Physical Abuse of Preschoolers: Identification and Intervention Through Occupational Therapy

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Child abuse is a major public health concern in the United States, one that has negative consequences on abused persons’ productivity and mental health throughout their lives. Occupational therapists who work with preschool-aged children are in a strategic position to screen for physical abuse and aid in the rehabilitation of children and families engaged in abuse. This article provides a review of the literature and accounts of clinical experience with children and families in a variety of settings. It offers an overview of behavioral risk factors that have been shown to correlate with physical abuse, including how these factors can be observed within the context of an occupational therapy evaluation. Guidelines for interacting with child protective services via reporting suspected cases of child abuse and working collaboratively with such agencies are provided. Strategies for occupational therapy intervention with abused children and their parents are described. These strategies include using activities to facilitate positive parent-child interaction, educating parents regarding child development and management techniques, and facilitating children’s psychosocial development.

Approximately 10% of the 20,000 occupational therapists who responded to the 1990 American Occupational Therapy Association (AOTA) Membership Data Survey indicated that they worked primarily with children aged 3 to 5 years (AOTA, 1991). These practitioners see their clients in a variety of community and outpatient settings, including public schools, early intervention programs, and hospital-based clinics. In these settings, children frequently obtain services such as developmental intervention, education, and health care. Research indicates that preschoolers are a high-risk group for physical abuse; one study indicated an incidence among preschoolers at least 1.5 times that of any other age group (Wolfner & Gelles, 1993).

Children whose cognitive, social, or physical development is delayed sufficiently to result in prolonged dependency or increased demands on adult caretakers are at the highest risk of abuse (Frodi, 1981). These conditions define most of the preschool-age clients who require occupational therapy.

Occupational therapists specialize in helping persons achieve, regain, and maintain satisfactory levels of performance in their daily activities (Hopkins, 1993). Parents who enact patterns of physical abuse toward their children are engaging in dysfunction that results in lasting harm to all family members. Young children who suffer chronic episodes of abuse are at increased risk of delayed social, language, and emotional development (Egeland, Sroufe, & Erickson, 1983; Haskett & Kistner, 1991; Hoffman-Plotkin & Twentyman, 1984). Therapists observe clinically that parents who abuse their children often feel overwhelmed and inadequately rewarded by their parental role. Parents who have suffered chronic physical abuse as children are at increased risk of behaving abusively toward their own children, thus perpetuating the cycle of maltreatment and developmental deficits (Prodgers, 1984). By developing an awareness of the risk factors for and signs of child abuse, occupational therapists can use their knowledge base and skills to take an important role in preventing, identifying, and ameliorating this major public health problem.

Although growing numbers of occupational therapists have focused their clinical efforts on young children, the literature related specifically to occupational therapy evaluation and intervention with preschool-aged children suspected or known to be abused is limited to one article, published by Colman in 1975. The purpose of this article is to provide general information about the causes and results of child abuse and neglect, methods of screening for abuse, strategies for involving child protective services, and techniques for evaluating and providing intervention. The following information is based on an extensive review of the literature and on clinical experience in a variety of community mental health, school, and hospital settings.

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Definitions and Incidence

The Child Abuse Prevention and Treatment Act Amendment of 1978 (Public Law 95-266) defines child abuse as "the physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child under the age of eighteen or the age specified by the Child Protective law of the State in question, by a person who is responsible for the child's welfare under circumstances which would indicate that the child's health or welfare is harmed or threatened thereby" (Section 102, p. 228). Wolfner and Gelles (1993) defined abusive violence as an intent to cause pain or injury, combined with actions that have a high likelihood of causing injury. Their extensive survey of 5,941 randomly selected families across the United States divided types of physical punishment into categories of minor violence (pushing, grabbing, shoving, spanking, or throwing an object at a family member) and major violence (hitting or trying to hit with an object, kicking, biting, burning, or threatening or harming a family member with a knife or gun). Subjects were asked to indicate the type and frequency of their responses to conflict situations with a particular child family member during the previous year. Results indicated that the base rate for minor violence was 61.9%, and the base rate for major violence was 11%. Results of this study also indicated that families who engaged in major violence toward their children were distinct from those who perpetrated minor violence, and that the two groups might require different intervention approaches. Differences between the groups included: socioeconomic level, with increased rates of major violence occurring in families earning below $10,000 per year; region, with residents of the Eastern states demonstrating abusive violence rates 35% higher than other regions; gender, with women having a higher incidence of minor violence than men; and race, with differing patterns of representation across African-American, Hispanic, and Anglo American races.

