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11. Psychology and Child Abuse

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Psychology as a profession is remarkably diverse. Different branches of psychology address themselves to different aspects of human functioning, such as cognition, personality, psychophysiology, and psychopathology. Psychologists may be trained to work as clinicians in hospitals, clinics, schools, industry, and private practice; or as researchers in universities, government agencies, or private consulting firms. This diversity is reflected in the many roles psychologists play in the child abuse field. As researchers, psychologists have contributed substantially to our knowledge of the causes and effects of child abuse. As clinicians, psychologists offer diagnostic insights, particularly through psychological testing and evaluation, and treatment of parents and children.

In this chapter, contributions of clinical psychologists to the evaluation and treatment of abused children and their families will be described. However, since evaluation and treatment are guided by theories of cause and outcome, current understanding of the psychology of the adult who abuses a child, and of the developmental outcome of the child who has been abused will first be reviewed.

PSYCHOLOGICAL CHARACTERISTICS OF ABUSIVE PARENTS

Child abuse is currently thought to arise from several possible sources. Societal factors [25], the physical and social environment [23, 24, 49], characteristics of the child [21, 44], and dysfunction in the parent-child relationship [16, 36, 37, 54] have all been identified as contributing to the incidence of child abuse. But the most abundant literature has been concerned with the psychological characteristics of parents who have abused their children. Kempe's [34] identification of the "battered child syndrome" in 1962 led to a plethora of studies and articles describing the "psychopathology" of abusive parents. In a review of the literature on child abuse, Spinetta and Rigler [59] were critical of these psychoanalytically oriented studies, calling most of them "professional opinions" rather than products of well-designed and reliable research. Their review emphasized the importance of understanding the methods by which data are obtained in order to evaluate whether interpretations and claims made by authors are truly justified. Before some of the major studies and findings about the psychology of parents who abuse their children are reviewed, a variety of research approaches in the field will be analyzed in order to provide some guidance for evaluating the findings of studies reported in the literature, as well as in this chapter.

Research Methods

Investigators basically use two methods to study psychological characteristics: clinical impressions gained from interviews and therapy hours, and standardized instruments, such as questionnaires and psychological tests, where the same tests are given to each participant. There are also two ways of deriving conclusions. The investigator can find common patterns within a selected group, such as a group of parents who have abused their children; or the selected group can be compared with another group that is similar to the selected group in important ways (such as ethnic background, social class, and ages of children) but that does not share the particular characteristic under study (in this example, a history of having abused a child). The investigator can then identify ways in which the selected group is different from this control or comparison group.

A controlled study provides information that is considered more sound than that derived from an uncontrolled study (a study without a comparison group). With an uncontrolled study, patterns found within the selected group can result from factors other than those for which the group was selected. For example, a study finding a high rate of prematurity among abused children might be more fundamentally related to the predominant social class of the group that was studied than to parental dysfunction. In a city hospital where many poor people receive their care and are identified as child abusers, poor people, who are more likely to have children born prematurely, will be studied. If, however, the child-abusing parents were to be compared with another group of parents from the same social class, the investigator would be in a better position to determine whether prematurity is a factor implicated in child abuse, or a concomitant of lower social class status, which is not in itself necessarily related to abusive behavior on the part of the parent. If prematurity were implicated in the etiology of child abuse, one would expect to find a higher rate of prematurity in the child abuse group and a lower rate of prematurity in the comparison group. If prematurity were related to poverty and not by itself associated with child abuse, a comparable rate of prematurity in the comparison group would be expected.

Another issue in evaluating studies is that of numbers and diversity of the people studied. Results of studies on small numbers of people, or with a group in which a particular race, social class, or family type is overrepresented may not be generalizable to larger numbers of people, or to families from differing backgrounds.

Research Findings

Only a few of the studies of the psychological characteristics of people who abuse children

have very small samples or samples from a narrow segment of the population. Yet many of the commonly held beliefs about abusive parents are based on these studies. One widely held belief is that child abuse is a product of parental psychopathology. This belief comes primarily from uncontrolled clinical studies in which the diagnosis was made on the basis of clinical interviews [7, 22, 30, 65], perusals of case records [57] , or test batteries and observations [43, 61, 62, 64]. By the end of the 1960s, the general consensus in the field was that the amount of severe psychopathology among abusive parents was not dissimilar from that in the general population (less than 10% of the total) [60]. A number of characteristics of the parents' childhood histories and current personalities, however, have been consistently cited in the literature.

