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PHYSICAL CHILD ABUSE:
A COMPREHENSIVE FAMILY BASED APPROCH TO TREATMENT

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ABSTRACT

Physical abuse within the family may be conceptualized as the outcome of a complex process in which a child with particular characteristics which rendered him or her vulnerable to abuse, is injured by a parent involved in an ongoing problematic behaviour pattern, subserved by particular belief systems and constrained by historical, contextual and constitutional predisposing factors. When families are referred by statutory child protection agencies to therapy services for treatment, initially a contract for comprehensive assessment should be established with the family and referrer. Assessment should involve interviews with all members of the child system and should cover relevant risk and protective factors and a verbal reconstruction of the abusive incident. A contract for treatment may be offered if the assessment shows that the parents accept responsibility for the abuse, are committed to meeting their child's needs, are committed to improving their own psychological well-being and where they have the ability to change. Treatment should be based on clear contracts to meet specific targets. Treatment and case management plans involve a central focus on improving parent-child interaction through direct work with parents and children together. This may be supplemented with couples work, interventions in the wider system and individual work for parents focusing on parent-craft and the management of personal difficulties such as mood and anger regulation. Children may also receive input in therapeutic pre-school placements.

INTRODUCTION

Physical abuse refers to deliberately inflicted injury or deliberate attempts to poison a child. Physical abuse is usually intrafamilial and may occur alone or in conjunction with sexual abuse, neglect or emotional abuse (Belsky, 1993). A systemic model for conceptualizing these types of problems and a comprehensive family based approach to therapy with these cases will be given in this paper. Estimates of the prevalence of physical child abuse depend upon the definition used. If all case of corporal punishment are classified, then the incidence is over 60% (Gelles, 1987). If only serious injuries identified by casualty departments are included then the figure would be under 1%. Gelles (1987) found a national annual incidence of 10.7% in the US for a definition of physical child abuse that excluded routine corporal punishment.

SYSTEMIC MODEL OF PHYSICAL CHILD ABUSE

For both clinicians and researchers, single factor models of physical abuse which focus on either characteristics of the child, characteristics of the parents or features of the family's social context, have now largely been superceded by complex systemic models (Belsky, 1993; Cicchetti & Toth, 1995, Kolko, 1996; Stevenson, 1999). Within such models, physical abuse is conceptualized as the outcome of a complex process in which a child with particular characteristics which rendered him or her vulnerable to abuse, was injured by a parent involved in an ongoing problematic behaviour pattern, suserved by particular belief systems and constrained by historical, contextual and constitutional factors. For example, a child may be vulnerable to physical abuse because his difficult temperament overtaxes his parents limited coping resources. The parent may become involved in coercive cycles of interaction with the child and come to believe that the child is purposely trying to punish the parent. Historical factors such as personal abuse in childhood; contextual factors such as high stress and low marital support; and constitutional factors such as vulnerability to depression may constrain the parent from finding alternatives to these destructive belief systems and behaviour patterns which ultimately culminate in the parent injuring the child.

Behaviour patterns and beliefs

Most abusive episodes occur in response to a triggering behaviour by the child which the parent experiences as aversive such as crying, wetting, refusing to eat, stealing, lying or aggression. Most abusive incidents are disciplinary encounters between parents and children, where parents use physical punishment in response to a child's trigger behaviour. The parent intends to punish the child for wrong-doing and uses physical punishment since this is their typical method of disciplining children. However, the punishment is severe because of the high level of anger and the lack of inhibition. The high level of anger which fuels the parents abusive act is determined by the parent's arousal level and the parent's beliefs about the child's trigger behaviour. If the parent's level of anger before the trigger behaviour is high, then this may be displaced on to the child. Parents who have been involved in a marital conflict or a stressful conflict with someone in their work situation, extended family or community may displace their anger into their punishment of the child. In other situations

where the parents have been involved in a repetitive escalating cycle of stressful conflict with the child, the trigger behaviour may the last straw in this escalating negative interaction pattern.

Prior to an abusive act, the parent typically believes that the child's behaviour is intentionally negative and this belief system leads to the high level of anger. Parents who physically abuse their children fail to inhibit the extreme anger they experience in response to the child's trigger behaviour. Parent's who do not abuse their children empathize with the child's position or use self-talk to control their tempers. Parent's who abuse their children have difficulty empathizing with children and may use self-talk to justify their anger. The escalating severity of physical punishment which precedes abuse may desensitize parents to the dangerousness of their actions which culminate in a serious injury.

Predisposing historical contextual and constitutional factors

A range of historical, contextual and constitutional factors associated with the child, the parents, the parent-child relationship, the marriage and the family's social network may predispose families to the occurrence of physical child abuse

Predisposing child factors. The following child characteristics are risk factors for physical abuse since they place additional demands upon parents: being under 5, prematurity, low birth weight, developmental delays, frequent illness, difficult temperament and oppositional or aggressive behaviour

Predisposing parent factors. Personal characteristics of the parents may place them at risk for physically abusing their children. Young parents are more likely to abuse their children than older parents. Physical abuse is more commonly carried out by mothers, but fathers may be more likely to abuse their children when considered from the point of view of opportunities, i.e., acts of physical abuse per hour of time they spend in the role of the child's primary caretaker.

Parents from families with pro-aggressive attitudes are more likely to abuse their children. About a third of parents who were abused as children go on to abuse their offspring. Psychological problems including depression, borderline personality disorder and substance abuse, are more common among parents who abuse their children than those that do not. Poor emotional regulation and poor empathy skills are two of the most important components of these broader psychological disorders from the point of view of increasing risk. Poor empathy skills, are a particular handicap for parents since sensitive parenting necessitates reading the child's signals and inferring the child's emotional state. Poor personal emotional regulation is also a handicap because parents may have difficulty prioritizing the need to respond to the child in a way that regulates the child's emotional state since they are unable to carry out this function for themselves. Rather they find themselves descending into a pit of depression or flying into a rage of anger and feel powerless to regulate these extreme emotional states. They also have difficulty reducing stresses associated with the wider social context in which they live. These include, crowding, social isolation and financial problems.

Predisposing historical parent-child relationship factors. The parent-child relationship in cases of physical abuse is typically conflictual. Many parents who physically abuse their children have not experienced parental sensitivity to their needs, so these parents therefore have no mental model

to use as a basis for responding sensitively to their own children's needs. Abusive parents' set unrealistically high standards for young children's behaviour and attribute their children's demanding or difficult behaviours to the child's intentional defiance.