Factors Correlated with Physical Abuse

Three categories of factors are thought to interact to produce and perpetuate abusive situations: (a) the parents' personalities and backgrounds, (b) environmental stress, and (c) characteristics of the child (Hoffman-Plotkin & Twentyman, 1984; Kempe & Helfer, 1972). Although not all families who display one or more of these characteristics are abusive or neglectful, abusive persons generally demonstrate problems in each of the three categories.

Parents' Personalities and Backgrounds

Persons who engage in abusive or neglectful parenting often have a history of unhealthy relationships with their own caretakers. Their childhood experiences often include disorganized families and multiple caretakers, situations that may have interfered with early emotional bonding and the subsequent ability to form intimate, caring relationships (Prodgers, 1984). Abuse and neglect are common features in the histories of these parents (Main & Goldwyn, 1984; Pollack & Steele, 1972; Steele, 1980). Personality development may have been impaired, as demonstrated by their egocentric preoccupations, low self-esteem, poor impulse control, and difficulty in establishing and maintaining meaningful relationships (Ogata et al., 1990; Prodgers, 1984). Poor control of aggressive impulses and annoyance with or lack of empathy for the distress of others is evident (Frodi & Lamb, 1980). Inadequate parenting skills may also be related to general immaturity, as reflected in the overrepresentation of very young parents who engage in physical abuse (Wolfner & Gelles, 1993). Drug use and unemployment have been shown to correlate with child abuse (Wolfner & Gelles, 1993). Marital problems or single parent status are common characteristics of abusive persons, and family or friends are rarely used as resources or supports in times of need (Steele, 1980).

Environmental Stress

The lack of personal and social resources leaves parents who are at high risk for committing abuse extremely vulnerable to environmental stress. The higher the daily level of stress, the more likely the person is to resort to impulsive physical punishment and angry acting out toward others. The influence of poverty on the measured incidence of child abuse has been debated, but most experts in the field agree that although physical abuse occurs across all socioeconomic groups, persons who live in poverty are more likely to abuse their children (Helberg, 1983; Oates, Peacock, & Forest, 1984; Wolfner & Gelles, 1993). Persons who live in poor communities often must cope with increased rates of violent crime, inadequate housing, daily struggles to meet basic needs, and chronic discontentment. When coping skills are maximally stressed on a consistent basis, events that might otherwise be perceived as minor assume catastrophic proportions; a broken dish or a messy diaper can trigger an extreme emotional response and subsequent violence.

Cultural norms also affect parenting styles and generate environmental stress. If the abusive parent's society, community, or extended family regards violence toward children as acceptable, parenting practices and philosophies are more likely to reflect this belief (Simon, 1993; Vondra, 1990). Although our society grants persons the right to live according to many self-chosen values, it also maintains that children have the right to protection from abuse as defined by law (Simon, 1993).

Characteristics of Children Likely to be Abused

No child deserves physical abuse or any other type of
maltreatment. However, children who have traits or behaviors that create stress for their parents are more likely to be abused than are their siblings who do not exhibit these qualities (Steele, 1980). Medical or developmental problems that result in parental stress include prematurity, low birth weight, feeding problems, and chronic illness (Steele, 1980). Children who are the product of an unwanted pregnancy or are of a gender considered to be undesirable by the parent are also at higher risk of abuse (Frodi, 1981).