The most widely accepted characteristic of abusive parents concerns the quality of their childhood homes. Although sound data are difficult to obtain, the prevailing opinion holds that abusive and neglectful parents were raised in abusive and neglectful homes. Their abuse as children is then repeated in the abuse of their own offspring. These parents are thought to continue to bear feelings of anger against their parents, and to be burdened with unresolved needs for nurturance and dependency [9, 29, 45, 61]. The belief that abuse as a child leads to abusive behavior as a parent has been questioned by several thinkers. They point out that this clinical assumption is based on research without comparison groups, and in which abuse and neglect are not consistently defined. They also criticize the retrospective design of the research used to support this formulation [20, 31, 33].

In a retrospective study, in which individuals with the condition under study are questioned about events in their history that may be related to that condition, if a relationship is found between the condition and some particular antecedent event, the assumption is often made that the antecedent event caused the condition. What is missing is an understanding of whether everyone who experiences the antecedent event also experiences the condition under study. The answer can be determined only through a longitudinal study, in which a group of individuals with the antecedent event are followed over time to see if they develop the supposedly subsequent condition. As applied to research on child abuse, the claim that people who abuse children were themselves abused as children is derived from studies that ask abusive parents about their own childhoods, rather than follow abused children into adulthood to see whether they are more likely to abuse their children than other individuals from similar backgrounds who were not themselves abused.

One recent study that lends some greater credence to the hypothesis that events in the parent's childhood are related to abuse of

is also retrospective, it is strengthened by the use of a comparison group. When comparing mothers whose children had been abused (not all subjects had actually abused their children themselves; several had failed to protect their children from abuse or had neglected them) with mothers whose children had not been abused or neglected, Scott found that mothers of abused children were significantly more likely to have been separated from or abused by one or both parents in childhood.

The childhood histories of parents of children who have been abused or neglected have been consistently described as violent, deprived, or both. This characterization raises further questions about the emotional consequences in parenthood of a childhood in which at least some of the individual's needs for nurturance and love have not been met. Indeed, many of the formulations of the psychology of parents who have abused their children is based on the assumption that personality characteristics observed are a consequence of abusive and deprived childhoods. Dependency and unmet dependency needs have been identified as a salient personality characteristic of abusive parents in many studies [9, 17, 20, 29, 61]. Because their own needs have not been met, it is argued, these parents are left with feelings of worthlessness, inadequacy, and accompanying anger [32, 43, 61].

The concept of "role reversal," which has been cited by several authors as a causal factor in child abuse, stems from this cluster of characteristics [45, 62]. Role reversal can be described as the need in dependent and deprived individuals with low self-esteem to look to their children for the love and nurturance they did not receive in their own childhoods, or that they cannot obtain elsewhere. When the child cannot fulfill such needs, the parent considers that the child does not love the parent, and lashes out at the child.

A perhaps related characteristic noted by several investigators is a lack of understanding of the child's capabilities, needs, and perspectives. Abusive parents have been described as treating their children as if they were older, expecting behavioral control and an understanding of right and wrong not possible at the children's developmental level [22, 32, 61]. Other studies report that parents who abuse their children frequently lack an awareness of the effects of mistreatment or neglect on their children [6, 58]. In other words, they fail to comprehend their children's experience from their children's point of view.

Two recent studies have further explored differences in understanding of children and the parental role between parents who have abused or neglected a child and parents from similar backgrounds who do not have such a history. These studies are based on research conducted by the author regarding the nature and development of parental understanding of the child as a person, the parent-child relationship, and parental responsibility [47]. From interview data, four developmental levels into which parental understanding can fall were identified and described. These levels of parental awareness, which characterize increasingly comprehensive and psychologically oriented conceptions of children and the parental role, are defined as follows:

Level 1 *Egoistic orientation.* The parent understands the child as a projection of his or her own experience, and the parental role is organized only around parental wants and needs.

Level 2 *Conventional orientation.* The child is understood in terms of definitions and explanations of children that are externally derived (i.e., influenced by tradition, culture, and "authority"). The parental role is organized around socially defined notions of correct practices and responsibilities.

Level 3 *Subjective-individualistic orientation.* The child is viewed as a unique individual who is understood through the parent-child relationship rather than through external definitions of children. The parental role is organized around identifying and meeting the needs of this particular child, rather than around the fulfillment of predetermined role obligations.

Level 4 *Analytic-systems orientation.* The parent understands the child as a complex and changing psychological self-system. The parent grows in the role, as well as the child, and recognizes that the relationship and the role are built not only on meeting the child's needs, but also on finding ways to balance one's own needs and the child's in order that both can be responsibly met.

