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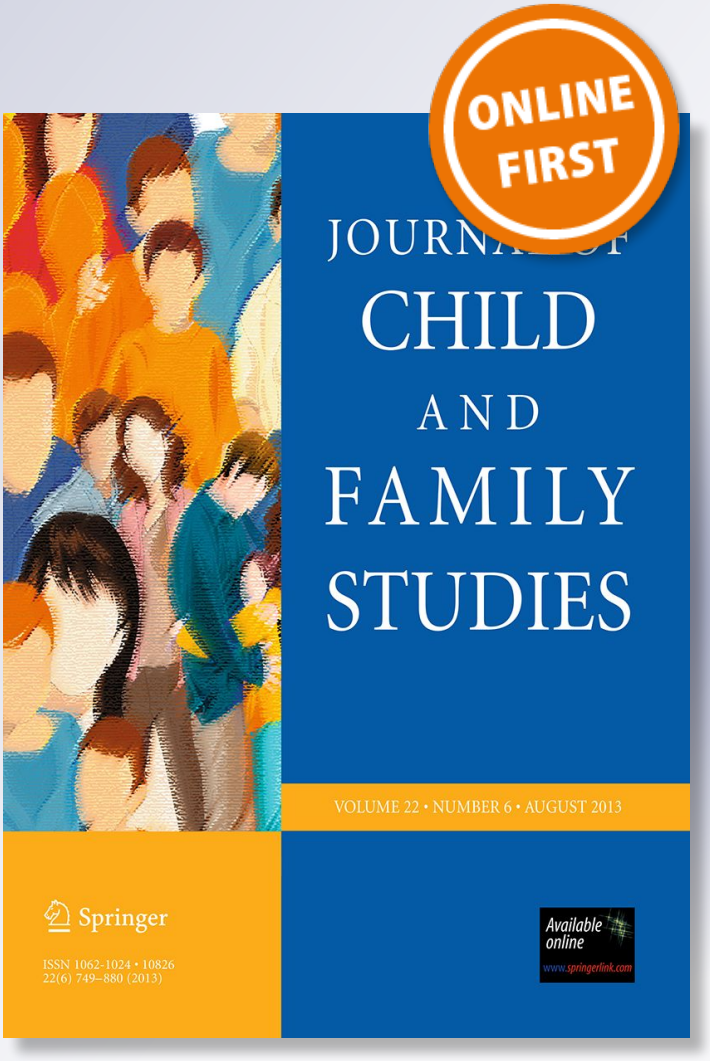

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ORIGINAL PAPER

The Assessment of the Attitudes and Behaviors about Physically Abused Children: A Survey of Mental Health Professionals

Amy J. L. Baker[1] · Steven Miller[2] · William Bernet[3] · Trinae Adebayo[1]

Abstract

Objectives The purpose of the current study was to assess clinician reports of behaviors and attitudes of physically abused children in order to determine whether they generally behaved in a manner designed to maintain the attachment to the caregiver rather than disrupt the attachment.

Methods Three hundred and thirty-eight clinicians were surveyed about the attitudes and behaviors of physically abused children. Some clinicians rated a specific severely abused child, some rated severely abused children in general, some rated a specific moderately abused child, and some rated moderately abused children in general. Half of the items on the survey pertained to attachment-enhancing behaviors (caring about the parent's feelings, staying connected the family of the parent, minimizing the harm, and so forth) and half of the items reflected attachment-disrupting behaviors (idolizing the other parent, being rude towards the parent, expressing trivial reasons for being hurt with the parent, and so forth).

Results For each of the four samples, abused children were rated as expressing significantly more attachment-enhancing behaviors than attachment-disrupting behaviors. They were also found to exhibit more extreme attachment enhancing behaviors than extreme attachment disrupting behaviors. For the most part, characteristics of the rater and the child were not associated with ratings.

Conclusions Physically abused children were reported to want to maintain relationships with abusive caregivers, which presents challenges as well as opportunities for clinicians working with this highly vulnerable population.

Keywords Child abuse · Attitudes · Foster care

Attachment is defined as an innate behavioral system designed to protect the infant by inducing proximity seeking to a caregiving adult (Bowlby 1969). As children develop and mature their need to maintain the attachment relationship remains although the child can experience security from an attachment figure in ways that extend beyond physical proximity.