Behaviour patterns involving parents and their abused children are typified by a high rate negative exchanges and disciplinary encounters which escalate in severity. Parents who abuse their children control by punishment, not praise, and the punishments which are often severe, are out of all proportion to the child's transgression of the parent's rules for good conduct. In families where abuse occurs, children do not respond consistently to such parental control. Parents become frustrated by this ineffectiveness but have difficulty analyzing why their approach to parenting is ineffective. They also have difficulty generating and testing out alternative solutions

Predisposing marital factors. Conflict, instability, dissatisfaction, negative behaviour patterns, negative narratives and belief systems and poor communication and problem solving skills are the main features of the marital relationship which place youngsters at risk for physical abuse. Unresolved marital conflict is very common among parents who physically abuse their children. Conflict underpins the structural instability in these relationships which are characterized by a history of multiple separations and a low level of commitment. Low satisfaction is another feature of these relationships. Partners have difficulty meeting each others needs for an acceptable level of intimacy and an equitable distribution of power. Conflict about intimacy often centers on the women in these relationships demanding more psychological intimacy and the men demanding more physical intimacy. Conflict about power may emerge in discussions about the division of labor within the household and about the way money is used.

These conflicts often remain unresolved because the couples lack the communication and joint problem-solving skills necessary for negotiation. These couples have difficulty conceptualizing a conflict being resolved to the satisfaction of both parties (i.e. a win-win resolution). Partners in these marriages may also selectively attend to negative aspects of each others behaviour and attribute vindictive intentions to their partners for many mildly irritating behaviours. This negative way of thinking along with the belief that in any negotiation there must be a winner and loser in turn promotes negative behaviour patterns. These patterns of interaction are characterized by blaming rather than empathy and escalating negative exchanges rather than positive exchanges. These negative exchanges may escalate into physical violence.

Violent abusive marital relationships and violent parent-child relationships may be two aspects of a violent family culture. Within this type of culture couples are more likely to work on a short term quid-pro-quo system, not a long term goodwill system. Often the child is triangulated into negative exchanges between the parents. For example, a father may refuse to feed or change the child or tolerate the child's crying because the mother has not met the father's need for power or intimacy**.**

Predisposing network factors. Low socio-economic status, poverty, unemployment, poor housing, single parenthood and a low educational level are all risk factors child abuse. Parental isolation and a low level of social support are also associated with physical child abuse. Parental

isolation often includes isolation from the parents' families of origin. This isolation may be associated with unresolved conflicts between the parents and the grandparents of the abused child. So, it is not only the case that the grandparents may be unavailable as a source of support, but they also may be perceived as a potential threat or source of stress.

A variety of environmental stresses, most notably crowding and inadequate housing are associated with child abuse. Remaining with a crying child in a cramped living quarters requires considerable frustration-tolerance and so it is understandable that crowding may be one of the factors that sets the stage for the occurrence of abuse.

Effects of physical child abuse

Physical child abuse has short and long-term physical and psychological consequences (Cicchetti & Toth, 1994; Malinosky-Rummell & Hansen, 1993).The physical consequences of abuse include disfigurement, neurological damage and stunted growth. The short-term psychological consequences include developmental delays, conduct and emotional problems, and relationship difficulties. For a proportion of physically abused children their behavioural, emotional and relationship difficulties persist into adulthood. The majority of physically abused children do not develop serious long-term problems. For those that do, the difficulties are related to the frequency and severity of abuse, the co-occurrence of neglect or emotional abuse and the number of risk factors present. These risk factors, detailed above include parental adjustment problems, child adjustment problems, problematic parent-child relationships; marital discord and high levels of family stress with low social support. Poor long-term adjustment is also associated with multiplacement experiences and protracted legal proceedings arising from involvement in statutory child protection procedures.

Protective factors

Not all children develop serious long-term problems as a result of abuse (Cicchetti & Toth, 1994; Malinosky-Rummell & Hansen, 1993). Children who are abused before the age of 5 and who do not sustain neurological damage tend to be more resilient, as do children with high ability levels, an easy temperament, and the capacity and opportunity to form socially supportive relationships with adults in the extended family and elsewhere despite the abuse. If parents have some capacity to empathize with their child, regulate their emotions and a willingness to develop accurate knowledge and expectations about child development, then this is also protective factor. Secure parent-child attachment and a stable satisfying marital relationship or the potential to develop these are protective factors too. Where families are embedded in social networks that provide a high level of support and place few stressful demands on family members, then it is less likely that parents' resources for child care will become depleted and abuse will occur. The availability of a well resourced preschool placement may also be viewed as a protective factor. Within the professional network good co-ordination of multi-professional input is an important protective factor also.

FAMILY BASED TREATMENT FOR PHYSICAL CHILD ABUSE

In families where physical child abuse has occurred effective family based treatment programmes, while premised on a broad based assessment, focus on very specific parenting problems, with one target being tackled at time using systematic behavioural and systemic treatment principles (Nichol, Smith & Kay et al, 1988; Brunk, Henggeler & Whelan, 1987; Browne & Herbert, 1997; Dale, 1986).

Contracting for assessment

Family based treatment may be used to help families in which physical abuse has occurred to reduce the risks of further abuse. Planning who to invite to intake interviews in such cases is a complex matter, especially where the child has been taken into statutory care following the abuse. Ideally, the statutory child-protection professional (usually a social worker) should be invited, along with the child's parents and the foster parents or child care workers if the child is in statutory foster or residential care.

The aim of the initial contracting meeting is to form a contract for assessment. Usually, the statutory child-protection worker is the main customer for change. This worker commonly wants help with reducing the risk of further abuse, and reintegrating the child from the temporary foster care placement back into the natural family. It is not unusual for the parents to be very ambivalent about treatment and to view the therapist as a potential threat: as another professional who is going to prevent them from retrieving custody of their child. Foster parents or care workers who are providing the child with short-term care in some instances are sympathetic towards the parents and wish to see the child re-united with them. In other instances, they are critical of the parents and want the child to remain in care for the long term. With these three different agenda's running (those of the child-protection worker, the parents, and the foster parents or care workers) the potential for conflict and confusion is very high. The key to therapeutic progress is to establish a very clear contract and not to begin assessment work with the family until the contract is crystal clear.

The outcome of the contracting meeting should be that the statutory child protection worker is viewed as enlisting the aid of the family therapy agency to help the family reduce the risk of further violence, so that the child may be returned to the custody of the parents. The parents may acknowledge their ambivalence but agree to attend therapy because they want to regain custody of their child. The foster parents or child-care workers should agree to facilitate regular and frequent supervised access between the parents and the child. Finally, agreement should be made to reconvene after a family assessment has been conducted to give feedback on whether or not the family therapy service judge the family to be suitable for family treatment.