In two small controlled studies, the relationship between level of parental awareness and child abuse or neglect was explored. Cook interviewed 8 parents from rural Maine who had a history of protective service involvement for child neglect, and 8 comparison parents [10]. The author examined 8 parents undergoing treatment at a large urban pediatric hospital for problems associated with having abused or severely neglected a child, and 8 comparison parents [47]. With both studies, a strong relationship was found between lower levels of parental awareness and a history of having abused or neglected a child. These studies lend support to the hypothesis that child maltreatment is related at least in part to immaturity of the parent's understanding of the child and of parental responsibility.

A number of other personality characteristics that have been ob-

served in psychological studies of abusive parents are depression [9, 32, 61, 63], hostility accompanied by poor impulse control [9, 17, 29, 32, 61], and paranoid tendencies [9, 61, 65]. Clearly, there is no single "personality profile" of the abusive parent; many psychological factors that influence different people in different ways are implicated in the etiology of child abuse. A sensitive clinician does not bring predetermined stereotypes to his or her examination and treatment, but rather tries to be alert to each individual's characteristics and experiences, and how these operate to strengthen and to weaken family relationships.

THE PSYCHOLOGICAL EFFECTS OF ABUSE ON CHILDREN

The clinical literature on child abuse contains many assumptions about the effects of child abuse on the development of the child. As with the literature on parental psychology, these assumptions are too frequently based on clinical impressions, common wisdom, or poorly designed studies with small samples and no controls or unreliable measures. One of the most pervasive assumptions is that violence against children breeds violent adults. As discussed with parental psychology, retrospective inquiries of abusive parents as well as of adults who have been apprehended for committing violent acts indicate that a large number of these people recall having experienced violence against themselves as children. Other researchers find a positive relationship between high physical punishment of children and the expression of aggressive acts.

Corroboration for these studies is found in recent reports from the Select Committee on Child Abuse of the Legislature of the State of New York [1, 2]. In a study of 4,465 children and siblings who were reported as victims of maltreatment in the early 1950s in 8 New York counties, between 10 and 30 percent were identified in subsequent agency contacts for several categories of juvenile misconduct. In 3 counties, 44 percent of the girls and 35 percent of the boys reported to a court as delinquent or ungovernable had been previously reported as abused or neglected. The disproportionate representation of nonwhites and the prevalence of absent fathers (41%) and mothers (15%), raises the question, however, of the extent to which the preferential selection of poor children both for reporting for maltreatment and for delinquency may have affected the perceived association, and the extent to which poverty per se may have determined both problems. Because it is uncontrolled, we cannot determine from this study whether the proportion of mistreated children identified for juvenile misconduct is significantly different from that of children from similar backgrounds who are not known to have been mistreated.

A recent small but controlled study sheds some more light on the relationship between abuse and aggression in the child [49]. In this study, aggressive fantasies as well as overt aggressive acts in the classroom and on the playground were examined in 20 children who had been abused, 16 children who had a history of neglect, and 22 matched controls. The abused children had significantly more aggressive fantasies than the children in the other two groups, as well as more aggressive behavior during free play. Both the abused and neglected children were rated higher than the comparison children on aggressive behavior in the classroom. This study adds further support to the argument that experiencing abuse leads to aggression; however, the association between neglect and aggression in the classroom suggests that the relationship is more complex than the "violence begets violence" notion. The experience of deprivation or lack of parental nurturance, as well as the experience of violence, may be importantly implicated in subsequent aggression on the part of the child.

In a controlled retrospective follow-up study of abused and grossly neglected children, Kent found that the neglected children were described as even more aggressive than the abused children [35]. Further, follow-up of intervention indicated that the management of aggression improved in the abused group, but little change occurred in the neglected group, although there was improvement on nearly all other problem behaviors, such as emotional withdrawal. Violence may not simply be a "learned" phenomenon, but also an expression of the sense of helplessness and despair that may accompany either abuse or neglect. In an attempt to explain aggression in children who have been abused, Young offered a psychoanalytic formulation [65]. Of Young's total sample, 41 percent of the school-age children had records of truancy, and 8 percent were considered delinquent. She found that activities or contacts with other children or expressions of individuality seemed denied to the victims of abuse under study. Withdrawn from contacts and experiences that might show how all families were not like their own, the children seemed to settle on the conviction that they were "bad." She reasoned that this conclusion may have been the only possible explanation of their environment, and their lack of self-esteem was then translated into acts that were, indeed, socially unacceptable.

