible. At the time of assessment, he worked in a nearby city (approximately 75 miles away) and was primarily home on weekends.

Ms. Reed completed high school and had not worked outside of the home since that time. Ms. Reed reported that she was attending computer classes at a community college; however, soon after the intake interview she stopped attending these classes. Mr. Blake held a variety of jobs in recent years, and was currently employed as a mechanic for a trucking company.

Ms. Reed and Mr. Blake expressed a strong desire to have Samantha returned to their custody. At the time of the referral, Ms. Reed had been receiving services from a variety of professionals and agencies (e.g., CPS, the community mental health center, and others). Ms. Reed reported that she and Mr. Blake were very dissatisfied with the services they had received thus far in their improvement period since the removal of Samantha from their care. They did not take any responsibility for the problems they had in attempting to work with the various helping agencies (e.g., not attending scheduled appointments, lack of transportation to sessions) and tended to complain

about the professionals and the various agencies (e.g., that these professionals were not interested in helping them get Samantha returned to their custody).

OVERVIEW OF CURRENT ASSESSMENT

The goal of assessment was to select target areas for intervention, with special attention to parenting skill and discipline style. Procedures used to gather the following information took place over a period of approximately 4 months. At onset of assessment, there were two clinic sessions, and subsequently nine sessions took place in the home. In general, sessions were approximately one hour long. For the clinic visits, Ms. Reed arrived on time or early. She was usually at home when the therapist arrived for scheduled home sessions, though she missed and canceled a couple of sessions over the 4-month period. Much of the assessment was intermingled with intervention and instruction (e.g., about child management strategies or child care) throughout these sessions. Often, the initial portion of a session was dedicated to the completion of assessment procedures and the latter portion to treatment-related issues.

ASSESSMENT OF PARENT BEHAVIOR AND FUNCTIONING

On the Wechsler Adult Intelligence Scale-III (Wechsler, 1997), her Full Scale IQ fell in the low average range of functioning. No significant difference was noted between the Verbal and Performance IQ scores, suggesting that her verbal comprehension and perceptual organizational skills were comparable.

The MMPI-2 (Butcher et al., 1989; Butcher & Williams, 1992) was completed in valid fashion. The profile was characteristic of individuals who are low in selfconfidence and have feelings of inadequacy, are lacking in energy, and are irritable and moody. Ms. Reed's responses on the Symptom- Checklist-90-Revised (Derogatis, 1994) did not suggest significant psychopathology, but did reflect symptoms of depression.

Ms. Reed identified a moderate number of daily hassles on the Hassles Scale (Kanner et al., 1981), with an average severity in the mild range. Responses indicated that her primary hassles or concerns were over not having enough money (e.g., for basic necessities, housing, entertainment) and having too much to do (e.g., too many responsibilities, not enough time to do things that need to be done).

As indicated on the Community Interaction Checklist (Wahler, 1980), with the exception of occasional contact with one female friend, the majority of Ms. Reed's social contacts were with members of her family and professionals from helping agencies, such as her therapist or CPS workers. She generally viewed these contacts as neutral in nature. Ms. Reed's verbal report throughout the assessment period indicated she was experiencing social isolation.

On the Parental Anger Inventory (Hansen & Sedlar, 1998), Ms. Reed identified many child-related situations that were sources of mild to moderate anger (e.g., child makes messes around the house, child screams and yells when you say "no" to a request, child misbehaves after you have had a bad day, child demands something immediately, child breaks things on purpose). Overall, her scores on the Parent Opinion Questionnaire (Azar & Rohrbeck, 1986) were unremarkable, with the exception of the subscales of Help and Affection to Parents and Proper Behavior and

Feelings, where her scores suggested that her expectations regarding what to expect from her child were possibly inappropriate and unrealistic. Ms. Reed's responses on the Knowledge of Behavioral Principles as Applied to Children Inventory (O'Dell et al., 1979) indicated that she had limited knowledge of basic child-management skills. Interview of Ms. Reed further supported that she had limited knowledge of child development, particularly regarding communication and self-help skills of young children, and a limited repertoire and understanding of child-management skills.