Insert Figures 1,2 and 3 about here

Assessment

Assessment of families where physical child abuse has occurred with a view to offering family based treatment is a complex process (Reder & Lucey, 1995). To illustrate the processes of assessment

and treatment, a case example is given in Figure 1. The first aim of family assessment is to construct formulations, like those presented in Figures 2 and 3, of the abusive process and exceptions to it. In constructing a problem formulation, the behaviour pattern containing the abusive act is set out in the right hand column of the formulation. The belief systems which subserve this are placed in the middle column and the predisposing risk factors are placed in the left hand column. In constructing an exception formulation, the behaviour pattern in which the abuse was expected to occur but did not, is placed in the right hand column of the formulation. The belief systems which subserve this exceptional non-abusive episode are placed in the middle column and the protective factors are placed in the left hand column. Constructing both problem formulations and formulations of exceptions to the problem is important, since it is the exceptions to the problem that provide the basis for many aspects of effective treatment (Carr, In Press; Miller, Hubble, Duncan, 1996; White, 1995).

The second aim is to assess the family's capacity to benefit from family based treatment. A comprehensive schedule of assessment procedures is presented in Table 1. The schedule includes provision for assessment of all relevant family subsystems, the wider professional network and the use of sample therapy sessions to determine the family's capacity to use marital and family therapy sessions to learn new skills and reduce risk. Assessment may span a number of sessions and include sessions with various subsystems of the family and aspects of the wider social network. Initially assessment should focus on a reconstruction of the abusive incident and previous similar incidents, i.e. the problem maintaining behaviour pattern. Belief systems of parents and other family and network members that underpinned action in this cycle of violence may then be clarified. These in turn may be linked to predisposing risk factors which have been listed above in the systemic model of physical abuse. Against this back-drop assessment may progress to an exploration of exceptional circumstances in which abuse or parent-child conflict was expected to escalate to abuse but did not. related belief-systems and protective factors underpinning these may then be explored.

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Insert Tables 1 and 2 about here

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Contracting for treatment

When contracting for treatment, following assessment, the statutory child-protection professional, the child's parents and the foster parents or child care workers if the child is in statutory foster or residential care should be present in the contracting meeting. A summary of the family' strengths, exception incidents in which escalating conflict was expected but did not occur, and a three column formulation of the family process in which the abusive incident was embedded should be given. In light of this, a statement should be made about the capacity of the family to benefit from family based treatment. The checklist set out in Table 2 offers a framework for assessing a family's capacity to engage in treatment. Where parents accept responsibility for the abuse, are committed to meeting

their child's needs, are committed to improving their own psychological well-being and where they have the ability to change, the prognosis is good. In such cases it is worth allocating scarce resources to treatment. Where three out of four of these conditions are met the prognosis is fair. Where less than three of these conditions are met, it is unlikely that even the most skilful professional team would be able to offer a viable treatment programme. In such instances foster care should seriously be considered as the least damaging option for the child.

If the family treatment service can offer therapy to the family because it meets the criteria for treatment suitability, then specific goals, a clear specification of the number of treatment sessions and the times and places at which these sessions will occur should all be specified in a contract. Such contracts should be written and formally signed by the parents, the family therapist and the statutory social worker. Many families in which physical child abuse occurs have both financial problems and organizational difficulties. Non-attendance at therapy sessions associated with these problems can be significantly reduced by using a home visiting format wherever possible or organizing transportation if treatment must occur at a clinic.

The central aim of family therapy should be preventing the occurrence of negative cycles of interaction and promoting positive exchanges between the parents and child. Ideally this should involve intensive contact of up to three sessions per week over a three month period (Nichol, Smith & Kay et al, 1988). It is less confusing for clients if child-focused family therapy sessions which have this overriding aim are defined as distinct from concurrent marital therapy sessions in which the focus is on couples enhancing their relationship so that they can support each other in caring for their child.

In some instances it may be appropriate for some sessions to be held which involve the parents with their own parents to help resolve family of origin difficulties and facilitate support from the extended family. Where parents have particular personal vulnerabilities, sessions which target these and aim to increase their child-care knowledge and skills and manage their own personal problems may be appropriate. Arranging intensive input for the child in a specialist day-care or nursery setting is appropriate where children have developmental delays.

Treatment

The following sections offer some guidelines for implementing different aspects of family based therapy programmes which include child-focused and couples-focused components along with supplementary individual and network interventions. One broad aim of treatment is for the whole family to acknowledge that the parent abused the child; is no longer denying this; wishes to atone for this injustice; and wishes to take concrete steps so no further abuse will occur.

Insert Tables 3,4 and 5 about here

Interventions for parent-child behaviour patterns and belief systems

The following principles are useful in guiding interventions that specifically aim to change destructive parent-child behaviour patterns. Therapists should work with parents intensively (one to three sessions per week for three months). Wherever possible, sessions should occur in the home rather than the clinic, since lessons learned in therapy sessions are more likely to generalize to routine home-life if these lessons are learned within the home. Within sessions, the therapists role is that of a coach. The parents and child are coached in how to engage in positive exchanges and avoid negative exchanges. Between session, parents and children practice what has been learned in the sessions. As families successfully achieve targets, the frequency of the sessions is reduced.

The principal behaviour focused interventions are changing behavioural consequences using reward systems (Table 3) and behavioural control programmes (Table 4). Target behaviours should be highly specific and easy to count so progress can be easily monitored by parents using a simple recording system. Smaller targets should be tackled before larger targets are attempted. Typical targets for families with pre-schoolers include developing a positive parent-child play sequence and engaging in it once a day; managing episodes of crying so that they end with the child being soothed by the parent; developing a pre-sleep routine; and managing feeding time routines without fights. For every target that involves reducing a negative behaviour or exchange (such as a parent shouting at a child or a child crying) a positive target should also be selected (such as the parent cuddling the child or the child playing).

For positive behavioural targets, there should be an emphasis on developing clear daily routines involving these targets. Thus, if the target is for the parent and child to play together without conflict for 15 minutes per day using the skills for supportive play set out in Table 5, a routine needs to be evolved where the parent and child in preparation for this 15 minute period go to a particular room at a particular time each day and run through a particular sequence of anticipatory exchanges such as *Its nearly playtime for Mummy and Billy. What is it? Its nearly playtime for Mummy and Billy. What is it? Yes it is....* and so forth. This sequence is appropriate for a pre-schooler. Older children will require more age appropriate exchanges.