Aggression is but one of the characteristics that have been studied in abused children [51]. Significant differences have been found in intelligence test scores between children who had been abused or neglected and matched controls. Kent found developmental and persistent language delays in abused and neglected children relative to standardized norms and a matched comparison group [35]. Appelbaum found significant differences in developmental functioning

when comparing abused and nonabused infants, which could be detected as early as 4 months [5].

Several researchers have followed abused children longitudinally. Although these studies suffer from methodological problems, such as small sample sizes or lack of matched comparison populations, they share several important observations. In a 3-year follow-up of 21 abused and neglected children, Morse, Sahler, and Friedman found that only 6 were within normal limits intellectually and emotionally at the time of follow-up [46]. The remaining 15 children were judged to be mentally retarded, and 6 of these were also considered emotionally disturbed. The majority of children who appeared to be developing normally seemed to share good mother-child relationships, as perceived by the mother, during the follow-up interviews. In contrast, the mothers of the children who were judged emotionally disturbed reported poor mother-child relationships. The lack of premorbidity data and a control population limits the confidence with which one can infer a causal relationship between maternally reported mother-child relationships and the psychological status of the child at follow-up, or a causal relationship between child abuse and mental retardation. One does not know whether these children "triggered off" abusive behavior in vulnerable parents because they were retarded and hence more difficult to begin with; or whether their morbidity derived from lack of parental care or the physical trauma itself.

Martin [41] followed 42 abused children during a 3-year period. This study indicated that the critical factor in the subsequent development of these children was the type and quality of intervention once the diagnosis of abuse was made and confirmed. When initially examined, 33 percent of the children were found to be mentally retarded, 38 percent showed language delay, 33 percent showed failure to thrive, and 43 percent had neurological sequelae. Most of the children were fearful, withdrawn, and uncooperative. With removal from the family to a foster home, some children showed marked improvement in intellectual functioning, and language and motor abilities. Certain stable personality deviations appeared to remain with the children, however, despite the quality of the foster homes. The children did not seem to have a strong sense of themselves to monitor their behavior, but searched out people and situations around them for the proper responses. They related to people agreeably but superficially.

The only method of intervention referred to in the preceding studies is removal of the child from the home, although separating the child from the family is acknowledged by these investigators not to be a happy solution. In some situations, removal from the home is necessary, but in others, the more humane and effective intervention may be attending to the needs of the family as a unit and ameliorating the destructive effects on family interaction of physical illness, and psychological and environmental stress, while working to strengthen the family's acceptance of the child and its ability to cope with stress.

Although the effects of foster placement on children's intellectual and emotional development are not yet completely understood, responsible critics of the child placement system suggest that a child with handicaps, as many abused children seem to have, is likely to have a succession of foster homes, many of which are not considered optimal nurturing environments by even the Welfare Department that places the children. Social case work by overburdened workers is rarely adequate either for the biological parents, who need to be prepared for the return of their child, or for the foster parents, who are frequently overburdened with charges, many of whom have special needs [27]. The effects of the resultant separation (or separations) and discontinuities of care for the child can be grave. "Multiple placement puts many children beyond the reach of educational influence and becomes the direct cause of behavior which the school experiences as disrupting and the courts label as dissocial, delinquent, or even criminal" [26].

In Martin's study of the developmental consequences of abuse, intervention is defined as removal to a foster home [40]. The reported persistent personality deviations, despite intellectual, language, and motor gains, may be as much a function of that removal and separation as of the abuse. Intervention directed toward strengthening the families of some of the children, where that would have been possible, rather than removing them, might perhaps have helped these children develop a stronger sense of themselves.

The recent contributions of Elmer bring into focus the limited state of our understanding of the long-term effects of child maltreatment [13, 14]. Elmer's "follow-up study" (her characterization) was composed of 17 abused children and 17 children who were victims of accidents, matched on age, sex, race, and socioeconomic status of their families. Each of these "traumatized" groups was matched on these variables with a group of hospitalized children who had not suffered early trauma. Nine still intact "abusive families" were identified from the original case pool and studied intensively in regard to the stability of demographic characteristics, indices of personal and social support for parents and children, the mother's behavior in relation to the child, and the following attributes of the children: health; language and hearing; perceptual-motor coordination; school ability and achievement; and behavior, focusing especially on impulsiveness, aggression, and empathy.

