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This study evaluates the level of behavior problems in a previously little studied group—children with founded cases of abuse and neglect receiving child welfare services in their own homes. A sample of 149 maltreated children, living at home, were evaluated on the CBCL as they entered a service program to which they were referred by a large public child protective service system. These children were found to have elevated levels of behavior problems, with 43.6% scoring in the problematic range, a rate similar to children entering foster care. Practice and policy implications of these findings are discussed and highlighted.

Introduction

The abuse and neglect of children is one of the most serious social problems facing our country. The number of reported cases of child maltreatment now stands at 44 cases per 1000 children (U.S. Department of Health and Human Services, 1998). Serving these children and their families is the responsibility of public child welfare systems.

Research has shown that abuse and neglect may have both short- and long-term negative consequences for many of its victims. In addition, numerous studies have documented the high rates of emotional and behavior problems of children in the foster care system. What has not been documented is the prevalence of emotional and behavioral problems in children served by the child welfare system but not placed in foster care—children with founded cases of maltreatment who are under the supervision of child protective services but receive services in their own homes. The reason for such a gap in the literature may lie in the fact that in-home services are frequently directed at the parent(s) in order to help determine whether the family should be preserved. Case assessment under such circumstance first focuses on the child's safety. Once determined that the child can be maintained safely in the home, the assessment then turns to the parent(s) and family's dynamics in order to resolve the concrete, personal, behavioral, and interpersonal problems that led to the maltreatment incident; intervention is often aimed at the parents or the family constellation to avoid placement rather than at the child's condition. Under these circumstances, the potential service needs of the maltreated child is often overlooked, since

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the service focus is on parental skills enhancement and the resolution of parental problems, rather than on the consequences of the maltreatment on the child.

This study looks at the rates of emotional and behavioral problems in a more narrowly delineated sample of maltreated children than other studies in the literature. It looks only at children under the supervision of the child protective service system and receiving services in their own home. This sampling choice was made to understand the unique service needs of this large and important population—children who have been found to be maltreated but whose safety representatives of the child protective service system believe they can be adequately protected at home. We explore this issue to determine whether these children have service needs apart from their parents—service needs which seemingly, under many circumstances, go unaddressed by the current child welfare system. We hypothesize that this will be the case, since children receiving in-home services have been victims of maltreatment, and maltreatment has been known to put children at risk for behavioral and emotional dysfunction in broader samples of maltreated children taken from numerous settings. If this is found to be the case, recommendations will be made to ameliorate this situation, since we believe that the public child welfare system has a responsibility to provide services to children under their supervision, whether or not they are placed in foster care.

Psychological Effects of Abuse and Neglect

Research has clearly established that victims of child abuse (sexual, physical, or a combination) often incur serious emotional and behavioral problems as a result of this trauma. Sexual abuse has been linked to higher levels of depression (Mennen & Meadow, 1994; Moran & Eckenrode, 1992; Wozencraft, Wagner, & Pellegrin, 1991), anxiety (Johnson & Kenkel; 1991; Mennen & Meadow, 1993), low self-concept (Caviola & Schiff, 1989; Hotte & Rafman, 1992), and behavior problems (Cohen & Mannarino, 1988; Einbender & Friedrich, 1989). Substantial rates of post-traumatic stress disorder (McClellan, Adams, Douglas, McCurry, & Storck, 1995; McLeer, Callaghan, Henry, Wallen, 1994), and major depression (Kaufman, 1991), have also been found in samples of sexually abused children. One study (Merry & Andrews, 1994) found that 63.5% of the sexually abused children in the sample continued to qualify for an Axis I diagnosis one year after their abuse had ended.

Physically abused children have also been found to suffer from depression (Allen & Tarnowski, 1989; Flisher, Kramer, Hoven, Greenwald, Alegria, Bird, Camino, Connell, R., & Moore, 1993; Kazdin, Moser, Colbus, & Bell, 1985; Livingston, Lawson, & Jones, 1993; Toth, Manly, & Cicchetti, 1992) and post-traumatic stress disorder (Famularo, Kinsherff,

& Fenton, 1992; Haviland, Sonne, & Woods, 1995; Livingston et al., 1993). Attention-deficit disorder also has been associated with the occurrence of physical abuse (Famularo, Kinsherff, & Fenton., 1992; Livingston et al., 1993). One study found that 79% of the children entering a treatment program for physically abused children and their families qualified for an Axis I diagnosis (Kolko, 1996). And there have been consistent empirical findings that relate physical abuse to externalizing behavior problems, including aggression, conduct disorders, and behavior problems (Famularo, Kinsherff, & Fenton, 1992; Livingston et al., 1993; Pelcovitz, Kaplan, Goldenberg, Mandel, Lehane, & Guarrera, 1993; Prino & Peyrot, 1994; Trickett, 1993).