Parents should be coached in how to neutralize the destructive effects of negative framings of their children's behaviour and the destructive effects of marital conflict before attempting to engage in anticipatory routines leading up to a target behaviour. Reframing and relabelling are the main skills parents need to be taught to break out of negative framings of their children's behaviour. Reframing involves interpreting an ambiguous behavioural sequence in a positive or empathic way rather than by attributing negative intentions or qualities to the child. For example in a situation where a child began crying when the mother answered the phone, the mother interpreted this ambiguous sequence to reflect *the eight month old child's wish to prevent her from talking to her sister on the phone*. The mother was invited to reframe this situation as one in which *the child was startled by the phone ringing and disappointed at the loss of the mother's exclusive attention*.

Relabelling involves using a positive adjective to label the child rather than a negative one, if the response that led to the labelling is sufficiently ambiguous to allow this. For example, a mother

who labeled her four month old child as *a brat* any time he cried, was encouraged to replace this with labels, like *you sometimes cry when your hungry, don't you?*

Marital conflict can also interfere with setting up positive parent-child routines. Methods for working with couples will be described in more detail below. However, here it is sufficient to say that the primary caregiver's partner (who may sometimes but not always be the father) must be given a specific role in the anticipatory routine that precedes episodes of positive caregiver-child interaction, otherwise there is a risk that the routine will be interrupted by conflict within the couple. Such conflict is often motivated by jealousy on the part of the partner.

Coaching should be used as a central therapeutic method. That is, successive approximations to the target behaviours should be praised. The therapist should praise the parent and child for successive approximations to positive interaction. The parent should be coached in how to praise the child for successive approximations to age appropriate positive behaviour.

The main emphasis should be on the use of reward system and praise to shape behaviour and reach targets. Parents should be praised by therapists and parents should be trained in how to use praise, star-charts and prizes for children who accumulate a certain number of stars for engaging in positive target behaviours.

Punishment should be avoided. Parents should be coached in how to anticipate problem behaviour on the part of the child and attempt to avoid it by distracting the child or ignoring problem behaviours if they occur. Where parents are taught to use time-out routines, following the guidelines Table 4 it is very important to frame these as brief episodes of no more than a couple of minutes in which the child has no access to positive interaction with the parent. Time-out periods should terminate when the child has been in time-out for 3 minutes or, thereafter has stopped protesting about being in time out for 30 seconds. Immediately after time-out , the parent must engage in a positive event with the child and re-establish positive parent-child interaction. There is always a danger that time-out will be used by stressed parents as an excuse to lock children in a room or closet for a couple of hours.

Parents should be encouraged to keep written records of and to celebrate success in reaching targets. There should also be an acceptance that relapses will occur. There should also be an acceptance that therapists and parents will meet patches of resistance where co-operation problems occur from time to time.

Insert Tables 6 and 7 about here

Interventions with couples

Marital intervention may focus on helping couples solve conflicts without recourse to escalating angry exchanges which are displaced onto the child. Four components are particularly important when conducting couples work with disorganized or chaotic couples following an episode of physical child

abuse. These are communication skills training; problem-solving training; behavioural exchange training; and coaching in affective self-disclosure, empathy and development of insight into relational patterns which underpin discord, violence and dissatisfaction.

Guidelines for training in communication and problem-solving are given in Tables 6 and 7. The overall strategy for training couples in refining these interpersonal skills is to explain the skills and point out how necessary they are for jointly handling stressful child-care tasks. Then couples are invited to demonstrate their current level of skill development by taking a non-emotive issue and communicating or problem-solving around it. The therapist then gives feedback, first indicating the couples competencies and then pinpointing areas where improvements are required. Once the couple show competence in managing non-emotive issues, they are invited to progress to discussing emotive issues. The therapist interrupts them when they break the rules of good problem-solving or communication and coaches them back on track. Homework assignment which involve practicing these skills are also given.

In communication training, couples need to be trained in both listening to each other and in sending clear messages to each other. Listening skills include giving attention without interruption, summarizing key points made by their partner and checking that they have understood accurately. Skills required to send clear messages include discussing one problem at a time; being brief; deciding on specific key points; organizing them logically; saying them clearly; checking that they have been understood and allowing space for a reply. Couple are encouraged to make congruent "I statements" such as *I would like to watch Into the West* rather than "you statements" such as *You would love Into the West* or declarations such as *Every one knows that Into the West is a great film.* Couples are praised for avoiding negative mind reading, blaming, sulking, name-calling or interruptions.

Problem solving involves defining large, vague and complex difficulties as a series of smaller and clearer problems; brainstorming options for solving these smaller problems one at a time; exploring pros and cons of each option; agreeing on a joint action plan; implementing the plan; reviewing progress; revising the original plan if it was unsuccessful; and celebrating if it was successful.

Once couples have been coached in the basics of communication skills and problem solving skills, they are invited to use them to try to solve emotive problems associated with joint child care responsibilities such as who should feed and change the baby on specific occasions and how personal time away from the responsibility of child-care should be organized for each person. The therapist should praise couples for using skills correctly and get them back on track of they fail to use problem solving and communications skills correctly. They should also be encouraged with emotive problems to declare that the problem (not their partner) makes them feel bad and to acknowledge their own share of the responsibility in causing the problem (rather than blaming their partner). They should be encouraged to anticipate obstacles when engaging in problem solving.

For families where child abuse has occurred, core beliefs about getting needs met are often a central obstacle to solving problems and reaching mutually acceptable agreements. Parents in these families tend to frame problems in terms of how they will get their own needs met, rather than how

both members of the couple and the child can get as many needs met as possible. A common theme is that everyone cannot have their needs met, and if one person's needs are met, it must be at the expense of the needs of another not being met. A related idea is that in any negotiation about family members having their needs met there must be a winner and a loser. The idea that everyone can win if enough thought is given to solving a problem, must constantly be reintroduced by the therapist.

Destructive behavioural routines are a second set of obstacles to solving problems and reaching mutually acceptable agreements. These routines may involve attributing negative intentions to one's partner without checking these out and then either criticizing, nagging, blaming, name-calling, and citing previous instances of the partner's misdemeanors on the one hand or withdrawing, sulking or becoming intoxicated on the other. Often anger from these types of exchanges is displaced onto the abused child.

Helping partners recognize these behavioural routines and patterns and the beliefs and feelings that underpin them is a critical part of couples work. Once they are recognized, alternatives to them may be developed. Most of these routines are based on fears that needs related to personal power, esteem and intimacy will be thwarted or a sense of being hurt when these needs have been thwarted. Alternative solutions to the escalating negative routines typically involve couples acknowledging and expressing feelings related to unmet needs and having their partner empathize with them about this. Therapists can help couples develop affective self-disclosure and empathy skills by interviewing them about these feelings and then empathizing with them. Couples may then be coached in how to interview each other about these feelings that are rarely articulated and how to empathize with each other.