A startling paucity of case control differences was found. A high prevalence of physical, developmental, and emotional disability was found in all three groups. These findings suggest that we must attend to the social and familial circumstances that equally affected the outcomes of cases and controls. The study concludes "that the effects on child development of lower-class membership may be as powerful as abuse."

Elmer's study suggests that neither health nor social intervention alone will allay the developmental impact of abuse or poverty, for both the case and the control groups suffered impressive developmental losses despite the provision of medical and social services.

This is not to say, however, that abuse or poverty dooms a child to failure. If the child and the family have available and can participate in several well-conceived and administered intervention opportunities, the child's prospect for healthy psychological growth is enhanced. Harold Martin points out, "We have especially focused on treatment for developmental delays and deficits, crisis care, psychotherapy and preschool or day care. . . . These various treatment modalities for the child have worked. They have made possible considerable growth and development in the abused child. They should be considered as treatment options for all abused children" [42].

THE ROLE OF THE CHILD IN CHILD ABUSE

Because the children in most of the studies concerning the effects of abuse were identified following abuse, it is difficult to tease apart the issue of cause and effect when looking at subsequent functioning. A natural assumption is that the abuse caused the disabilities observed. A plausible rival explanation is that children with developmental disabilities create stress in vulnerable families, which contributes to their abuse. The role of the child in child abuse is only recently being considered by investigators although it was suggested as early as 1964 by Milowe and Lourie, who noted that certain characteristics of the child may place added stress on the parent and thus act as a precipitating agent [44].

Among the characteristics noted have been physical handicaps, mental retardation, and difficult temperament [21]. The association of child abuse and prematurity has been reported frequently in the literature. The incidence of prematurity in children who have been abused has been reported in various studies as around twice that of the average in the geographic areas from which the samples came [15, 18, 37, 41]. It must be remembered, however, that parents who share other characteristics frequently linked to abuse, such as poverty, lack of mobility, and isolation, that may result in poor access to prenatal care, are also more likely to have children born prematurely [48]. In other words, prematurity may be part of a constellation of factors that are related to each other and to abuse.

An important clue toward understanding the relationship between prematurity and child abuse has been offered in a study by Faranoff, Kennell, and Klaus, who analyzed the frequency of visits between 146 mothers and their premature infants [16]. They noted how often the mothers visited their babies during a 2-week period, and then followed the families from 6 months to 2 years after the babies were discharged from the hospital. From this group, 11 babies were either abused or failed to thrive; of these infants, 9 had mothers who were in the group of 36 mothers who visited least frequently. In other words, 82 percent of the abused or failing-to-thrive babies, in contrast to 20 percent of the other premature babies, had mothers who visited fewer than 3 times during the 2 weeks. Of the 36 mothers who visited least frequently, 25 percent had infants who were abused or failed to thrive; the babies of only 2 percent of the mothers who visited more frequently were from this group. This study indicated that prematurity does not predict abuse, nor does infrequent contact. But infrequent contact between a premature baby and the mother increases the likelihood that dysfunction in the parent-child relationship will occur; conversely, in those relationships where dysfunction has occurred, a lack of contact appears to be implicated.

The importance of contact between infant and parent, and the subsequent establishment of a bond of attachment, has been the subject of new interest in the child abuse field. Studies of animal infants and their mothers as well as of human infants and their parents indicate that, with sufficient interaction, an attachment will occur between the infant and the principal caregiver [8]. This attachment on the part of the infant means that the infant will direct attention preferentially to the object of attachment, which is usually, but not always, the mother. When frightened or in distress, the infant will seek the mother. When the infant is stimulated and excited, the mother's face will be the recipient of the smiles and cries. Human babies attach to their fathers, too, but not usually with the same intensity. This process of contact and interaction also attaches the mother (and father) to the baby. The baby's responsiveness to parental handling and care rewards the parent's actions, and serves to maintain the closeness of their reciprocal bond. The biological function of attachment is thought to be the maintainance of proximity of mother to child, and the protection of the child [8].

The closeness of parents and children in different cultures, and within the cultures and families found in the United States, varies tremendously. There appears, however, to be some evidence that

failures of attachment might figure importantly in child abuse. Retrospective studies have noted a higher than expected proportion of separations between abused children and their mothers, and between mothers of abused children and *their* mothers [37, 54]. Separations may make it more difficult for the mother to attach to her baby and for her baby to attach to her, and for them to develop a pattern of mutually rewarding and reciprocal actions and responses. Difficulties in attachment may also result from developmental immaturity where the child has either difficulty establishing patterns and rhythms that the parent can "read" and tune into, or handicaps that limit the baby's capacity to respond to the parent. And when the mother is not rewarded by the child's responses, or when she has difficulty responding to the child, separations may be more likely to occur.