Behaviors common to children who have been chronically abused probably reflect the interaction of personality, neurophysiology, and learned responses. Abused children can appear either overly active, provocative, irritable, and noncompliant, or constricted, guarded, and emotionally unresponsive. Often, abused children do not receive the parental social responses that reinforce nurturant approaches (e.g., social smiling, reciprocal responses). Abused children do not display an emotional differentiation between familiar and unfamiliar adults; friendly approaches by both familiar and unfamiliar persons may be avoided and rejected, or there may be indiscriminate clinging to all adults (Martin & Beezley, 1977; Simon, 1993). Aggression toward adults and peers, noncompliance, and activity level are increased beyond that which is age-appropriate (Egeland et al., 1983; Hoffman-Plotkin & Twentyman, 1984).

It is well documented that a high proportion of abused children demonstrate developmental delays secondary to environmental deprivation, behavioral and emotional problems, and neurological impairment. Poor performance on tests of development has been documented in terms of cognitive abilities (Hoffman-Plotkin & Twentyman, 1984), language (Martin, Beezley, Conway, & Kempe, 1974; Oates et al., 1984), play (Howard, 1986), and adaptive skills (Hoffman-Plotkin & Twentyman, 1984). Environmental and experiential deprivation accounts for some of the developmental delays but does not explain the entire problem (Martin et al., 1974).

The role of neurological impairments in the development of neglected and abused children is considerable; such impairments may be precursors to or resultant from physical abuse. In a study of 58 abused children, 53% demonstrated neurological dysfunction or damage, ranging from subtle “soft” neurological signs (22%) to severe abnormalities such as focal signs and impaired cranial nerve functioning (17%). It was noted that 43% of these children had no known history of head trauma (Martin et al., 1974). The causes of neurological impairment are not limited to blows to the head and brain. Other possible contributors include prenatal and perinatal complications such as anoxia and fetal alcohol syndrome, low birth weight, and malnutrition before and after birth (Martin et al., 1974; Oates et al., 1984).

A unique finding in evaluating the development of abused and neglected children is the occasional demonstration of specific abilities that are advanced beyond those suggested by the child’s overall developmental level. However, these splinter skills may be seen secondary to the child’s adult-like caretaking responsibilities, which abused children sometimes assume in an effort to gain parental approval or to meet family needs (Martin, 1972). Clinical examples are a 4-year-old who makes his mother’s breakfast before waking her up every morning, a 7-year-old who takes primary responsibility for the care of her infant sibling, or a 5-year-old who vigilantly watches his father’s reactions and quickly brings him comfort items such as beverages or cigarettes when he appears to be upset.

Occupational Therapy Evaluation

The ultimate goals of the evaluation process in cases of known or suspected child abuse and neglect are (a) to help the child and his or her family by supportively, but objectively, contributing to the assessment of the parents’ current ability to adequately care for their child; (b) to help determine and enhance the child’s developmental and functional status; and (c) to help the parents identify all available resources that will optimize family functioning. The following guidelines are suggested when assessing the needs of young children who are being seen in community settings such as schools, early intervention programs, preschools, and outpatient clinics.

It is essential when performing the evaluation that the clinician maintain a positive therapeutic approach. This entails a belief that all parents are invested in their children’s well-being, even though they may be currently unable to behave accordingly. Entering the situation with an attitude of support toward a person who wants to be a good parent is imperative to the development of rapport and to subsequent progress in treatment (Pollack & Steele, 1972).

The occupational therapy assessment can be used to evaluate risk factors of abuse related to the parents, child, and environment within the context of a developmental assessment. Occupational therapists can ascertain qualities of the parent from intake interviews, subsequent developmental history interviews, and observations of parent-child interaction. They can ascertain characteristics of the child through developmental evaluation and through observation of the child’s social interactions with the parents and with the therapists themselves. The level of environmental stress and availability of supports can be assessed during interviews and inferred by observing and questioning the family’s overall pattern of service usage (e.g., Are scheduled appointments usually attended? Is assistance sought only for crisis intervention? Is the family using an array of services?).