Behavioural exchange, offers a way to introduce greater positive reciprocity into a relationships marked by patterns of mutual punishment and conflict. It involves inviting both couples to list specific positive activities that their partner's could carry out to show that they care for them. These items must be phrased positively rather than negatively and must not be the focus of a recent argument. The couple are invited to put the lists in a visible place in the house and to make a commitment to carry out some of the items on the list for their partner each day. However, quid-pro-quo arrangements are to be avoided. The idea is to increase the number of positive exchanges but within the context of a good-will ethic rather than a quid-pro-quo contract.

When couples engage in more positive exchanges; use communication and problem-solving skills; and engage in affective self-disclosure and empathy, solving child-care problems becomes far less stressful and far less likely to result in domestic violence.

Network meetings

Interventions in the wider system aim to reduce stress and increase social support. Such interventions must be tailored to the ecology of the family as mapped out during the assessment process. The following are common examples of interventions that fall into this category: work with the extended family to increase the amount of support they offer the child's primary caretaker; arranging a befriender, a home-help or a counsellor home-visiting service for an isolated parent;

arranging participation in a local parent support self-help group; organizing a place for the child and caretaker in a local mother and toddler group; introducing the family to a baby-sitting circle; setting up periodic relief foster care; supporting an application for housing transfer to a less cramped residence; referring family members to medical or other professional services to solve problems requiring specialist input..

Parent-focused interventions

Individual interventions for the parents fall into two broad categories (Azar, 1989). In the first are those interventions which aim to improve parenting skills and knowledge about child development. In the second are those which aim to help parents with other psychological problems which are not exclusively associated with the parenting role such as anger management, mood regulation and drug abuse. Parent-craft and child development classes should include a structured curriculum covering on the needs and competencies of children who fall into the same age-band as the parents children. The curriculum should be organized in such a way that parents are given a conceptual understanding of a topic followed by a practical exercise in which they plan how they will put this new knowledge into practice in caring for their child. Individual work with parents to help develop anger and mood regulation skills should offer parents a way to conceptualize how in specific situations they are likely to become apparently uncontrollably angry, sad or anxious, and then provide them with a way of controlling their emotional states in these situations.

CLOSING COMMENTS

The approach to treatment outlined in this paper is expensive, time consuming and emotionally demanding for staff. However, in the long run evidence from studies such as those by Nichol et al 1988 and Brunk et al, 1987 suggest that these high initial costs may pay long term dividends both in financial terms but most importantly in terms of children's wellbeing and connectedness to their families. For a service adopting this approach to treatment, in order for the service to be able to operate effectively over the long term, two requirements are essential. First, therapists or case worker must have strict upper limit of no more than 6 active cases in treatment at any on time. With higher case loads the quality of treatment offered deteriorates due to the emotional exhaustion experienced by therapist. Second, therapist must receive intensive initial training in both generic family therapy skills and behaviour therapy skills (Carr, In Press) and subsequently ongoing weekly therapy supervision. This therapy supervision may be conducted within the context of a peer supervision group or with an team supervisor. Only a subset of families in which physical child abuse has occurred are able to engage in and benefit from the approach to treatment outlined in this paper. Cases that cannot benefit for this type of intervention may benefit more from out-of-home placement.

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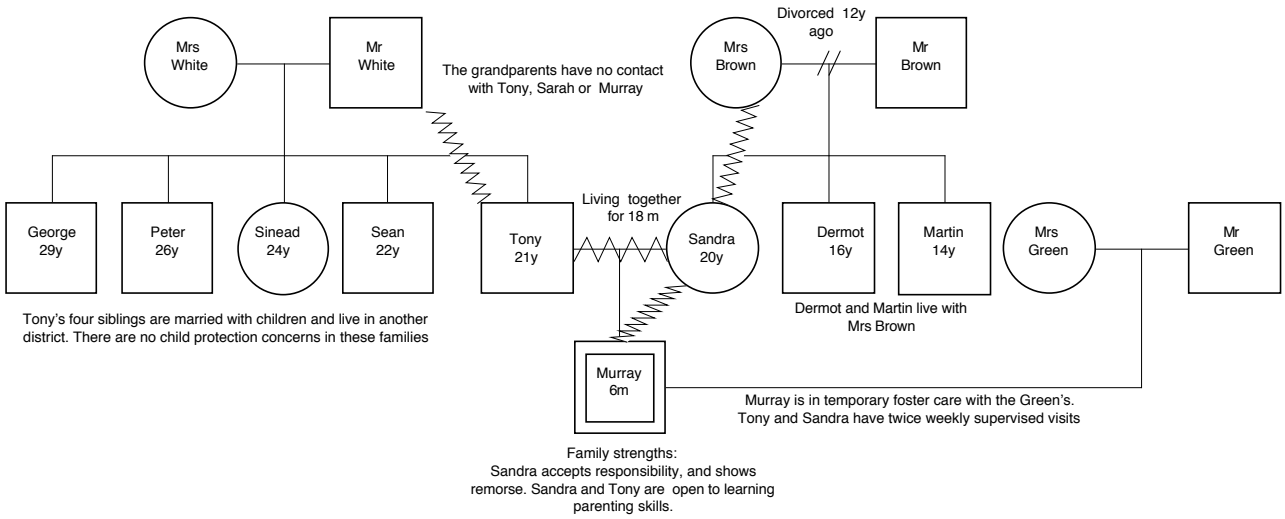
Figure 1. Case example of physical child abuse



Referral. This case was referred to a child and family mental health team by social services following a non-accidental injury, identified by the pediatrician in the district general hospital. The purpose of the referral was to see if Murray could be returned to custody of parents. At the time of the referral, Murray was in temporary foster care with the Greens. Murray had a torn frenulum, extensive facial bruising and burn marks from an electric heater on his arm. Sandra, the mother, brought the child to casualty after the child accidentally brushed against the heater. Sandra and Tony said the torn frenulum and bruising were due to two episodes of falling down. The paediatrician's said the bruises and frenulum injuries were due to recent non-accidental injury (NAI). A place of safety order was taken and after medical treatment, Murray was placed in foster care with the Greens. The parents were granted twice weekly supervised access and these visits occurred at the Green's house. The mother was charged, by the police with grievous bodily harm, found guilty and put on probation. The team interviewed Tony and Sandra, observed family access visits and liased with all involved professionals.