Humans are hard-wired to form and maintain attachment relationships with caregiving adults (Ainsworth et al. 1978; Bowlby 1969). Maternal behaviors of emotional availability and contingent responsiveness have been identified as essential qualities that promote a secure attachment (Crittenden and Ainsworth 1989; Koehn and Kerns 2018). Behavioral indicators of security in the infant include using the mother as a secure base from which to explore the environment and seeking proximity to and comfort from the mother when distressed. Attachment in young children is assessed by both direct behavioral observation and assessment of the internal representation (Shmueli-Goetz et al. 2000). Attachment in teens and adults has been assessed as an internal state of mind (Allen et al. 2003; Bretherton 1985) rather than a set of specific behaviors. Regardless of assessment technique, a prevailing finding is that children will form and strive to maintain a relationship with a caregiving adult, if such an adult is available (Bowlby 1969; Cassidy 2016).

This is true even for children who have been maltreated by a parent. Baker and Schneiderman (2015) reviewed the different sources of evidence for this premise including the writings of clinicians working directly with abused children.

✉ Amy J. L. Baker
AmyJLBaker@aol.com

[1] Vincent J. Fontana Center for Child Protection of the New York Foundling, New York, USA

[2] The Massachusetts Medical Education Group, 61 Kodiak Way #2511, Waltham, MA 02451, USA

[3] Vanderbilt University, Nashville, USA

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For example, Fairbairn (1952) observed that children will assume "the burden of badness" to avoid recognizing that a parent is behaving in a harmful manner. Similarly, Briere (1992) identified the "abuse dilemma" occurring when children struggle to maintain a belief that both the self and the parent are good, when being abused by a parent shows that is not the case. Trauma specialist Herman (1992) recognized that children will go to great lengths to construct an explanation for abuse that absolves the parent of blame. Also, Blizard and Bluhm (1994) wrote that, "One of the greatest conundrums for therapists treating abuse survivors is the problem of understanding the attachment of the victim to the abuser."

Memoirs written by adult survivors of childhood maltreatment (both abuse and neglect) further contribute to an understanding of maltreatment. Regardless of the gender of the author, gender of the abusive parent, age that the abuse occurred, or type of abuse perpetrated on the child—there was an attachment of the abused child to the abuser and a desire for a repaired relationship with that caregiver. The authors of such memoirs revealed that as maltreated children they loved their abusive caregivers and wanted to maintain the attachment with them, no matter what.

Evidence can also be found in the attitudes of children in foster care. Baker et al. (2016) analyzed 27 studies and found that many children in foster care were reported to miss their abusive caregiver, yearned to be reunited with that parent, were afraid of being separated from that parent, minimized the impact of the abuse, and blamed themselves for the bad behavior of their parent.

Primate research by Harry Harlow has been seminal for understanding the behaviors of abused offspring. In his original study he demonstrated that baby monkeys would form attachments with surrogate "mothers" (1958). In subsequent research, Harlow constructed "monster mothers" to abuse and reject their babies in order to measure the attachment exhibited by the abused babies. He found that the babies spent *more* time clinging to the monster mother than babies raised by a non-abusive mother spent clinging to their mothers and concluded that the aversive mothering induced *more* clutching and proximity-seeking in the babies (Rosenblum and Harlow 1964). The babies appeared to love their monster mothers and sought comfort from them, despite the fact that it was the mother who inflicted the pain on them.

Harlow's (1958) primate research presciently anticipated the field of attachment theory and several decades of attachment research with humans since then have established the primacy of the infant-parent bond. A meta-analysis of ten attachment studies conducted with maltreated children found that the maltreated children generally did form an attachment relationship with their abusive parents, although for most the attachment was insecure as opposed to secure, meaning that the children had not received the contingent emotional responsiveness from their mothers and hence were not able to subsequently rely on them as a secure base (Cicchetti et al. 2006; Cyr et al. 2010).

A small set of studies on the experience and expression of pain inflicted by mothers also contributes to our understanding that child abuse is experienced differently than other kinds of harm. Moriceau and Sullivan (2006) studied the pairing of smell and pain in rat pups both with and without the mother present. The rat pups who experienced the smell-pain pairing while in proximity to the mother did not learn to fear the smell while the rat pups who experienced the smell-pain pairing not in the presence of the mother did fear the smell. The researchers concluded that the presence of the mother functioned like a biochemical off switch for learning fear. The authors noted that rat pups are hard-wired to not experience their mothers as aversive, because, "If a helpless newborn infant does not form an attachment to its caregiver, even to an abusive one, its chances of survival diminish" (Sullivan et al. 2000, p. 38). Later, Sullivan and Lasley (2010, p. 7) noted, "The fear, avoidance, and even memories associated with pain are extinguished—explaining why an abused child, even while trying to escape pain, will later seek contact with the abuser". In another study on the topic of pain experienced by victims of abuse, researchers found that medical doctors rated the pain expressed by abused children as lower than the pain expressed by accident victims, even when blind to the status of the children (Drouineau et al. 2017).