Parenting Assessment

The initial interview is a time to engage the parent and set
the tone of the therapeutic relationship, and to observe the spontaneous behaviors of the parent and child. As the therapist describes the evaluation process and the therapist’s role relative to those of other helpers, attention should be focused on the parent. The assessment provides an opportunity to learn about the child’s growth and development as well as the concerns, goals, and wishes of the parent. A supportive, concerned attitude should be conveyed by the therapist’s verbal and nonverbal communication, with an emphasis on active listening. Advice or recommendations are generally inappropriate at this stage. A discussion of the therapist’s commitment to confidentiality can help to alleviate fears regarding the sharing of personal information. It is often helpful to assure parents that their written approval will be sought before disclosing information to persons other than the treatment team, except in situations where the child’s safety is at risk. If a parent does not have custody, the child protective services caseworker or other legally appointed guardian must grant permission to disclose information to other agencies.

Documented observations during the initial interview and subsequent evaluations and therapy sessions should include the parent’s physical appearance and affective behavior. The parent’s style of relating to the therapist is important, and can range from appropriate to overly dependent, hostile, anxious, or passive (Pollack & Steele, 1972). The occupational therapist should also (a) note the parent’s ability to discuss issues related to the child versus the demonstration of an egocentric focus, (b) observe the parent’s style of managing the child as the child interacts spontaneously with the environment (e.g., does the parent display encouraging, warm, and appropriate behavior in terms of the timing and manner of limit-setting?), (c) listen for any mention of chronic housing, financial, marital, and health problems, and (d) keep records of attendance at scheduled appointments, bearing in mind that family disorganization, practical problems, and ambivalence about attending sessions often result in the need for more flexibility than that required by other clients. Outreach may be needed in the form of telephone reminders about upcoming appointments, telephone meetings, and home visits (Green, 1980).

The interview that I developed to identify parents of young children at risk, parts of which are outlined in the Appendix, provides opportunities for identifying problems related to the child, parent, and environment. It provides occupational therapists with a way to elicit information regarding the three categories of risk factors of abuse while gathering traditional developmental data. The interview is meant to be administered verbally: Questions are worded in a conversational style with listening cues for the interviewer. The first two sections address environmental and situational factors; answers provide an impression of the family’s daily routines. Questions in the third section relate to developmental milestones as well as to the parent’s past and present feelings about the child. Those questions relevant to the child’s current developmental status elicit direct information about the child’s abilities and experiential opportunities and the parent’s expectations. The interview questions often lead to spontaneous discussion of disciplinary management or other issues related to child rearing, discussions that provide additional information about family members’ behaviors and attitudes and facilitate a rapport between parent and therapist.

Although interviews quickly provide concentrated information, family relationships are complex and difficult to characterize adequately in words. A client’s ability to report information about family dynamics may be reduced by limited verbal skills, emotional involvement in the interaction process, and the complexity that is present in most family systems. Thus, traditional interviewing techniques produce limited or inaccurate information. When mothers are asked, “What do you do when your child has a tantrum or disobeys?” clinical observations indicate that most respond with the socially desirable solutions (e.g., declaring a time out, disallowing treats). Common responses are, “I take away television,” or “I make her sit in the corner.” Further probing typically results in repetitions of such responses, even with parents who are known to use physical violence to discipline their children.

To supplement traditional interview techniques, occupational therapists can gather information by interpreting persons’ responses during activity, when spontaneous and typical interactions between parent and child can be observed. A mother who gives only socially desirable answers to questions about child management practices may demonstrate during an activities session how difficult it is for her to structure the experience at an appropriate level, how stressed she becomes when the environment becomes messy or unpredictable, or how she tends to compete with her child to get her own needs met.