Lack of consideration of fathers is a serious deficiency in the child abuse literature. One must wonder whether the father's greater emotional distance from the child in our culture, and the high prevalence of stepparenting where the stepfather commonly has not had an opportunity to develop early and close bonds with the child, may also contribute to abusive behavior by men toward children in their care.

THE ROLE OF THE PSYCHOLOGIST IN THE DIAGNOSIS AND TREATMENT OF CHILD ABUSE

The essential message of the preceding review is that the psychological determinants and consequences of child abuse are complex and various, and each family must be understood in terms of its own realities and characteristics. The job of the psychologist is just that: to clarify and enhance the functioning of individuals in their contexts.

Research into the causes and effects of abuse permits the psychologist and other clinicians to generate hypotheses and to focus inquiry when evaluating and treating families and children. Research seeks to find common patterns among individuals sharing a syndrome or experience. In contrast, the task of the clinical psychologist is to understand particular individuals in a particular family with its personal realities, and to apply techniques to effect desired personality or behavioral changes.

The clinical psychologist has two major roles: evaluation and treatment.

Evaluation

The psychologist's observations of the child and the parent can be very helpful in contributing to a better understanding of the nature of the home and community environment; the personality of the parent, and the capacity for and likelihood of change; and the social, emotional, and developmental status of the child. Information can be gathered by the psychologist for the purpose of evaluation in several ways, the most common of which are diagnostic interviews with the parent, interviews or play sessions with the child, family interviews, and diagnostic testing.

Diagnostic testing is the psychologist's unique contribution to the understanding and treatment of child abuse [4, 53]. Psychologists can test both adults and children, although some specialize in work with either children or adults. Psychological testing is a form of clinical assessment. The information gathered from it is not necessarily different from that gathered from extensive clinical interviews or during therapy. What differs are the methods and tools for collecting the information. The tools of the examining psychologist are standardized tests, which, by their uniformity, enable the clinician to compare the patient's responses with established norms, and to have more reasonable confidence that the diagnostic conclusions reflect the patient's competence and personality and not the diagnostician's selective questions or interpretive slant. Each test presents a problem or set of problems to be resolved. Consistent ways in which the individual responds to and solves the problems posed by the tests are thought to inform us about how that individual would be likely to function when faced with tasks and problems of life that share common properties with those on the tests.

In general, psychologists employ a *battery* of tests; that is, a variety of tests that tap different aspects of functioning, including cognitive functioning (how one regards and understands the world), affective functioning (emotions and fantasies), adaptive functioning (how feelings and skills are employed to deal with the challenges and tasks life presents to an individual), and pathological functioning (ways in which the individual's internal conflicts and drives distort or overwhelm the ability to deal effectively with the demands of external reality).

There are several reasons for using a battery of tests rather than one or two. Since it permits an assessment of many aspects of functioning and their interaction, the test battery enables the psychologist to discern how pervasive problems in adjustment might be. By using different kinds of tests, from highly structured tests for which there are correct answers to every question to highly unstructured tests in which the nature of the task is ambiguous and the patient must create his or her own sense out of the material, the psychologist is able to look not only at the adequacy of the examinee's responses but also at the circumstances under which the individual is able to function more and less adequately.

To provide a clearer idea of how psychological testing operates,

let us take a hypothetical example. A pediatrician has asked a psychologist to evaluate a father who came to his office greatly distressed because he loses control when his 2½-year-old child soils, eats messily, or does not stop crying. The father is concerned that he might seriously hurt his child. The psychologist gave Mr. Smith a test battery that included an intelligence test (which has correct answers and clear expectations), a Thematic Apperception Test (telling stories to pictures), and a Rorschach test (finding images in inkblots). The Thematic Apperception Test (TAT) and the Rorschach test are frequently used "unstructured" tests through which the individual is thought to reveal his or her inner thoughts, feelings, and style in the stories or images. The psychologist found that Mr. Smith scored quite well on the structured intelligence test but that, when asked to tell stories on the TAT cards or to find images in the Rorschach cards, his performance was considerably less adequate. He seemed to shut himself off from the tasks, telling very minimal stories with little detail, or seeing only the most obvious features on the Rorschach cards. When he came to the last three Rorschach cards, which were colored, he became quite anxious and gave very few responses, except on the last card about which he offered several descriptions that did not fit the blot very well. As color on the Rorschach cards is thought to stimulate strong emotions, Mr. Smith's response should suggest that, when his emotions are stimulated, he may not be able to keep them well enough under control to attend successfully to the task in front of him (in this case, finding a good image to fit the blot). His sparse stories and images in general on the unstructured tests indicate that he tries to keep himself functioning with good control by avoiding experiences that may stimulate emotions. For the most part, avoidance may be a wise way for Mr. Smith to cope with his particular vulnerability; we could see from his Rorschach test performance that the cost for him of emotional involvement can be the loss of some control over his impulses (his response to the final card reflected more the push of his internal feelings and impulses than the shape of the inkblot). In situations where expectations are clear and well defined, as Mr. Smith's good performance on the intelligence test suggests, he may function well.