The current study was designed to extend and build on these disparate strands—i.e., that abused children form and maintain attachments to their abusive caregivers—by assessing the attitudes of physically abused children toward their maltreating caregiver, through surveys of clinicians who work with this population. The primary hypothesis in this study was that children would be reported by their clinicians to exhibit more frequent and more extreme levels of attachment-enhancing (AE) behaviors than attachment-disrupting (AD) behaviors. Specifically, it was expected that mean scores for the AE variables would be higher than AD variables for all four samples of children rated. It was also expected that the frequency of the AE variables would be higher than for the AD variables. This was examined with respect to both frequency of the behaviors and the number of behaviors exhibited. There were also three exploratory research questions: (1) Would there be differences in the ratings between the specific children and children in general? (2) Would there be differences in the ratings of severely and moderately abused children? and (3) Would there be differences in ratings based on characteristics of the rater?

Methods

Participants

Two populations were drawn upon for the sample of this study. The first was mental health clinicians in one city's child welfare agencies. It was presumed that all would have experience providing clinical services to children who had been physically abused, so no screening was deemed to be necessary. The directors of 24 clinical departments within a large northeastern city's child welfare agencies were contacted, provided general information about the study (that it involved participants reporting in a confidential manner on the attitudes and behaviors of physically abused children toward their caregivers), and asked to provide the names and e-mail addresses of agency clinicians. One agency responded that there were no on-staff clinicians, so the eligible number was reduced to 23. Of the remaining 23 agencies, one declined to participate, four never responded to the e-mail query, and 18 provided the requested information for 180 clinicians, resulting in a 78% response rate. No information was available on the clinicians whose contact information was not provided.

The second population was the internet listing of all clinicians who had been trained in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (https://tfcbt.org/members/, accessed in July 2018). It was deemed likely (but not certain) that such clinicians would have experience working with physically abused children. Thus, a screening e-mail was sent to the first 396 names on the list to determine who did have experience with physically abused children. (We intended to sample the first 400 but there were a few duplicates, reducing the N to 396). The e-mail explained the study and asked whether the recipient had worked with physically abused children. Of the 396 e-mails sent, 89 e-mail addresses were invalid. Of the remaining 307, 233 people responded (76% response rate). Of this 233, 218 people affirmed that they had experience working with physically abused children. Thus, at the start of the study the sample was comprised of 398 individuals (180 from child welfare agencies and 218 from the TF-CBT list).

Of the 180 clinicians in child welfare, 13 had bad e-mails and/or left the agency by the time the study started. Of the 167 remaining clinicians, 143 completed the survey (86% response rate). Of the 218 TF-CBT clinicians, 6 had invalid e-mail addresses by the start of the study. Of the 212 remaining clinicians, 166 completed the survey (78% response rate). The combined response rate from the two samples was 80%. An additional 29 mental health professionals completed the survey without having been invited (some clinicians who completed the survey shared it with them) and their data were included. The final sample was 338 professionals.

Table 1 Sample characteristics

	N	%
Gender		
Male	39	12.1
Female	282	87.6
Other	1	00.3
Highest education		
Masters	255	78.9
Doctorate	58	18.0
Medical	10	03.1
Missing = 5		
Discipline		
Social work	151	46.2
Counseling	70	21.4
Psychology	84	25.7
Psychiatry	06	01.8
LMFT	06	01.8
Other	10	03.1
Missing = 1		
Work Setting		
Agency	286	78.2
Private Practice	42	12.8
Experience		
Training	164	50.2
Research	43	13.1
Custody evaluations	31	09.5
Teaching	34	10.4

Table 1 presents demographic characteristics of the sample.

The final sample was comprised of 143 clinicians in child welfare, 166 clinicians from the TF-CBT listing, and 29 additional clinicians. The sample ranged in age from 23 to 69 (Mean = 39.1, SD = 11.4). They worked in 43 different U.S. states and Puerto Rico. About 13% were in private practice and the remaining worked in a variety of agencies including child welfare agencies, child advocacy centers, hospitals, and clinics. About 80% had a master's degrees and about 20% had doctoral degrees. About half of the sample had degrees in social work, around 20% had degrees in counseling, another 20% had degrees in psychology, and the remaining had degrees in psychiatry or "other" discipline.

Procedure

The survey began with a screening question to ensure that the recipient had experience with physically abused children. The second question was a statement of informed consent that described the purpose of the survey, the

funders and sponsors, the benefits and risks, contact information for any questions, and ended with a place to provide informed consent.