Deitrich-MacLean and Walden (1988) studied the teaching styles of mothers who were known to have a history of physical abuse and those of mothers who were not abusive. They hypothesized that, although previously published studies indicated little support for the use of clinical observations made during free play activities, involving the parent and child in a structured, goal-focused task that required interaction might allow child protective services workers to discriminate between abusive and nonabusive mothers. The sample consisted of 52 caseworkers from child protective services with a wide range of experience levels. After viewing 3 min of randomly selected film from sessions during which mothers tried to teach their children to open a Chinese puzzle box, the subjects were able to correctly identify whether the mothers were abusive 76% of the time. The probability that these findings occurred by chance was extremely low (p < .0001), and they support the use of clinical observa-
ations of parent–child interaction during structured tasks as a part of the multidisciplinary assessment. Deitch-MacLean and Walden’s study validates the effectiveness of an activities-based approach to evaluating parent–child interaction. Occupational therapists have the expertise to select appropriately challenging activities and to interpret clients’ responses.

Evaluation of the Child

Throughout the evaluation process, it is essential to document observations of the child’s physical appearance and affective and social behavior, because repeated, documented observations made over time are more reliable and admissible in court than those that are documented only once. Hygiene, dress, and the presence of bruises or scars should be documented. Those behavioral indicators of abused and neglected children described previously should also be noted. When evaluating children, a consistent, supportive, and nurturant approach is usually most effective; this is especially true when the child has experienced abuse. Beneath a stubborn, passive, provocative, or ingratiating demeanor is a confused child who has come to expect criticism and unpredictability from adults. Often it helps to observe the child for a series of sessions in order to establish trust and develop a therapeutic relationship.

A comprehensive developmental assessment provides an excellent opportunity for observing and documenting the problems common to abused and neglected children. Norm-referenced evaluation tools should be employed as much as possible to maximize the credibility of the data in the event that they are used as evidence in court (Helberg, 1983). Tools such as the Bayley Scales of Infant Development II (Bayley, 1993) and the Miller Assessment for Preschoolers (Miller, 1982) are useful for this purpose. Criterion-referenced evaluations such as the Hawaii Early Learning Profile (Furuno et al., 1984) and the Brigance Diagnostic Inventory of Early Development (Brigance, 1978) can also produce useful information. Clinical observations of the child’s sensory integration can be of value as well.

Developmental assessment of children suspected or identified as being abused not only helps secure needed services and design intervention programs, but also assists in evaluating the extent to which environmental factors have contributed to delayed development. Standardized developmental assessment before and after therapeutic intervention or foster home placement can indicate rapid developmental spurts over a period of a few weeks or months. If development in several areas shows marked improvement after a relatively brief period in a different environment, the argument for substantial environmental contribution to the child’s problems is given objective credibility (Martin, 1972).

Case Example

Monique M. was a 4-year-old girl who attended an early childhood intervention program for children from low-income families. During a developmental assessment she maintained a flat affect and displayed no spontaneous exploratory behavior with the numerous toys available. She remained silent throughout the session. Her gross motor skills were age appropriate, but her manipulative and pencil skills were underdeveloped. When it was time to pick up Monique, Mrs. M. arrived with Monique’s two younger siblings. She appeared stressed and disorganized. She frequently slapped the legs of one of the children, whom she admonished to “get over here before I beat your behind.” When Mrs. M. entered the room, Monique glanced up briefly with no change of expression and continued to sit and slowly munch on a cookie. Her mother responded minimally to the therapist’s greeting, then asked, “Has she been bad again?” After the therapist explained that Monique had worked well during the evaluation, Mrs. M. replied, “I’ve had a headache all day and nothing to eat. Come on, Monique, you can’t sit there all afternoon.” The family left without further comment.

On another occasion, Mrs. M. was asked to help her daughter string beads for a necklace. Mrs. M. was enthusiastic. Initially there was mutual eye contact and smiling between Mrs. M. and her daughter. However, Mrs. M. was overconcerned with the appearance of the necklace, and she frequently corrected Monique, saying, “No, Mama [sic], that’s ugly,” or removing beads from the string because she did not like their color. After several of these interactions, Monique became apathetic and passive, leaving her mother to complete the task.