Ms. Reed's score on the Abuse Scale of the Child Abuse Potential Inventory (Milner, 1986) was elevated, indicating that she may have characteristics similar to parents who have abused their children. In addition, her scores on the Distress and Unhappiness scales were elevated suggesting that she might be experiencing some emotional difficulties that could impact her parenting ability. When questioned about any distress or unhappiness, she indicated that her unhappiness was primarily related to not having custody of her daughter.

Ms. Reed's scores on the Child subscales of the Parenting Stress Index (Abidin, 1995) were within normative range with the exception of a high score on the Reinforces Parent subscale. A high score on this subscale indicates that Ms. Reed may not view Samantha as a source of positive reinforcement. Her elevated Parent Domain scales were Depression and Social Isolation.

Given his engagement to Ms. Reed and his stated commitment to parenting Samantha, Mr. Blake was asked to complete the CAP Inventory and the Parenting Stress Index. Mr. Blake's score on the Abuse scale and the six other scales of the CAP Inventory were all within normal limits. His scores on the PSI were not elevated on any Child or Parent subscales.

ASSESSMENT OF CHILD BEHAVIOR AND PARENT-CHILD INTERACTION

On the Eyberg Child Behavior Inventory (Eyberg & Ross, 1978), Ms. Reed reported that she considered a variety of Samantha's behaviors to be problems, and that these behaviors occurred fairly regularly. For example, problem behaviors included dawdling at mealtime, refusing to eat food presented, getting angry when she doesn't get her own way, having temper tantrums, whining, crying easily, yelling or screaming, and constantly seeking attention.

Direct observation of Ms. Reed's interactions with her daughter were done on three separate occasions during home visits. In general, her behavior with Samantha appeared appropriate and positive. She verbally prompted Samantha away from dangerous situations, such as *telling* her to move away from the door to the stairway and *locking it,* and *instructing* her to remove a pen from her mouth, then physically removing it when she did not comply. She also allowed Samantha to sit next to her, put her arm around Samantha, and talked with her while she completed some forms. Ms. Reed's language was age-appropriate for Samantha. Samantha complied with her mother's instructions most of the time, and when she did, Ms. Reed thanked her and praised her for "doing a good job." There were no angry or physically abusive incidents during the observations.

Both Ms. Reed and Mr. Blake reported that Samantha was a difficult child to feed. The therapist observed Ms. Reed feed Samantha on one occasion, and although she had several appropriate strategies (e.g., verbally reinforcing Samantha for sitting down and taking a bite), Ms. Reed appeared to become very frustrated when Samantha was noncompliant. Ms. Reed reported frustration that Samantha was a "picky eater" and that she did not know what foods her daughter liked.

On the morning of one session, Ms. Reed attempted to feed refried beans to Samantha, although she did switch to applesauce when Samantha did not eat the beans.

It was reported by Ms. Reed and her CPS worker that some visits with Samantha had been terminated early for a variety of reasons (e.g., Ms. Reed not feeling well or having another commitment, such as spending time with her fiancé in the nearby city where he worked). The inability to regularly complete 48 to 72 hour visitations raised concerns whether Ms. Reed had the personal commitment and resources to care for Samantha on a full-time basis.

ADDITIONAL ASSESSMENT OF THE HOME ENVIRONMENT

Given Samantha's young age, the safety and cleanliness of the home environment was a concern of the therapist. The therapist initially requested to conduct an assessment of the home, which would have involved viewing each room of the house for safety and cleanliness issues that may have been harmful to the child, and providing suggestions for improving the environment. During the first three home visits, Ms. Reed indicated that the house was "messier than usual" and promised to clean it for viewing by the next session. Eventually, despite her concerns that the house was still "too messy," Ms. Reed allowed the therapist to briefly look at each room of the house, but did not permit a detailed inspection (e.g., opening cupboards under sinks or viewing other areas the child may access, such as closets). The house was cluttered, with a variety of items strewn throughout on the floors and furniture (e.g., clothing, dirty dishes). The ashtrays were full of cigarette butts and lighters were observed on the tables. With the exception of a few books and one doll, very few age-appropriate toys for Samantha were in the house. Samantha did not have a baby bed or high chair. Samantha did have a small table and chairs and Ms. Reed was attempting to teach Samantha to eat her meals at this table. Establishment of good rapport and providing a rationale was important for gaining access to viewing the various rooms of their home. Overall, Ms. Reed recognized potential hazards in the home environment and took some necessary precautions (e.g., blocking access to the staircase). She reported always utilizing a car seat when traveling with Samantha.