Less is known about the emotional and behavioral problems associated with being a victim of neglect, as research has focused on issues of development rather than on the psychopathology or psychiatric sequelae that results from this interpersonal insult. Studies have found that neglected children are more withdrawn, have poorer social skills (Egeland, Sroufe, & Erickson, 1983; Rino & Perot, 1994), and have poorer academic achievement (Kendall-Tackett & Eckenrode, 1996; Wodarski, Kurtz, Gaudin, & Howing, 1990) than demographically similar, non-neglected children. Because such developmental problems are related to the emergence of social and behavioral problems, however, it is reasonable to assume that neglected children are at increased risk for such problems.

Rates of Emotional and Behavioral Problems in Children Entering Out-of-Home Care

Research has clearly established that many children who enter the foster care system display emotional and behavioral problems and that negative experiences within the foster care system increase the likelihood of negative outcomes. In some cross- sectional studies, the rates of emotional and behavioral problems among foster children is truly alarming. One foster care health assessment program found that 60% of the evaluated children had emotional problems and 29% had behavioral problems (the number with both types of problems was not noted) (Halfon, Mendonca, & Berkowitz, 1995). Ratings in the clinical range on at least one scale of the Child Behavior Check List (CBCL), the most commonly used measure of behavior problems and frequently considered a measure of psychopathology in these studies, have been found to be 82% in a Canadian sample (Thompson & Fuhr, 1992), 47% of a California sample (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998), 78% in a Tennessee sample (Glisson, 1996), and 31% in a second California sample (Urquiza, Wirtz, Peterson, & Singer, 1994). In Washington, 72% of a sample of protective services cases were indistinguishable from the emotionally disturbed children in the most intensive mental health treatment program in the state (Turpin, Tarico, Low, Jemelka, & McClellan, 1993).

A Canadian study found that foster children were very similar in symptom scores to children served in mental health facilities. Further, the authors of this study reported that 70% of their foster care sample had a history of treatment for mental health problems, and that 20% of their clinical sample had a history of placement in the foster care system (Stein, Evans, Mazumdar & Rae-Grant, 1996).

Little is known about the rates of emotional and behavioral problems in child welfare clients receiving services in their own homes. Until recently, family preservation and other in-home programs were concerned primarily with issues of cost-savings, and placement avoidance was considered to be the only (or at least the most important) outcome measure of importance. In addition, workers used the assessment of child safety to guide their actions, often without taking child functioning into account (Heneghan, Horwitz, & Leventhal, 1996; Rossi, 1992). One study that did employ the CBCL to evaluate seriously disturbed children receiving family preservation services found that the mean score for children after services was in the borderline clinical range (Wells & Whittington, 1993).

Method

The data reported here were collected as part of a larger study of families in Los Angeles County receiving in-home child welfare services. Families were contacted within two weeks of referral to in-home services, and in the original study were randomly assigned to either traditional public agency services or to a more comprehensive family preservation program (for a full description of the program and its evaluation, see McCroskey & Meezan, 1997). One child in each family was identified as the index child for purposes of the study; whenever possible, this was a child in school, since this age group was of particular interest to the funding source. When the family had more than one school-aged child, the index child was chosen randomly from the pool of elementary school children in the family.

Measures

The Child Behavior Check List (CBCL) (Achenbach, 1991) was completed as part of the research protocol for all index children six years of age and over. The CBCL is a widely used report of children's behavior problems, and has been considered a measure of child psychopathology in a number of studies concerned with children involved in the child welfare system (for example, Glisson, 1996; Clausen, et al., 1996; Wells & Whittington, 1993). It is completed by the child's caretaker and yields a Total Problem Score, scores for Internalizing and Externalizing Behaviors, and nine problem syndrome scores. The manual (Achenbach, 1991) reports Cronbach alphas of .96 for the Total Problem Score, and from .89 to .93 for the Internalizing and Externalizing scales. Alphas on the subscales range from

.54 to .93, with the sex problems subscale having the lowest alpha. Test-retest reliability at one-week was reported to be .95 for non-referred children on the problem scores. For referred children, the average reliabilities for the subscales are reported to range from .70 to .93.