This scenario exemplifies some of the behavioral indicators of risk for child abuse. Monique related poorly to adults in general and showed limited attachment behavior toward her mother. Her interactions with the environment were inappropriately inhibited given her age and the situation. Monique’s mother appeared to be overwhelmed and socially limited, and she did not generally interact with her children in a nurturant manner. She assumed that Monique was misbehaving. She tried to control Monique’s toddler sibling with threats of violence. Mrs. M. was consistently preoccupied with her own needs, to the exclusion of Monique’s. These observations are sufficient to alert the therapist that the children in this family are at risk of abuse. Continued evaluation of the child and parent would be indicated in this case, to be followed by preventive intervention and referral to child protective services if needed.

Referral and Documentation

Most states mandate that health care and educational professionals report suspected cases of child abuse and neglect to state children’s protective agencies. Referrals
involve a telephone call, followed by a letter that provides the client’s name, age, address, and a summary of the reasons for concern. Reports are categorized according to severity and type, and investigations are scheduled accordingly. Ideally, a referral to child protective services should be made with the parents’ knowledge, but this may not be possible if the child’s safety or that of others might be jeopardized. Repeated reports should be made if continued observations of the problem behaviors occur. Multiple referrals are sometimes needed before a case qualifies for an in-depth child protective services evaluation or a legal intervention.

Approximately 25% of reported child abuse and neglect cases reach the courts (Helberg, 1983). For documentation to serve as credible evidence in court, it must be completed in a reliable and valid manner (Barth & Sullivan, 1985; Kreitzer, 1981). Evidence is considered reliable if it is documented close to the event’s occurrence and, when possible, is documented by more than one observer. Repeated observations or measures taken over a period of time strengthen the report. Valid evidence is that which employs a variety of direct measures, involves standardized tests as much as possible, and is based on objective information rather than the therapist’s interpretation. If interpretative statements are to be included in the report they should be clearly indicated as such and used with caution.

By involving child protective services in a case, the occupational therapist adds another facet to the treatment team. The role of child protective services in most states is to screen families who have been referred for possible child abuse or neglect, evaluate those whose problems meet intake criteria, and intervene in identified cases of child abuse. In addition, many child protective services agencies offer an array of services to families who are admitted to the caseload. Such services include supplemented day care, parent support and education groups, homemaking aides, and transportation to therapy and medical appointments.

Child protective services agencies are frequent recipients of criticism from the media and from the community at large. They are traditionally overburdened and underfunded. Child protective services caseworkers typically carry large caseloads that are complex, demanding and emotionally stressful. In addition, caseworkers are usually not child development or mental health professionals by formal education (Faller, 1985). Awareness of these constraints facilitates the development of an effective working relationship by reducing the incidence of mutual misunderstanding and frustration. Occupational therapists whose clients are involved with child protective services should strive to initiate regular contact with caseworkers to share information that is pertinent to the family’s progress, such as indications of the parents’ motivation in and use of therapy and updates on the child’s developmental progress. Child protective services workers can in turn support therapeutic efforts by encouraging parents to attend appointments, incorporating recommendations into their daily lives, and assisting them with obtaining other needed services.

Occupational Therapy Intervention

Effective treatment of abused children and their families requires an interdisciplinary team approach that addresses the needs of the family as a system as well as the needs of individual family members. In most settings that serve children, occupational therapists function as part of a team that includes social workers, teachers, psychologists, physicians, nurses, speech therapists, and physical therapists.

Occupational Therapy With the Parents

The occupational therapist can assist parents in two major ways: by facilitating the establishment of a social support system and by educating them regarding child development and parenting skills. The development of a support system begins with the parent–therapist relationship, which is strengthened through communication of caring and respect. A milestone in treatment is reached when the parent views the therapist as someone to trust and confide in and as someone who will try to help. Parent support groups are also valuable. In such groups, parents find that they are not alone in their problems and discover that they have ideas and advice that will help others. More enduring forms of support can be developed by helping parents plan ways to cope with and prevent crises through the help of friends and family, such as asking a reliable neighbor or relative to watch a child for a few hours per week on a regular basis or during high-stress times. Parent education regarding nonpunitive behavior management techniques, such as praising approximations of desirable behaviors, sticker charting (rewarding desirable behavior by noting progress on paper), and declaring time out, is often needed. Information on healthy child development as it relates to social interactions, daily living skills, and safety can reduce the danger and frustration caused by parents’ unrealistic expectations. Discussion, role playing, and practice of new skills in parent–child activity-based sessions are effective techniques for parenting education. Assertiveness training helps parents develop child management skills, improve general communication abilities, and increase self-esteem.