The third section of the survey contained 13 items about the respondent: name, name of agency (if applicable), location of agency/clinical practice, age, gender, highest educational degree, discipline the degree is in, whether the respondent has engaged in other professional activities related to physically abused children (providing training, conducting research., conducting custody evaluations, teaching post-secondary courses, or other), whether the clinician utilized any manualized treatment protocols and, if so, which ones, about how many physically abused children the clinician has worked with (specified in two of the surveys as moderately physically abused and in two as severely physically abused).

The next section of the survey contained 18 questions about the attitudes and behaviors of physically abused children. There were four versions (randomly distributed to the participants). In version 1, the respondent was directed to rate a specific severely physically abused child, defined as: frequent and/or extreme non-accidental shaking, slapping, hitting, burning accompanied by major physical injury (bruise, welt, burn, and so forth) This definition was drawn from Gross and Keller (1992). The clinician was directed to select a severely physically abused child from his/her caseload based on the clinician being very familiar with the case and having observed the child's actions and/or attitudes toward the maltreating parent. If more than one child fit the description, the clinician was to select the child whose first name started with the same letter as the clinician's first name and proceeding through the alphabet until there was a child the clinician could complete the survey about.

In version 2 of the survey, the clinician was directed to select from his/her caseload a child who was moderately physically abused, defined as periodic non-accidental shaking, slapping, hitting, burning accompanied by minor injury (bruise, welt, burn, and so forth). This definition was drawn from Gross and Keller (1992).

In version 3 of the survey the clinician was directed to answer the 18 questions based on their experience with severely abused children in general and in version 4, the clinician was directed to answer the 18 questions based on their experience with moderately physically abused children in general.

All 18 items of the survey began with the same stem: At the time you were working with the child(ren) they … which was followed by nine behaviors determined from the literature to be "attachment-enhancing" (AE) and nine behaviors determined from the literature to be "attachment-disrupting" (AD) behaviors. The AE behaviors reflected the child's engagement with the parent, investment in the relationship, and a desire to stay close and connected to that parent. The specific items were: (1) worried about hurting the maltreating parent's feelings, (2) were invested in having a better relationship with the maltreating parent, (3) could recall positive memories about the maltreating parent, (4) maintained relationships with the family of the maltreating parent, (5) had complaints about the maltreating parent that were realistic and reality-based, (6) were able to see good and bad in the maltreating parent, (7) sided with the maltreating parent if that parent has a disagreement with anyone else, (8) minimized the impact of the maltreatment, and (9) blamed him- or herself for the maltreatment. These nine items were drawn from the literature as the types of behaviors children typically behavior in service of maintaining the bond with the caregiver.

The nine AD behaviors reflected the child's lack of investment in the relationship, hostility and anger, as well as disinterest in being close and connected to that parent. The specific items were: (1) adamantly refused to have a relationship with the maltreating parent, (2) idolized/idealized the *other* parent, (3) maintained a persistently negative view of the maltreating parent, (4) behaved in a rude and/or aggressive manner toward the maltreating parent, (5) offered weak, frivolous, trivial, and absurd reasons for being upset with the maltreating parent, (6) repeated bad things heard from others about the maltreating parent, (7) did not seem to care about the feelings of the maltreating parent, (8) went out of his/her way to say that his/her feelings about the maltreating parent have not been influenced by anyone else, and (9) seemed unnecessarily angry at the family of the maltreating parent. The 18 items were developed by the first author based on Bowlby's (1969) concept of the goal-directed partnership as well as the work of attachment in childhood which identifies the dimensions of idealization, preoccupation of anger, and balance of good/bad as essential for assessing attachment (Shmueli-Goetz et al. 2000). Each of the 18 items had the same response options of (0 = never, 1 = rarely, 2 = sometimes, 3 = very often, 4 = always).

Four versions of the survey were created. Each clinician was randomly assigned one version: (1) specific severely abused child (2) severely abused children in general (3) specific moderately abused child, (4) moderately abused children in general. The rationale was two-fold. First, we were concerned that some clinicians might rate moderately abused children while others would rate severely abused children so it seemed advisable to direct them to which level of abuse to consider rather than have this be a potential source of error or bias in the study. We didn't want to limit the focus on only one or the other as that would limit the generalizability of the study so we included both. Second, we felt that it was plausible that while moderately alienated children might behave in an attachment-enhancing manner

Table 2 Means and standard deviations of attachment-enhancing (AE) scores and attachment-disrupting (AD) scores for the four samples

	Attachment-enhancing	Attachment-disrupting	
Sample	Mean (SD)	Mean (SD)	*t*
Severely abused specific child	19.6 (5.2)	11.5 (4.2)	9.5***
Moderately abused specific child	18.5 (5.6)	12.7 (4.5)	7.3***
Severely abused children in general	21.7 (3.4)	13.9 (3.6)	14.0***
Moderately abused children in general	21.3 (3.3)	14.7 (3.3)	12.3***

***$p < 0.001$

toward the caregiver, we wanted to test whether this would also be true for severely abused children. We also were not clear whether clinicians selecting a specific child would choose one that was more extreme than if they were rating children in general so it seemed advisable to include both options rather than have uncontrolled error in the study.