Validity of the CBCL is supported by numerous studies, which have reported significant correlations between it and other problem measures (Achenbach, 1991). T scores have been developed to allow comparison by gender and age. The standardization sample had a mean score of 50 on the Total Problems, Internalizing, and Externalizing scale. A score of 60 on the Total Problem, Internalizing, and Externalizing scales has been established as the clinical cut-off point, with scores between 60 and 63 designated as the borderline range and scores above 63 considered to be in the clinical range (Achenbach, 1991). Thus, scores below 60 are considered within "normal" limits.

While the normative sample differed significantly from the current sample in a number of important ways, including race/ethnicity (fewer children of color) and socio-economic status (few children from poor homes), the CBCL has been widely used with children similar to those in this study and was thus assumed to be appropriate for use. For example, this instrument has been used with abused children (see, for example, Trickett, 1993; Trickett, Aber, Carlson & Cicchetti, 1991), neglected children (see, for example, Wodarski, Kurtz, Gaudin & Howing, 1990) foster children (see, for example, Clausen, Landsverk, Granger, Chadwick, & Litrownik, 1998; Glisson, 1996), and special-needs children adopted out of foster care (see, for example, Groze, 1996; Rosenthal & Groze, 1994).

Sample

The 240 families participating in the study had a founded case of abuse or neglect, had a dependent child living with them, were under the supervision of the child protective service agency, and were deemed appropriate by their public agency worker to receive child welfare services in their own homes. Thirteen percent of the families had at least one child placed outside of the home prior to the start of the project. In addition, many of the families were drug and/or alcohol involved (50%), had domestic violence present (24%), were involved with the penal system (24%), and/or had housing problems (23%). More detailed information on the original study sample, and the sources of information used to capture information about it, is available elsewhere (McCroskey & Meezan, 1997; Meezan & McCroskey, 1996).

Of the 240 families in the study, 149 had index children above the age of six, and these care givers completed the CBCL. The children upon whom parents reported averaged 10.0 years

old (s.d.=2.81). Forty three percent of the children were male and 57% were female. The sample included 73 Latino children (49.0%), 41 African-American children (27.5%), 31 white children (20.8%), and four children of other backgrounds (2.7%). The most common reasons for referral to child protective services were physical abuse (43.0%), neglect (22.1%), and sexual abuse (16.8%). Emotional abuse accounted for only 3.4% of the referrals. Information on the referral reason was not available in 14.8% of the cases.

Results

The maltreated children in this sample had significantly higher scores on the CBCL than the sample of children on which the instrument was normed. The study sample mean on the Total Problem Score of 56.68 (s.d.= 13.08) was significantly higher than the normative group ($t = 6.08$, $p < 0001$). Similarly, the mean of the study sample children on the Externalizing score was 57.27 (s.d. = 13.72), significantly higher than the normative group ($t = 6.30$, $p < 0001$). And the Internalizing score of 54.68 (s.d. = 11.58) was more than 4.5 points higher than the normative group ($t = 4.70$, $p < 0001$). (See Table 1). Thus, while the mean CBCL score for this sample was not in the clinical range, the group's mean was elevated on all three dimensions when compared to a normative sample, indicating that, on average, these children were reported to exhibit more problematic, if not clinically pathological, behavior than the standardization sample.

Table 1.Comparison of Child Behavior Checklist Scores for Child Welfare Clients vs. Normative Samples*

	Standardization Sample N=2368		Study Sample N=149				
	M	S.D.	M	S.D.	t	*df*	*p*
Total Problems	50.05	9.94	56.68	13.08	6.08	158.94	<0.000
Externalizing	50.07	9.71	57.27	13.72	6.30	157.47	<0.000
Internalizing	50.12	9.72	54.68	11.58	4.70	161.38	<0.000

* t test for unequal variances

Group means are only one way of determining the degree of behavioral disturbance in a sample of children. Examining the scores of individual children might be a better way to

ascertain the number of individual children who might be at risk for emotional or behavioral problems within the sample. This can be done by examining the number of children who actually scored within the clinical range in this sample as compared to the normative sample.