After a therapeutic relationship is established and the parent has been able to discuss problems, it may be possible to facilitate referral to other community resources, usually through the child protective services worker. Parents often resist premature referrals, but the timely and tactful presentation of suggested help, such as that provided by psychotherapists, preschool or day care
programs, and adult educational or vocational training programs, can aid in family functioning.

**Occupational Therapy Intervention With the Child**

As with the parent, the first step in intervention with an abused child is to establish a positive therapeutic relationship in which the child can learn to expect positive regard and help. Opportunities to engage in safe and pleasurable environmental exploration should be provided, and much encouragement and support given. Interactions, both verbal and physical, must convey caring for and consideration of the child as a person. Individual sessions best achieve this end.

Emotional bonding with a caring adult has been postulated to be a prerequisite for healthy personality development (Jernberg, 1979; Martin, 1972). To facilitate relationship-building, the therapist can use some of the interactions found in healthy parent-child relationships. These interactions include cuddling and holding, feeding, grooming, and teaching challenging but developmentally appropriate skills. Many of the techniques described in Jernberg’s book *Theraplay* (1979) specifically address the goals of interpersonal relating. Approaches for addressing the abused child’s psychosocial needs can be combined with occupational therapy techniques used in treating other developmental needs, such as motor skills, dressing, and eating. Therapeutic activities based on sensory integration theory, neurodevelopmental treatment, and behavioral approaches are easily performed with attention to the nature and quality of the therapeutic relationship.

**Case Example**

Martin was a 7-year-old boy with learning disabilities whose history of chronic emotional rejection and physical abuse had contributed to his severe social, emotional, and behavioral disturbances. He was hospitalized for setting fires in the home, overactivity and disruptiveness in school, and physical aggression toward peers and adults. His behavior had become dangerous to the point that the treatment team would recommend residential placement if substantive improvements could not be achieved. Once in the hospital, Martin did not relate well to adults or peers, and he generally withdrew from staff members’ attempts to engage him in play therapy or to talk about personal concerns. The therapeutic setting that motivated him the most was occupational therapy, where he reveled in the craft activities. The team decided to capitalize on Martin’s enthusiasm by assigning one occupational therapist to work with him on an individual basis during daily occupational therapy craft groups and in biweekly sensory integration sessions. The close, frequent interaction Martin experienced during the craft group allowed him to experience consistent support and caregiving, intermixed with appropriate limit-setting and guidance in getting along with peers. He responded to this experience by becoming increasingly accepting of rules and directives, demonstrating improved self-concept and organizational skills, and developing friendly relationships with several other boys. The individual sessions consisted of a blending of traditional sensory integration activities with nurturing activities. For example, Martin would lie supine in a net swing with blankets and pillows and sip a milkshake through a straw as the therapist gently rocked the swing and sang or spoke to him quietly. His immediate response was to act mildly resistant and uncomfortable, but this response quickly transformed into deep relaxation and satisfaction. Over a period of weeks Martin became invested in the individual sessions and trusting of the therapist, as reflected by his appropriate attention-seeking behaviors and an increasing frequency and depth of self-disclosure. Subsequently Martin developed healthier relationships with a number of hospital staff members and dramatically decreased the frequency and severity of dangerous behaviors. He was ultimately discharged to a foster family and began attending public school.