Participants were provided with a brief and general informed consent procedure which stated that they would be asked to rate the behaviors and attitudes of physically abused children whom they had provided mental health treatment to. Thus, they had first-hand experience of the children they were rating.

Results

Reported Behaviors of Abused Children

The first research question pertained to hypothesized differences in children's reported expression of AE behaviors and AD behaviors. It was hypothesized that the scores for the AE behaviors would be statistically significantly higher than the scores for the AD behaviors. In order to test this hypothesis, a summary score of the nine AE behaviors was created and a summary score was created for the nine AD behaviors (coefficient alpha 0.78 for AE scale and 0.68 for the AD scale). Mean imputation was employed for missing data as long as no more than ten percent was missing per participant. The summary score ranged from 0 (0 on all 9 items) to 36 (4 on all 9 items). A dependent *t*-test was conducted to compare these two summary scores. This was done separately for each of the four samples; (a specific severely abused child, a specific moderately abused child, severely abused children in general, and moderately abused children in general). Table 2 presents the means and standard deviations of the AE and AD scores.

As can be seen, in each of the paired *t*-tests, the mean AE score was statistically significantly higher than the mean AD scores. For sample 1 (ratings of a specific severely abused child) the AE summary score ($M = 19.6$, $SD = 5.2$) was statistically significantly higher than the mean AD summary score ($M = 11.5$, $SD = 4.2$), t (72) = 9.5, $p < 0.001$. For sample 2 (ratings of a specific moderately abused child), the mean AE summary score ($M = 18.5$, $SD = 5.6$) was statistically significantly higher than the mean AD summary score ($M = 12.7$, $SD = 4.5$), t (91) = 7.3 $p < 0.001$. For sample 3 (ratings of severely abused children in general) the mean AE summary score ($M = 21.7$, $SD = 3.4$) was statistically significantly higher than the mean AD summary score ($M = 13.9$, $SD = 3.6$) t (91) = 14.0, $p < 0.001$ and for sample 4 (ratings of moderately abused children in general) the mean AE summary score ($M = 21.3$, $SD = 3.3$) was statistically significantly higher than the mean AD summary score ($M = 14.7$, $SD = 3.3$), t (78) = 12.3, $p < 0.001$. Thus, in each of the four samples, the clinicians reported that the maltreated children exhibited higher rates of AE behaviors than AD behaviors.

Table 3 Frequency distribution of attachment-enhancing scores minus attachment-disrupting scores

	N	%
Negative Score	43	12.7
Score of 0	12	03.6
Positive scores	281	83.6

For each youth, their summary AD score was subtracted from their summary AE score in order to examine the difference. Negative difference scores indicated that the youth was more attachment-disrupting than attachment-enhancing, a score of zero indicated equal portions of AE and AD behaviors, and positive scores indicated greater amounts of AE than AD behaviors. It was predicted that the vast majority of the sample would have positive scores. The frequency distribution of this difference variable is presented in Table 3.

As can be seen, about 13% of the sample had negative difference scores indicating that the youth was more attachment-disrupting than attachment-enhancing. A small number had scores of zero, and the vast majority (83.6%) had positive scores, indicating a preponderance of AE behaviors. A binomial distribution test revealed that the proportion of positive scores (AE > AD) was statistically significantly greater than 50% as compared to negative and zero scores, $p < 0.001$.

A summary score was also created which represented the number (out of nine) of the AE behaviors compared to the number of AD behaviors. In this analysis the ratings were

Table 4 Means and standard deviations of number of extreme attachment-enhancing (AE) scores and number of mean attachment-disrupting (AD) scores for the four samples

	Attachment-enhancing	Attachment-disrupting	
Sample	Mean (SD)	Mean (SD)	*t*
Severely abused specific child	3.6 (1.9)	1.2 (1.2)	8.6***
Moderately abused specific child	3.3 (2.1)	1.5 (1.3)	6.3***
Severely abused children in general	4.3 (2.3)	1.0 (1.2)	11.5***
Moderately abused children in general	4.0 (2.1)	1.0 (1.1)	10.9***

***$p < 0.001$

dichotomized such that scores of never, rarely and sometimes were recoded as 0 and scores of very often and always were recoded as 1. The variable then represented the presence of a high degree or extreme presentation of the behavior. A dependent *t*-test was conducted within each of the four samples in order to determine if more attachment-enhancing behaviors were exhibited at this extreme level than attachment-disrupting behaviors Table 4.