Parenting a 2-year-old, however, is not a clear and well-defined task. When Mr. Smith is home with a messy, cranky, and incontinent 2-year-old, he does not have the right answers, and yet he cannot always avoid being with his son. Consequently, he risks losing control of his angry feelings.

The insights offered by the diagnostic evaluation might translate into a program for Mr. Smith that would build on his motivation to improve and his capacity to function rationally and well in a structured situation, where he knows or can learn answers to a problem. Some parent education on the part of a pediatrician, therapist, or parents' group might provide Mr. Smith with knowledge of expectable child behavior, so that he could put his rational skills to use in justifying his child's actions to himself. He might profit from help in learning to apply specific child management skills. Also, since the testing material indicated that when his coping strategies fail, he has difficulty on his own achieving sufficient control to do what is asked of him (e.g., finding an image that fits an inkblot; handling his child without hurting him), he may need someone "on call" to turn to at those times when knowledge and techniques are not enough. With individual therapy, Mr. Smith may be able to achieve some insight into the origins of his vulnerability and achieve some greater harmony between the pressure of his impulses and emotions and his responsibility to his child to maintain control and be an understanding and protecting father.

What is learned from psychological testing depends on the questions asked about an individual, the tests used to answer those questions, and, of course, the skill of the examiner as administrator and interpreter of the test material. Psychological testing can address the following kinds of questions about an individual:

1. What are the intellectual strengths and limitations (capabilities and overall achievements)?
2. Is there evidence for neurological immaturity or impairment?
3. What is the nature of past knowledge and achievements, interests, and aptitudes?
4. How adequate is reality testing (how accurately the individual perceives what others commonly perceive)?
5. What is the quality of interpersonal relationships?
6. What are the adaptive strengths (application of assets and liabilities to new problems; flexibility of approach, persistence, frustration tolerance, reaction to novelty)?
7. To what degree are impulses maintained under control (undercontrolled, overcontrolled)?
8. How does the person defend psychologically (protect the self from feelings, ideas, and experiences that create anxiety through avoidance, repression, and so on) against unacceptable internal needs and demands, or external experiences? How rigid are his or her defenses?
9. What are the areas of conflict?

When making a referral for psychological testing, the pediatrician must think carefully about the questions he or she wishes to have addressed. This information will guide the psychologist in choosing the appropriate tests, and focus the inquiry and analysis on those

issues that are of the most importance in further planning. A referral note is most helpful if it contains pertinent background information as well as the important questions to be answered.

These questions are addressed by a variety of observations and information gathered during the testing sessions. Data include test scores (relative to established norms); the contents or themes of the examinee's responses (what he or she consistently talks about when telling stories or finding pictures in inkblots); the emotions the person displays when responding, including his or her attitude toward the testing and particular aspects of the testing; and the interpersonal relationship the respondent initiates with the examiner.

Although diagnostic testing is not and should not be routine, it can be an important adjunct in the initial stages of management and decision making. Testing is not used as a basis for deciding whether or not to report suspected child abuse. Referrals for diagnostic testing and the testing itself take more time than is appropriate or allowed in most states. Rather, testing can be used to augment the collection of data about the current ability of a parent to nurture and protect a child, the parent's capacity for and motivation to change, and how change toward better functioning as a parent might best be effected. Data about the developmental status and psychological functioning of the child are also important for making management and treatment decisions about both the parent and the child.

When case histories and interviews supply adequate and consistent information, on the basis of which clinical and therapeutic decisions can be made, psychological testing is not usually indicated. A referral for psychological testing is appropriate when the information available is inadequate or inconsistent. In cases of child abuse, in which the clinical issues are likely to be unusually complex, and decision making particularly onerous, psychological testing serves to do more than clarify issues. Additional data which confirm the impressions of other professionals involved may enable them to feel more confident that their observations are accurate and their action judgments justified.