The CBCL scales are normed so that 95 % of children fall in the normal range of scores, leaving 5% in the problematic range (2% in the borderline range and 3% in the clinical range) (Achenbach, 1991). In the study sample, 43.6% of the children scored in the problematic range on Total Behavior Problems, with 10.1% in the borderline range and 33.6% in the clinical range of problems. On the Externalizing Scale score, 42.3% of the sample was in the problematic range, with 9.4% in the borderline range and 32.9% in the clinical range. The Internalizing Scale score had 36.2% of the sample scoring in the problematic range, with 13.4% in the borderline range and 22.8% in the clinical range. (See Table 2).

Table 2. Comparison of Child Welfare Client Sample and Normative Sample for Clinical Scores

	Normal Range		Borderline Range		Clinical Range		Borderline + Clinical Range	
	Study	Normed	Study	Normed	Study	Normed	Study	Normed
Total Behavior Problems	56.4%	95%	10.1%	3%	33.6%	2%	43.6%	5%
Externalizing	57.3%	95%	9.4%	3%	32.9%	2%	42.3%	5%
Internalizing	63.8%	95%	13.4%	3%	22.8%	2%	36.2%	5%

Of particular interest is the way in which these in-home service children compare to children in foster care. Two studies (Clausen et al., 1998; Urquiza et al., 1994) evaluated children entering the system as was done in this study. However the Urquiza et al's (1994) study used earlier CBCL norms, and thus, it is not possible to make a statistical comparison. When this sample is compared to the Clausen et al., sample, there is no difference between the two samples on any of the three scales of the CBCL (See Table 3).

Table 3. Comparison of In-Home Clients with Children Entering Foster Care

	Study Sample (In-Home)		Clausen, et al. (1998) Sample (Foster Care)				
	M	S.D.	M	S.D.	t	df	*p*
Total Problems	56.68	13.1	57.00	13.8	0.22	387	0.587
Externalizing	57.27	13.7	56.15	14.6	0.67	387	0.748
Internalizing	54.68	11.6	54.4	11.5	0.15	387	0.559

Analysis of variance revealed that demographic factors had little relationship to scores on the CBCL. (See Table 4). Race did not differentiate scores on the Total Behavior Problem score ($F = 0.06$, $p > 0.95$), the Internalizing score ($F = 0.16$, $p > 0.90$), or Externalizing score ($F = 0.29$, $p > 0.80$). There were also no differences between boys and girls on the Total Behavior Problem score ($F = 0.04$, $p > 0.80$), the Internalizing score ($F = .44$. $p > 0.50$), or the Externalizing score ($F = 0.62$, $p > 0$ .40). In addition, the child's age was not related to the Total Behavior Problems score ® = 0.149, $p > 0.20$), or the Internalizing score ® = 0.073, $p > 0.35$). There was, however, a relationship between age and externalizing problems ® = 0 .18, $p < 0.05$). Similarly, when the subjects were placed into the dichotomous age groups of pre-adolescence (those 12 and under) and adolescence (over 12), there were no differences between the two groups on Total Behavior Problems ($F = 2.04$, $p > 0.15$) or on the Internalizing score ($F = 0.14$, $p > 0.70$). However, age did predict scores on the Externalizing score ($F = 5.35$, $p = 0.02$)—younger children showed fewer externalizing problems than older children.

Table 4. CBCL Scores by Demographic Variables

		Total Problems			Externalizing			Internalizing		
		M	F	*p*	M	F	*p*	M	F	*p*
Age	Under 12	55.73	2.04	.155	55.55	5.35	0.22	54.46	.14	.713
	12 & Over	59.12			61.36			55.24		
Gender	Male	56.93	.04	.839	56.25	.62	.434	55.41	.44	.507
	Female	56.49			58.03			54.13		
Race/ Ethnicity	African-American	56.37	.06	.981	55.98	.29	.831	53.60	.16	.920
	White	57.19			59.03			54.84		
	Latino	56.53			57.29			55.16		
	Other	58.75			56.50			55.50		
Type of Maltreat-ment	Sexual Abuse	56.12	.25	.858	54.12	1.06	.369	55.84	.13	.939
	Physical Abuse	58.01			59.38			55.17		
	Neglect	57.15			55.85			56.18		
	Emotional Abuse	53.80			58.60			53.00		

The type of abuse also failed to predict any differences in the scores; there were no significant differences between children who were sexually abused, physically abused, emotionally abused, or neglected on their Total Behavior Problems score ($F = 0.25$, $p > 0.80$), their Internalizing score ($F = 0.13$, $p < 0.90$, or their Externalizing score ($F = 1.06$. $p > 0.35$).