Assessment of the child. Murray was a difficult temperament child who reacted strongly to all new stimuli by crying and was difficult to soothe. He slept and ate at irregular times. He often vomited his food up. He did not look like a bonnie baby and probably bore little resemblance to Tony and Sandra's idea of a good baby. He had placed heavy demands on them since his birth and they were both exhausted from trying to care for him.

The mother's family history. Sandra, the mother, had a history of poor school performance. She had difficulty making and maintaining peer relationships. Her parents had a highly conflictual and violent marriage which ended when she was eight. She had a difficult relationship with her mother. Sandra experienced episodes of low mood that bordered on clinical depression and had poor frustration tolerance.

The father's family history. Tony, the father, had a history of truancy and was the youngest child in a conflictual and chaotic family. In particular he had conflictual and violent relationship with his father. He also had limited skills for resolving conflicts and often resorted to violence when others disagreed with him. He had a checkered employment record. His parents disapproved of Sandra. Tony's three brothers and his sisters all had partners (either co-habitees or spouses) and children and all lived outside of Tony's village now.

Parenting resources. Tony had little time for the baby and had few parenting skills and limited parenting knowledge. Sandra had a good knowledge of the practicalities of looking after a baby but little sense of what was developmentally appropriate for a six month old child. She found it difficult to interpret what his crying meant and usually attributed it to him trying to annoy her. She was unable to empathize with her child's position. She would scold him as if he were a five year old. Usually when he cried she would leave him to lie alone in the other room. Sometimes, in frustration, she would thrust his bottle at him and say I'll ram this down your throat if you don't shut up.

The couples relationship. Tony and Sandra vacillated between extreme closeness and warmth and violent rows. They had known each other about a year when Murray was born. They were unmarried and had no immediate plans to marry. They settled their differences usually by engaging in escalating shouting matches that occasionally involved mutual violence. Usually after these stormy episodes on or both would leave the situation and one or both would get drunk. Later the issue would be dropped until the next heated exchange, when it would be brought up again.

Social support network and family stresses. Tony and Sandra were very isolated with few friends. They were unsupported by the extended family and had no regular contact with either Tony's or Sandra's parents

or siblings. They were financially stressed., since neither of them worked and relied on welfare payments to support themselves. They lived in a two room rented flat over a shop.

The abusive incident. The abusive incident involved the following sequence of events. Murray began to cry at 3.00 AM and would not stop. This was typical of him as a child with a difficult temperament. Sandra interpreted the crying as Murray trying to prove she was no good as a mother and as his attempt to punish her by stopping her from sleeping. When she expressed this view to Tony, he argued with her, which further upset Murray, and then Tony went back to sleep. Sandra's anger at the child escalated, and this was fuelled by her negative attributions concerning the child's motives, her lack of empathy for Murray, her anger at Tony, and her exhaustion. She took the child's bottle and shoved it into Murray's mouth and tore his frenulum. He tried to spit it out. She hit him twice. Picked him up and then dropped him next to the heater which he fell against. This act was influenced by her own punishment experiences as a child. Her mother had relied on corporal punishment as a routine method of control and often she was very severe. The act was also influenced by her habit of using a bottle to stop Murray from crying.

Capacity to co-operate with the team. Sandra accepted that the abuse was the result of her being unable to control her frustration in a stressful situation. She was committed to learning how to manage her child in stressful situations and to engaging in family work to learn child management skills. Sandra and Tony refused to accept that counseling for their personal or relationship difficulties would be of any benefit to them. Sandra was able to co-operate with the team and engaged well in the assessment. Tony found co-operation very difficult and only went along with the assessment procedures to placate Sandra.

Formulation. Three column formulations of problematic episodes and exceptional non-problematic episodes are contained in Figures 9.2. and 9.3. The main protective factor in this case was the mother's acceptance of responsibility or the abuse and willingness to work with the team to develop parenting skills. However, an important related risk factor was the couple's refusal to acknowledge the contribution of personal and marital difficulties to the occurrence of the abuse, and the necessity of working to enhance mood regulation skills and marital communication.

Treatment. The parents were offered joint parenting skills training following the guidelines set out in this paper. They attended some but not all sessions and difficulty co-operating with joint homework assignments. However, feeding and sleeping routines were established and a specific role for Tony in these was negotiated. Attempts to promote increased support for Sandra from her mother were largely unsuccessful. However, support for Sandra was increased by offering her a place in a support group for mothers. the prognosis in this case was guarded because of the couples refusal to acknowledge the role of marital factors and personal factors in occurrence of the abuse.

