A COGNITIVE APPROACH TO PREVENTING CHILD MALTREATMENT

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The maltreatment of infants is an enigma that has troubled academics, professionals, and the general public. Just as puzzling is that maltreating parents often see themselves as victims and the child as the perpetrator within their family systems. In order to understand and thus prevent maltreatment, it is necessary to consider the ways in which such parents think about the caregiving relationship.

The theoretical and empirical origins of the family thriving program

In our program to address child maltreatment, called the Family Thriving Program, we have developed an intervention that grew out of our research on harsh and abusive parenting. The program began with our early findings with respect to the causal beliefs that characterized physically abusive parents (Bugental et al., 1989). We found that abusive parents often believed that caregiving problems were under the control of the child (e.g., the child is stubborn) and were not under their own control. Such parents may be thought of as having low perceived power. We also found that these parents were more likely to abuse children who were, or seemed to be, socially unresponsive.

We went on to track the early history of parents and infants during the child’s first year of life (Bugental & Happaney, 2003). Before the child was born, we measured mothers’ caregiving beliefs (i.e., their attributions about what makes things happen in parent-child relationships). When the child was born, we obtained information on early medical problems and birth complications. Our expectation was that when mothers with low perceived power gave birth to a child with a mild or moderate medical problem (e.g., mild levels of prematurity, moderately low Apgar scores), they would be more likely to maltreat those children. This is indeed what we found. Powerless mothers were much more likely to maltreat their medically at-risk infants than were other mothers. In addition, they were more likely to become depressed. No comparable maternal reactions were shown to healthier infants.

What are the effects of harsh or unresponsive parenting?

As the next step, we studied the effects of parental behaviours on the stress reactions of their infants. In order to test the early hormonal responses of infants to 1) harsh or abusive parenting or 2) maternal depression, we obtained measures of cortisol, a central stress hormone, on children when they were toddlers (Bugental et al., 2003). We found that children who had been treated harshly were hyper-reactive to stress involving a brief separation from their mothers. Their rise in cortisol levels was twice as high as that shown by other children. This same pattern was found even when children had been spanked (but not physically abused by California legal standards). We found a different pattern among infants whose mothers were depressed. In this case, children’s cortisol levels were continuously high. In the first case, we may think of mothers’ actions as a source of stress for the infant. In the second case of maternal depression, mothers are unable to buffer their infants against stress. A key role of parents during the child’s infancy is to assist in the regulation of their emotional responses—to calm, to comfort, and to re-assure. When parents do not (or are unable to) do this, infants experience the cost of a poorly regulated stress response system. If stress continues too long and without recovery, it can lead to changes at the level of the brain. This in turn has a negative impact on children’s social development, their cognitive development, and their health (Bremner & Narayan, 1998; McEwen, 2001).

Developing and evaluating the effectiveness of a cognitively enhanced child abuse prevention program

The final step in the program was to develop a child abuse prevention program grounded in our previous findings about combinations of mothers and children that are at particular risk for maltreatment. The program we developed involves home visitation during the first year of the child’s life (Bugental et al., 2002). In order to evaluate the effectiveness of the program, at-risk families were invited to participate in the program. This at-risk group included families in which mothers were experiencing stress as a result of separation from extended families, acute poverty, a history of having been abused as a child, etc. About one-third of the infants was born at mild or moderate medical risk. Families were randomly assigned to one of three conditions:

1. **Standard Community Services.** In the first condition, families were given information about services available to them in the community.
2. **Healthy Start Home Visitation.** In the second condition, families received an average of 17 home visits during the first year of the child’s life focusing on social support and parent education (e.g., Breakey & Pratt, 1991).
3. **Cognitively-Enhanced Home Visitation.** In the third condition that we designed on the basis of our past research, families received an average of 17 home visits during the first year of the child’s life. These visits included assistance in parental reframing of caregiving problems.
Within the third condition, every visit began with the following sequence: The mother was asked how things had been going and what kind of problems she had been experiencing in the caregiving relationship. For example, a mother might report that the infant cried continuously and was seemingly inconsolable. She was then asked to speculate as to why she thought this was happening. Mothers often came up with statements of blame directed to themselves, their infant or others. For example, they might believe that the child was mad at them, or that they were bad mothers, or that their milk was bad. Mothers were then encouraged to think of alternative reasons for the problem until they came up with a benign reason — one that did not involve blame.

Next, mothers were asked to generate some possible solutions that they could try (e.g., singing to the baby, changing the baby's formula, massaging the baby's back). They subsequently tried out one of the possible solutions and reported how things had worked out during their next meeting with the home visitor. This series of events served to facilitate mothers' problem-solving abilities. What began as a blameworthy threat was reframed as a resolvable challenge.

Approximately 100 families entered the program, and the retention rate was approximately 75%. At the end of one year we measured the control tactics parents reported using with their infants on the Conflict Tactics Scale (Straus, 1979). We also measured infant health at that time. Our findings yielded a clear advantage for the cognitively-enhanced condition. Whereas 26% of parents in the first condition and 23% of parents in the second condition physically abused their children during the first year, only 4% of parents in the cognitively-enhanced home visitation condition did so. A similar pattern was found for use of harsh (but legally non-abusive) parenting. That is, a significantly lower level of spanking and slapping was found in the cognitive condition (18%) than in the other two conditions (47% in the first condition and 38% in the second). In addition, parents in the first two conditions were more likely to abuse medically at-risk than healthy children. No such effect was found among mothers in the cognitive condition.

Finally, we looked to see if children showed health benefits in response to any of the three conditions. We found that the greatest health benefits occurred for children who were at medical risk if their mothers had participated in cognitively enhanced home visitation. Such children may be thought of as thriving in the face of their early adverse medical history (Bugental, 2003). In contrast, medically at-risk children in the other two conditions were sicker at one year of age than were children who were not at risk (Bugental & Beaulieu, in press). We found that parents in the cognitively-enhanced condition showed a high level of investment in their at-risk infants. As they came to see their experiences as resolvable challenges, they were interested in learning more about their children and finding ways to improve the level of care they provided.

Conclusions

All of this suggests the importance of considering the role of parental cognitions in the creation of programs designed to prevent child abuse. In doing so, our home visitors did not come in as experts with advice to give. They were simply the facilitators of mothers’ own problem-solving efforts. These efforts included greater attention to the cues that infants provide regarding their needs and states. As mothers became more experienced problem-solvers, they became less depressed, and as they became less depressed, they were less likely to deal harshly with their infants. From a different perspective, when mothers themselves were treated with respectful consideration, they became more respectful and considerate of the needs of their young children.

Our findings also suggest the importance of considering the characteristics of the child as well as the characteristics of the parent in offering home visitation services to families. Children with medical or physical disorders have been found to be at greatly elevated risk for parental maltreatment and neglect (Sullivan & Knutson, 2000). As a result, they have the most to gain when their stressed parents receive assistance. Ultimately, the children themselves stand to gain long-term benefits in their ability to manage stress in an adaptive fashion. Thus the pay-off is not just in stopping the short-term damage to maltreated children, it also fosters physiological changes that have implications for the child’s cognitive development, social development, and health.

References