Discussion

The results of this study indicate that many abused and neglected children under the supervision of the child welfare system who receive in-home services appear to have emotional and behavioral problems. In this sample, 43% scored in the problematic range on Total Behavior Problems. This rate is much like the rates found in samples of children in the foster care system. When compared with the two California samples (those that measured children entering the system), the study sample is very close to the rate of 47% in Clausen et al.'s (1998) sample; in fact there is no statistical difference between the mean scores in the two studies. It is higher than the 31% in Urquiza, et al.'s (1994) sample. Although the rate of behavior problems in the sample is lower than those found in Glisson's (1996) Tennessee sample and Thompson & Fuhr's (1992) Canadian samples, these differences might be due to differences in sampling procedures and other methodological

choices. Glisson's (1996) study evaluated the functioning of children before they entered care, and Thompson and Fuhr's (1992) study measured children who were already in care.

The only significant finding in relationship to demographic factors was that younger children had lower scores on the Externalizing scale than older children. It appears that older children in this sample have more problems with their acting out behavior than younger children. The reasons for this are unclear; age itself is not the reason, since the CBCL is standardized to control for the differences in age related behaviors (Achenbach, 1991).

Perhaps older children are more able to act out if left in their home environments under their parents' supervision. Or, perhaps the older children in this sample had experienced a longer duration of maltreatment, and that experience has had a cumulative effect that increases over time, particularly in reference to acting out behaviors. Or, perhaps because parents are better at reporting externalizing behavior problems (Costello & Angold, 1988), it would be in this measure that such a time effect might be evidenced. It is possible that internalizing problems also increase with age, but that parents are less able to recognize those problems and report them. If this proved to be true, it would be in line with other studies that have found that the duration of abuse is related to increased symptom severity, particularly in sexually abused children (for example, Bagley & Ramsey, 1986; Sirles, Smit & Kusama, 1989; Friedrick, Urquiza, & Beilke, 1986).

This study adds to that rather meager literature on race/ethnicity and child maltreatment. Like the majority of those studies (for example, Mennen, 1995; Wyatt, 1990), this study did not find that race/ethnicity was related to the level of symptoms in maltreated children. Likewise, gender failed to be related to the level of behavior problems in this sample of children.

It is important to note that the type of maltreatment was not related to the level of behavior problems in these children—symptom scores of neglected children were no different than those of children who suffered from active abuse. This is noteworthy because the relationship between neglect and mental health problems has received little attention (Dubowitz, 1994). Thus, these findings add to the growing suspicion that neglect has serious mental health consequences for children, and that much more research is needed on the its psychological and emotional effects.

This study has implications for policy and practice in child welfare. It lends support to the contention that the experience of maltreatment can result in emotional and behavioral problems. Children who also experience the disruption of removal from their own home and

the dislocation of an out-of-home placement may have additional mental health problems beyond the behavioral problems measured by the CBCL. But, the results of this study support the assertion that children under the protection of the child welfare system, whether they are receiving foster care or in-home services, have similar rates of emotional and behavior problems. It is thus likely that it is their shared experience of maltreatment that is related to the similar rates of elevated problem scores.

This finding highlights the need to attend to the emotional and behavioral problems of children in maltreating families receiving in-home services. Unfortunately, child assessment and the treatment of their emotional and behavior problems has often received less emphasis than parental rehabilitation in the provision of public child welfare services when a child is left at home. Many child protective agencies have been primarily parent focused, and have been concerned with increasing parenting skills, improving the physical surroundings, and securing mental health, drug, and alcohol treatment for maltreating parents (Heneghan, Horwitz, & Leventhal, 1996; Schuerman, Rzepnicki, & Littell, 1994). While this continues to be an important aspect of services to these families, the mental health needs of the children must also receive attention since the deleterious effects of maltreatment cannot be ignored.