As can be seen, each of the four dependent *t*-tests was statistically significant, $p < 0.001$. Specifically, for sample 1 the AE score ($M = 3.6$, $SD = 1.9$) was statistically significantly higher than the mean AD score ($M = 1.2$, $SD = 1.2$), $t\ (72) = 8.6$, $p < 0.001$. For sample 2 the mean AE score ($M = 3.3$, $SD = 2.1$) was statistically significantly higher than the mean AD score ($M = 1.5$, $SD = 1.3$), $t\ (91) = 6.3$, $p < 0.001$. For sample 3, the mean AE score ($M = 4.3$, $SD = 2.3$) was statistically significantly higher than the mean AD score ($M = 1.0$, $SD = 1.2$) $t\ (91) = 11.5$, $p < 0.001$ and for sample 4 the mean AE score ($M = 4.0$, $SD = 2.1$) was statistically significantly higher than the mean AD score ($M = 1.0$, $SD = 1.1$), $t\ (78) = 10.9$, $p < 0.001$. Thus, in each of the four samples the children were rated as exhibiting a greater number of extreme scores for the AE behaviors than the AD behaviors.

The frequency distribution of these two summary variables representing the number (out of 9) of extreme scores is presented in Table 5 (extreme scores were scores of 3 or 4 compared to scores of 0, 1 or 2). As can be seen, looking at AE behaviors, one third of the sample had between 0 and 2, about one third had between 3 and 4, and the remaining third had between 5 and 9. In contrast, with respect to extreme AD, one third of the sample had none, one third had one, and the remaining third had between 2 and 4. No child was reported to have exhibited all nine AD behaviors. In fact, only 3% of the sample exhibited 3 or more of the AD behaviors while over half of the sample was rated as exhibiting 3 or more AE behaviors.

Table 5 Frequency distribution of the number of extreme scores

	N	%
Attachment enhancing behaviors		
0	09	02.7
1	43	12.8
2	60	17.9
3	51	15.2
4	48	14.3
5	39	11.6
6	37	11.0
7	38	11.3
8	13	03.8
9	02	00.1
Missing = 2		
Attachment disrupting behaviors		
0	115	34.2
1	118	35.1
2	61	18.2
3	25	07.4
4	11	03.2
5	04	00.1
6	02	00.1
7	00	00.0
8	00	00.0
9	00	00.0
Missing = 2		

Differences Between Moderately and Severely Abused Children

The next research question pertained to differences in the ratings of moderately abused versus severely abused children. The two moderate groups (general and specific) were combined and the two severe groups (general and specific) were combined and a MANOVA was conducted with the 18 behaviors as the dependent variables, which was not statistically significant, $F\ (18,172) = 1.2$, $p < 0.24$; *Wilks Lamda* = 0.88

Differences Between Ratings of a Specific Children and Ratings of Children in General

The third research question pertained to differences in the ratings of a specific child as compared to ratings of abused children in general. A MANOVA was conducted, which was statistically significant, $F\ (18,184) = 5.7$, $p < 0.001$;

Table 6 Mean differences in responses for specific vs general ratings

	Specific Mean(SD)	General Mean (SD)	F
Attachment-enhancing behaviors			
Worried about feelings of maltreating parent	1.7 (1.2)	2.4 (0.88)	16.3***
Invested in better relationship with maltreating parent	1.8 (1.3)	2.3 (0.72)	9.3**
Recalled positive memories of maltreating parent	2.3 (0.98)	2.4 (0.76)	0.49
Maintain relationships with kin of maltreating parent	2.1 (1.2)	2.4 (0.71)	3.9*
Had realistic complaints about maltreating parent	2.6 (1.1)	2.6 (0.72)	0.00
Saw good and bad in maltreating parent	2.1 (0.95)	2.3 (0.72)	2.4
Sided with maltreating parent in all conflicts with others	1.4 (1.8)	2.1 (0.75)	26.1***
Minimized impact of abuse by maltreating parent	2.4 (1.1)	2.7 (0.65)	7.0**
Blamed self for abuse by maltreating parent	1.7 (0.95)	2.6 (0.68)	49.5***
Attachment-Disrupting Behaviors			
Refused to have contact with the abusive parent	1.7 (1.1)	1.7 (0.6)	0.02
Idolize the other parent	1.3 (1.1)	1.9 (0.6)	20.8***
Persistently negative view of maltreating parent	2.1 (0.99)	1.9 (0.68)	4.6*
Rude and arrogant toward maltreating parent	1.4 (1.0)	1.8 (0.8)	9.5**
Weak, frivolous reasons for upset with maltreating parent	1.0 (0.98)	1.3 (0.81)	6.0**
Repeated negative comments about maltreating parents	1.6 (1.1)	2.0 (0.82)	5.9**
Did not care about feelings of maltreating parent	1.6 (0.94)	1.4 (0.67)	4.1*
Denied influence of others	1.1 (1.2)	1.2 (0.91)	0.53
Unnecessarily angry at family of maltreating parent	0.83 (0.85)	1.2 (0.68)	13.7***