**Intervention for the Parent-Child Relationship**

As the parent and child become better able to receive and respond to nurturance from the therapist, the likelihood of improving their positive interactions with each other increases. The occupational therapist can select activities that elicit appropriate caretaking behaviors, such as encouraging the child and structuring play in a warm, relaxed manner. Activities should be selected for appropriateness in terms of the parent’s and the child’s developmental levels, and presented in a supportive, nonevaluative mode. The therapist may need to demonstrate and teach some of the activities initially. Gentle massage, interactive songs, and nursery rhymes such as “Pat-a-cake” and “Where is Thumbkin?” are appropriate activities for a parent and infant. Toddlers and their caretakers often enjoy rolling balls or cars to one another, feeding each other cereals or small candies, combing each other’s hair, and playing with water. Preschool and young school-age children can sit on a parent’s lap while reading aloud or building with blocks on a table top. Simple crafts, cooking activities, and other tasks that provide parents opportunities to teach skills that are valued by the child and parent can also be extremely therapeutic. In all activities, gentle physical contact, pleasant conversation, and mutual enjoyment are the main goals. The occupational therapist can use parent-child sessions to teach concepts of child development, so that the parents can establish more realistic expectations of their child’s motor, cognitive, and social-emotional capabilities as they relate to issues of safety and daily living skills. Parent-child sessions also allow parents to observe and practice...
behavior management skills, such as praise, verbal correction, and time out.

Summary

Unlike most causes of developmental disabilities, such as prenatal distress and genetic error, child abuse is a common problem that occupational therapists can help to prevent. Occupational therapists who work in school- and community-based settings are in a strategic position to routinely screen children for abuse and provide preventive intervention and referral.

Occupational therapists’ evaluation of a child’s developmental status includes measurement and observation of neurodevelopmental progress, social and emotional behavior, communication, and daily living skills. Any of these aspects of a child’s abilities may indicate abuse. When a child and parent are seen together, their styles of interacting may reflect dysfunction. During interviews, parents may share concerns about child rearing practices or misconceptions about typical child development. Activities-based assessment provides an opportunity to observe parent-child interactions in order to support or invalidate information obtained through interviews. Evaluation materials indicating the likelihood of child abuse should be referred to child protective services. A working dialogue with child protective services and activities-based treatment approaches can be an effective format for parenting education and child-oriented intervention.

The negative effects of physical abuse have been documented as early as in infancy and have been shown to persist through adulthood. Chronic child abuse in families tends to perpetuate an intergenerational cycle of troubled interpersonal relationships, emotional distress, and malparenting (Main & Goldwyn, 1984; Ogata et al., 1990; Prodgers, 1984). Effective intervention with families who engage in violence toward their children is an investment in the occupational performance and well-being of this and future generations.

Appendix

Developmental Interview Questions for Parents of Preschool Children at Risk of Physical Abuse

Please tell me about your family.

(a) Who are the members of your household? What are their ages?
(b) Who does most of the childcare in your household?
(c) Do other family members help? How?
(Listen for: adult-child ratio, quantity and quality of social relationships among adults)

Even young children have unique personalities. How would you describe (identified child) as a baby?
Did he or she feed and sleep easily?

(a) Did you nurse or bottle feed?
(b) When did you begin to give solids?
(c) When was he or she completely weaned?
(d) How did you decide to stop bottle feeding?
(Listen for: difficulty with eating and sleeping, parent’s interpretation of the baby’s behaviors, parent-driven structuring versus child-driven timing, day-to-day stress levels)

How would you describe (identified child’s) personality at this time?

(a) Who is he or she like?
(b) Is he or she easy or difficult to live with most of the time?
(c) What are the most effective ways to teach or discipline him or her?
(d) What are (identified child’s) most recent accomplishments?
(e) Do you have any concerns or questions about (identified child’s) development or behavior at this time?
(f) Are you experiencing a lot of stress in your life at this time?
(g) Is there someone who you talk to about problems or concerns?
(h) Are you having any difficulties that I may try to help with?
(Listen for: generally positive versus negative outlook, knowledge of the child, adaptive skills and resources, social support, overtly and indirectly communicated concerns)

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