When testing is complete (a process that may take several weeks), the psychologist writes a report containing the following information: tests administered; observations regarding behavior and attitudes toward the various test experiences and toward the examiner; test results on individual tests and what they mean; areas of conflict; a summary description of the personality of the patient, for instance, how the patient copes with the limitations and possibilities of his or her environment and abilities; evidence for particular strengths, pathology, or both in that coping process; and how inner forces and reality demands are interwoven and managed. Sufficient illustrative material should be included to provide a sense of the data from which these formulations, as well as recommendations for further evaluation or treatment, are derived.

The purpose of diagnostic testing is to understand the person better, not simply to attach a diagnostic label or category. Diagnostic labels are summary statements suggesting certain psychological processes within the individual, whereas a good diagnostic evaluation attempts to clarify and specify the psychological processes that are typical of the way an individual adapts to life's various demands [3]. In the evaluation of an abusive adult, the psychologist's report will not necessarily enable a prediction of whether that individual will continue to abuse a child, but will provide a description of the individual that can enrich and extend our understanding, and clarify dimensions that were not previously considered or available.

Psychological Intervention

Psychologists practice many different approaches to treatment, from behavior modification to play therapy to family therapy to one-to-one therapeutic conversations between therapist and patient. In general, psychological intervention as applied in cases of child abuse has not differed substantively from that practiced by psychiatrists and psychiatric social workers. Psychologists may work with adults and children individually, in family or subfamily units, or in groups. Through the therapeutic process, the psychologist strives to reduce the patient's sense of isolation and to enable the patient to examine experiences, feelings, and behavior in order to achieve better control and to make acceptable choices about actions under circumstances that have triggered undesirable responses in the past. The psychologist may also help a parent to develop skills in managing the child and achieving an understanding of the child's needs and capabilities. Helping the client to change the environment and to cope more effectively with those aspects of the environment that cannot be changed may also be an emphasis of the therapeutic process. The therapist also may provide structure for the parent, a set of rules concerning acceptable and unacceptable behavior toward the child, while working toward change in the parent so that standards for parental behavior become internalized.

If the child is placed in foster care, it is important to recognize that the foster parents may also need help in understanding and nurturing the child. Abused children often are slow to develop trust in other adults, and may be fearful, withdrawn, or aggressive. With adequate support, which can be offered by a psychologist perhaps in conjunction with psychological treatment for the child, foster parents can be helped to understand better the child's behavior and re-

actions, and their own reactions toward the child. Foster parents may become discouraged by the child's slow progress, and blame themselves or feel anger at the child for failing to respond adequately to their care. Such work with foster parents may help to avoid the breakdowns in foster placements that result in multiple placements for the child [38].

The most important intervention for children who have been abused is the provision or reestablishment of a stable and nurturant home. It is sometimes appropriate, however, to provide psychological treatment for the child. As with parents, abused children vary greatly in their physical and emotional status. No one psychological pattern seems typical, and the psychologist must tailor evaluation and treatment to the particular needs of each child and family. In general, the psychologist must attend to several dimensions of the child's functioning, including the child's developmental status motorically, intellectually, linguistically, and socially. Developmental delays may need to be addressed through specialized intervention programs or activities designed to enhance development that are integrated into the therapeutic process.

Of particular concern regarding abused children is that, owing to the frequently unpredictable nature of their home environment, a sense of trust in adults may be compromised. In therapy, the child experiences a consistent and accepting relationship with an adult. A model is provided for a relationship that the child may never have experienced before. The child is valued and accepted, regardless of the behavior he or she brings to therapy, although the behavior may be controlled. Additionally, through play or talk, the child has an opportunity to express fears, dreams, and conflicts, which are respected and attended to. Through the process of expression and recognition the child can relieve the intense pressure of keeping feelings hidden both from others and the self.

Of particular importance when working with children is to work at the same time with the parents or caregivers. A second clinician may assume this function or it may be achieved with family therapy. Working with the child alone is simply not sufficient. The direction of a child's growth is in large part a function of the environment within which the child must adapt and interact, and the capacity of that environment to facilitate or inhibit growth. Caregivers can be helped to create a more optimal nurturing environment for the child, and to understand better the needs and capabilities of the child as well as the limits and extent of their responsibilities. Their own needs, both practical and emotional, must be addressed so that they will be better equipped to meet the needs of the child. Through collaboration between caregiver and clinician, the therapeutic environment may be extended from the office into the home.

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