Figure 2. Example of a three column formulation of physical child abuse

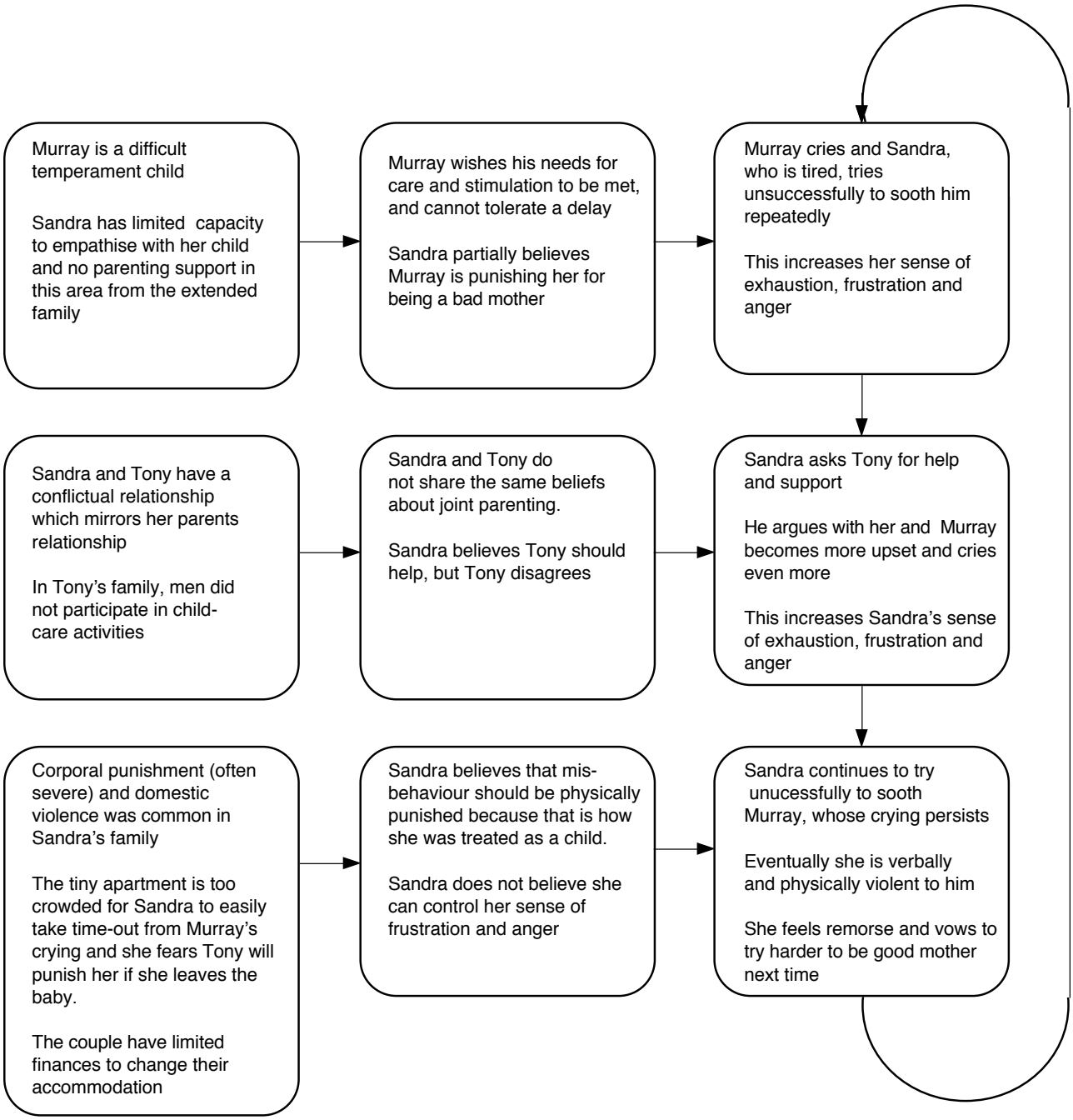


Figure 3. Example of a three column formulation of an exception to physical child abuse

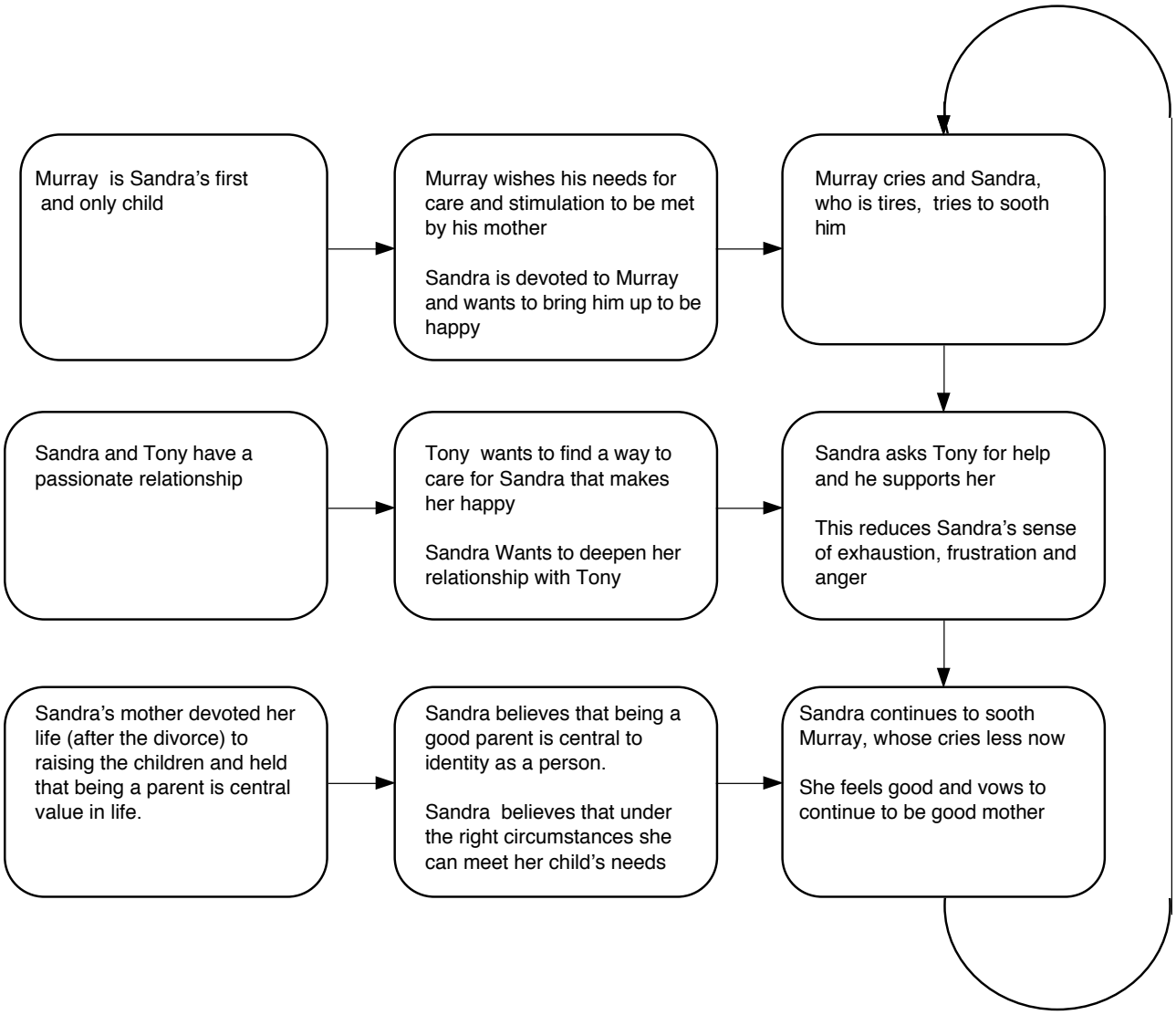


Table 1. Schedule for a comprehensive family assessment package for use in cases of physical child abuse