***$p < 0.001$

Wilks Lamda = 0.60. Table 6 presents the comparisons of the data for children in general and the specific children.

As can be seen, six of the nine AE behaviors were different, with the scores for the general ratings higher than the scores for the specific ratings. Likewise, seven of the nine AD behaviors differed by specific versus general. In five of the instances the ratings for general children were higher than the ratings for a specific child and in two cases the difference was in reverse, with the scores higher for a specific child than a child in general (persistently negative view and did not care about the feelings of the maltreating parent.)

Characteristics of the Child

The next set of analyses focused just on the ratings of specific children because for these children we had information about their age and gender. We conducted Pearson correlations to test whether age and gender were associated with AE and AD scores and found that age was associated with summary AE scores ($R = -0.26$, $p < 0.01$) summary AD scores ($R = 0.25$, $p < 0.01$), number of extreme AE behaviors ($R = -16$, $p < 0.04$), and number of extreme AD variables ($R = 0.23$, $p < 0.01$. Thus, younger children were rated as showing higher levels of AE behaviors, lower levels of the AD behaviors, more extreme AE behaviors, and fewer extreme AD behaviors. There was no association between the gender of the child and the ratings of the child's behaviors.

Background Characteristics of the Clinicians

Nine characteristics of the respondents were examined as possible correlates of summary AE and AD ratings: age, gender, highest educational degree, number of years working with abused children, number of abused children worked with, whether the respondent has provided training on maltreatment, whether the respondent has engaged in research on maltreatment, whether the respondent has conducted custody evaluations, and whether the respondent has taught graduate courses in child maltreatment. Of the 36 correlations, eight were statistically significant, greater than what would be expected by chance. The findings are as follows: age, gender, education, and number of years working in the field were not associated with any of the four variables. Whether the respondent provided training on the topic of child maltreatment was correlated with the summary AD score ($R = 0.11$, $p < 0.04$). Whether the respondent conducted research on child maltreatment was associated with the number of AE extreme scores ($R = 0.13$, $p < 0.02$). Whether the respondent taught courses on child maltreatment was associated with summary AE score ($R = 0.14$, $p < 0.01$) and the number of AE extreme behaviors ($R = 0.13$, $p < 0.01$). The total number of maltreated children

the clinician had worked with was correlated with the number of extreme AE scores ($R = 0.15$, $p < 0.005$).

A regression analysis was conducted with the number of AE extreme scores as the dependent variable and the independent variables entered simultaneously (number of abused children worked with, whether conducted research, and whether taught). Results revealed a small total variance accounted for ($r^2 = 0.04$) and number of children worked with as the only significant variable (beta = 0.14, $p < 0.01$).

Discussion

This study was conducted in order to gather empirically derived data regarding the actions and attitudes of physically abused children toward their maltreating caregiver, as reported by their therapists. Over 300 clinicians reported on their experience with physically abused children, 166 rated a specific child and 172 clinicians rated children in general, having worked with roughly 17,500 such children.

Several notable findings emerged from the current study. First, as hypothesized, abused children were reported to exhibit statistically significantly higher levels of attachment-enhancing behaviors than attachment-disrupting behaviors. The sum of their AE behavior scores was statistically higher than the sum of their AD behaviors. This was also true for the number of extreme scores. No child was reported to have exhibited more than four AD behaviors very often or always while one third of the sample was reported to have exhibited five or more AE behaviors at that frequency. Thus, as a group, the children were rated as expressing more of the behaviors identified as preserving the relationship than behaviors that could disrupt it.