This is not to suggest that every child who enters the protective service system will need mental health services; in this study, just over half of the children did not have elevated CBCL scores. Rather, it is to suggest that every child who enters this system should be screened for emotional and behavioral problems, and when found, should be offered service to ameliorate problems. The data suggest that in-home child welfare services need to pay greater attention to the children it protects. Perhaps the system has neglected these children because of the urgency of serving parents in order to keep families together, but clearly there is a price to pay for inaction on this front.

The parent-child system is a transactional one—not only does the maltreatment affect the child, but the child's symptoms influence the parents and their interaction with the child (Bronfenbrenner, 1979; Kadushin & Martin, 1981; Walsh, 1996). While it may be the maltreatment that causes the child's emotional and behavior problems, the resulting symptoms may sustain and exacerbate the maltreatment. A behaviorally disordered child may make it very difficult for a parent to employ new discipline measures learned in parenting class. A depressed withdrawn child may make it hard for a neglectful mother to increase her interaction with and care of her child, since difficult children bring out less effective parenting in care givers. Services that address the child's problems (in individual, conjoint, or family treatment) can help remediate the child's symptoms and aid the parent in reacting more appropriately to the child. Research in sexual abuse has confirmed that

both parent and child treatment is more effective than either parent only or child only treatment (Deblinger, Lippmann, Steer, 1996).

Limitations

While this study is important in that it is one of the first to attempt to evaluate the level of problems in children receiving in-home child welfare services, there are a number of limitations that should be noted. First is the measurement of symptoms. The CBCL has a number of advantages that make it appropriate for this kind of study. It is the most common measure employed in measuring child problems making the data easily comparable to other studies, is easy for caretakers to use and understand, is relatively easy to administer, and measures children on a number of dimensions. However, it may not give as accurate an assessment of a child's functioning as desirable. More comprehensive measures, provided by multiple informants, evaluating children on different dimensions of functioning, would give a more comprehensive picture of a child's functioning within the context of a maltreating family (Achenbach, 1995; Meezan & McCroskey, 1997; Pecora, Fraser, Nelson, McCroskey & Meezan, 1995).

Second, the sample size needs to be larger to better allow small differences between groups to emerge when they are present and statistically significant. While relatively large for this kind of study, when comparisons are made between groups, the cells become rather small and may possibly obscure some small but important differences.

Third, this study did not have a measure of the severity of maltreatment that would have helped elucidate the relationship between this dimension and the level of symptoms. It may be that it is the severity of the maltreatment rather than the type of maltreatment that is more related to psychopathology. This is a chronic problem in research on maltreatment and psychopathology and one that needs more attention. The Severity of Maltreatment Scale developed by Barnett, Manly, and Cicchetti (1993) offers promise as a way to attend to this issue but was not available at the time of the study.

Additionally, it should be remembered that maltreating parents, particularly those with high physical abuse potential, perceive and evaluate their children's behavior more negatively than other observers or those with less abuse potential (Kolko, Kazdin, Thomas, & Day, 1993). It is therefore possible that the high frequency of elevated CBCL scores in this study is a result or parental bias rather than problematic behavior. However, it should be remembered that these children's scores are very similar to those of maltreated children in foster care who were evaluated by their foster parents rather than their maltreating care giver (Clausen et al., 1998).

Finally, it should be remembered that it has long been recognized that child maltreatment and child behavior problems are interactional (for an early investigation into this issue, see Kadushin & Martin, 1981). Not only can maltreatment result in children's behavior problems, but difficult children, including those with behavior problems, may generate more abusive and neglectful behaviors from their parents. Thus, the reader is cautioned that a causal link has not been established in this study, and that the correlations reported here are the result of relationships whose directionality has not been established.

Future Directions

The results of this study highlight the need to devote more attention to the problems, treatment, and outcome of children and maltreating families who receive child welfare services in their own homes. This requires more cooperation among researchers, child welfare organizations, government, and private funding sources in developing resources, designing studies, and carrying them out in a way that is both scientifically rigorous and attentive to the realities of practice in a complex system. Not until we are able to meet that challenge will we understand these families, their children, and the most effective ways to help them.

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