Subsystem	Assessment procedures
Child	• Individual interview with child (if the child is old enough) to assess personal strengths and resources (including assertiveness) and his or her account of the abusive incident; perception of all relevant risk and protective factors; and wishes for the future
Parents	• Individual interviews with parents to assess acceptance or denial or responsibility for abuse, parenting skills and deficits, personal resources and problems, reconstruction of the abusive incident and perception of all relevant risk and protective factors.
Parent-child interaction	• Parent-child interaction observation sessions to assess positive aspects of parenting and risk factors associated with parent-child interactions • A sample session of treatment to assess responsiveness to behavioural coaching in supportive play, use of reward systems and non-violent behavioural control methods
Marital couple	• Marital interview to assess marital risk factors especially joint communication and problem-solving skill for dealing with child care issues and conflict management • A sample session of treatment, to assess couples responsiveness to coaching in joint communication and problem-solving skills for managing child care issues
Family accommodation	• Visit to family residence to assess crowding, hygiene, safety of the home for the child and opportunities for age appropriate cognitive stimulation and play
Role of extended family	• Individual interviews with other members of nuclear and extended family to assess their acceptance or denial of the abuse, their perception of risk factors, their reconstruction of the abusive incident (if appropriate), their child-care skills and deficits • Joint interviews with extended family and nuclear family to observe quality of their relationship to nuclear family and assess potential for support
Role of other involved professionals	• Individual interviews or written reports from other involved professionals in child protection, social services, health, education, and justice to obtain their expert view of risks and resources within the family and their potential future involvement in supporting the family or providing services • Joint interviews with other community based resource people such as the foster parents with whom the child is temporarily based, home-help, befriender, leader of mother and toddler group, director of nursery or day-care facility etc to observe relationship to parents and assess potential for supporting the family in future

Table 2. Checklist of four conditions that predict positive treatment response in families where child-abuse has occurred

1. Acceptance of responsibility for abuse	• Do the parents accept responsibility for abuse (or neglect)? • Do parents blame the child for provoking the abuse? • Do the parents deny that the abuse occurred?
2. Commitment to meeting their child's needs	• Do the parents accept that they have to change their parenting behaviour in order to meet their child's needs? • Are the parents committed to using therapy to improve their parenting skills? • Can the parents place the child's needs ahead of their own needs?
3. Commitment to improving their own psychological well-being	• Do the parents accept that their own psychological problems (depression, substance abuse, anger management problems, marital discord) compromise their capacity to meet their child's needs? • Do the parents deny that they have psychological problems? • Are the parents committed to using to improve their psychological well-being?
4. Ability to change	• Do the parents have the ability to learn the skills necessary for meeting their child's needs? • Do the parents have the personal flexibility to change their parenting behaviour? • Do the parents have the emotional strength to follow through on therapeutic tasks which require considerable tolerance for frustration? • Do the parents have the capacity to maintain a co-operative relationship with the therapy team?
Will definitely benefit from treatment	4 conditions are met
Will possibly benefit from treatment	3 conditions are met
Unlikely to benefit from treatment	2 or less conditions are met

Note: Adapted from Skuse and Bentovim, 1994.

Table 3. Guidelines for reward systems

SPECIFIC GUIDELINES	GENERAL GUIDELINES
• Define the target behaviour clearly • Decide when and where the monitoring will occur • Make up a smiling-face chart or points chart • Explain to the child that they can win points or smiling faces by carrying out the target behaviour • Ask the child to list a set of prizes that they would like to be able to buy with their points or smiling faces • Agree on how many points or faces are necessary to buy each prize • Follow through on the plan and review it for effectiveness	• Present the reward system to your child as a way of helping him or her learn grown-up habits • All parental figures in the child's network should understand and agree to using the system • Use a chart that is age-appropriate. Smiling faces or stars are good for children and points may be used for adolescents • The sooner points are given after completing the target behaviour, the quicker the child will learn • Highly valued prizes lead to faster learning • Try to fine tune the system so that successes are maximized • If prizes are not being won, make the target behaviour smaller and clearer or the cost of prizes lower and make sure that all parent figures understand and are committed to using the system • If the system is not working, do not criticize the child • Always keep the number of target behaviours below 5

Table 4. Guidelines for behaviour-control programmes

SPECIFIC GUIDELINES	GENERAL GUIDELINES
BEHAVIOUR CONTROL PROGRAMME • Agree on a few clear rules • Set clear consequences • Follow through • Reward good behaviour • Use time-out or loss of privileges for rule breaking • Monitor change visibly **TIME- OUT** • Give two warnings • Bring the child to time-out without negative emotion • After five minutes engage the child in a positive activity and praise him for temper control • If rule-breaking continues, return child to time-out until thirty seconds of quietness occurs • Engage in positive activity with child and praise for temper control	• Set out with the expectation that you can teach your child one good habit at a time • Build in episodes of unconditional special time into behavioural control programme • Frame the programme as learning self-control • Involve the child in filling in, designing and using the monitoring chart or system • Monitor increases in positive behaviour as well as decreases in negative behaviour • Do not hold grudges after episodes of • negative behaviour • Avoid negative mind reading • Avoid blaming, sulking or abusing • Ask for spouse support when you feel bad about the programme • Celebrate success

Table 5. Guidelines for supportive play

SPECIFIC GUIDELINES	GENERAL GUIDELINES
• Set a specific time for 20 minutes supportive play per day • Ask child to decide what he or she wants to do • Agree on an activity • Participate wholeheartedly • Run a commentary on what the child is doing or saying, to show your child that you are paying attention to what they find interesting • Make congruent *I like it when you...* statements, to show your child you feel good about being there • Praise your child repeatedly • Laugh and make physical contact through hugs or rough and tumble • Finish the episode by summarizing what you did together and how much you enjoyed it	• Set out to use the episode to build a positive relationship with your child • Try to use the episode to give your child the message that they are in control of what happens and that you like being with them • Try to foresee rule-breaking and prevent it from happening or ignore it • Avoid using commands, instructions or teaching • Notice how much you enjoy being with your child

Table 6. Guidelines for listening and communications skills

SPECIFIC GUIDELINES	GENERAL GUIDELINES
LISTENING SKILLS • Listen without interruption • Summarize key points • Check that you have understood accurately • Reply **COMMUNICATION SKILLS** • Decide on specific key points • Organize them logically • Say them clearly • Check you have been understood • Allow space for a reply	• Make a time and place for clear communication • Remove distractions and turn off the TV • Discuss one problem at a time • Try to listen with the intention of accurately remembering what was said • Try to listen without judging what is being said • Avoid negative mind-reading • State your points without attacking the other person • Avoid blaming, sulking or abusing • Avoid interruptions • Take turns fairly • Be brief • Make congruent *I statements*

Table 7. Guidelines for problem-solving skills

SPECIFIC GUIDELINES	GENERAL GUIDELINES
• Define the problem • Brainstorm options • Explore pros and cons • Agree on a joint action plan • Implement the plan • Review progress • Revise the original plan	• Make a time and place for clear communication • Remove distractions and turn off the TV • Discuss one problem at a time • Divide one big problem into a few small problems • Tackle problems one at a time • Avoid vague problem definitions • Define problems briefly • Show that the problem (not the person) makes you feel bad • Acknowledge your share of the responsibility in causing the problem • Do not explore pros and cons until you have finished brainstorming • Celebrate success