CASE SUMMARY AND RECOMMENDATIONS

Several possible treatment targets have been identified for Ms. Reed. It appears that she is continuing to experience problems of mild depression, as well as feelings of social isolation and stress (e.g., regarding financial concerns). Therapy to address these issues will likely be necessary to facilitate her ability to participate and implement additional interventions to improve parenting and child-care abilities. Intervention to improve parenting skills is considered important, with an emphasis on gaining knowledge and acquiring skills to enhance parent-child interaction and improve child management techniques, and improving her knowledge of child care and child development. Alternatives to physical discipline (e.g., time out) and increasing child compliance (e.g., via more appropriate and effective commands, praise and reinforcement) are considered priorities to reduce likelihood of abuse in the context of excessive physical discipline. In particular, improving anger and stress control during child-management and childcare situations is viewed as essential. Improving the parent-child relationship through increasing the occurrence of positive parent-child

interactions will also be valuable (e.g., via increased compliance as well as increased opportunities for appropriate play between mother and child). As much as possible it will be important to include Mr. Blake in the intervention activities, to improve his skills as needed and further support and reinforce changes made by Ms. Reed.

Continued assessment throughout the course of treatment is warranted, and several of the devices mentioned previously will be used as dependent measures. For example, the Eyberg Child Behavior Inventory, the Parental Anger Inventory, the Parent Opinion Questionnaire, and the Parenting Stress Index are examples of relevant measures that are easily completed and may be used repeatedly to identify treatment effects. In addition, repeated direct observation in the home (e.g., of parent-child interactions and child care situations such as feeding) will be invaluable for monitoring and implementing treatment. As Ms. Reed and Samantha become more accustomed to being observed, it may be found that the interactions are more representative of what normally occurs (e.g., possibly more problems and conflicts may arise). Additional measures that directly assess treatment procedures and effects will be added as treatment progresses (e.g., via parentmonitoring of child management procedures, anger control skills, child-care activities, or child behavior). Mr. Blake will be included when possible in assessment and information gathering, and input will be sought from other professionals and agencies also involved with the family (e.g., CPS, the community mental health center).

CONCLUSION

Widespread attention to the problem of child physical abuse has increased dramatically in recent decades. Extensive research evidence has described child physical abuse as a complex, multidimensional phenomenon that is best assessed by procedures using multiple modalities (e.g., interview, self-report, direct observation) that address multiple content areas. Comprehensive assessment is essential for identifying risk and occurrence of abuse, guiding the focus or direction of treatment, as well as monitoring treatment efficacy and outcome, all of which may be disseminated to interested parties as appropriate (e.g., CPS, judicial system, school, other treatment providers). Increasingly specific and relevant procedures have become available for many of the commonly targeted areas of assessment. In general, recent advances have been especially significant in the development of self-report and analogue assessments to measure parental responses in a variety of contexts (Hansen & MacMillan, 1990; Lutzker, 1998; Lutzker et al., 1998; Wolfe & McEachran, 1997).

The complex, multiproblem nature of maltreating families and child physical abuse presents many assessment difficulties for both clinicians and researchers. The assessment of physically abusive families is complicated by issues such as mandatory reporting and other legal considerations, the potential unwillingness of parents to cooperate, and contextual factors and stressors that interfere with a family's ability to participate (e.g., social isolation, relationship problems, financial difficulties). Although there are many suggested strategies, further research on the. most effective and appropriate methods of addressing these issues and conducting comprehensive and accurate assessments is needed.

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