Therefore, despite being physically maltreated by a parent—some severely—the over 17,500 children reported on in general and the 166 children reported on specifically were noted to engage—for the most part—in behaviors that foster feelings of closeness with the maltreating parent such as caring about the parent's feelings, taking that parent's side in conflicts with other people, expressing realistic complaints, seeing both good and bad in the maltreating parent, maintaining relationships with the family of the maltreating parent, being invested in the relationship, and being able to recall positive memories. Physically abused children were noted to behave—for the most part—in ways that were likely to express love, care, and concern for a parent and to elicit love, care, and concern in return. Moreover, it was reported that such children did not engage in behaviors that were likely to disrupt their attachment or activate rejection from their caregivers. For the most part, the abused children were *not* described as behaving in a rude or unkind manner toward the caregiver, refusing contact with the parent, expressing weak reasons for their hurt or anger, idolizing the other parent, being persistently negative, not caring about the parent's feelings, denying negative influence from others, and being angry at the caregiver's family.

This finding supports the primary hypothesis of the study that even abused children will engage—for the most part—in behaviors that are designed to maintain an attachment bond with a parent—even an abusive parent—a finding that is consistent with the body of research in related fields (e.g., Baker and Schneiderman 2015). Collectively, the pattern of findings strongly supports the clinical literature that in general—and even for severely abused children—child victims of physical abuse behave in ways that are likely to preserve the attachment bond with the maltreating parent rather than disrupt it. Their actions and attitudes indicate an investment in the relationship despite the harm caused to them by the parent. They are described as expressing cognitive distortions in order to preserve their attachment (e.g., blaming themselves for the abuse and minimizing its impact on them), Cohen and Mannarino 2002). These cognitive distortions are consistent with those observed in trauma victims (Briere and Scott 2015).

A second notable finding is that clinician ratings of the severely abused children were not significantly different than the ratings of the moderately abused children. This was true for ratings of children in general as well as specific children. This might mean that there is no actual difference between moderately and severely abused children on these behaviors. If so, one possible explanation is that AE behaviors are so hard-wired into the human brain, that no level of abuse can eradicate these behaviors. On the other hand, perhaps the definition of moderate versus severe abuse was not clear or accurate enough to elicit nuanced responses from the clinicians. Future research should aim to determine which of these explanations is supported by the data.

With respect to differences in ratings of children in general compared to ratings of specific children, we had no specific hypotheses but did find that ratings of children in general were higher than ratings of a specific child. Perhaps when thinking about children in general, the clinician's mind is drawn to more extreme cases. Perhaps the affection the clinician had for a particular client resulted in toning down their perceptions in a way that did not happen when thinking about "children in general." There are other explanations as well including implicit bias regarding how children behave "in general." Although there were differences between the ratings of the moderate and severely abused children, they did not wipe out the statistical effects with respect to differences between AE and AD behaviors. Therefore, the differences between the ratings of the general and the specific children remain an intriguing and unexplained finding that requires additional attention in future research.

We also found that older youth were more likely to be rated as engaging in AD behaviors than younger children. We understand this finding in light of the increased negativity and independence from parents expressed during adolescence (Erikson 1968, Marcia 1980). Part of the normal developmental processes that occurs in the teen years make it more possible for them to see their parents as separate and flawed humans (Blos 1967; Frank et al. 1990). Thus, patterns of parent–child interaction shift as children enter adolescence when the child is developing emotional and cognitive autonomy from the parent (Collins and Steinberg 2006). These shifts may be seen in the increased conflict that occurs during adolescence, which signals the child's ability to develop and express independent thoughts and decreased reliance on the parent for emotional support (McElhaney et al. 2009). Perhaps the developmental trajectory of increased separateness and individuation from parents allows the adolescents to express their hurt and anger toward their maltreating parents more than younger abused children, who are more dependent on their parents and, therefore, more invested in maintaining the idealized version of the parent.

We also found that few of the characteristics of the respondents were related to their ratings of the children. Because the size of the correlations was so small and combined they accounted for about four percent of the variance, it is clear that characteristics of the respondents played a very small role in their ratings of how maltreated children were likely to behave, although it is important to note that implicit bias is notably pervasive and yet difficult to measure (Greenwald and Banaji 1995).

Taken together, there are several clinical implications of these findings. To begin with, abused children in therapy may feel ashamed at how desperate and forgiving they are of their abuser (Blizzard and Bluhm 1994). Their strong feelings of yearning for connection and self-blame may be confusing and/or embarrassing. Clinicians who are aware of the findings (and the literature and data upon which they are based) can provide some psycho-educational feedback to their clients about how humans are hard-wired to form and maintain attachments and that these feelings of connection are very difficult to extinguish—even in the face of severe abuse. Understanding that children have a powerful cognitive and emotional tendency to preserve parent–child attachments may help abuse children to accept their own responses in that regard. Otherwise, the desire to stay connected to an abusive parent may be experienced as a weakness or pathetic, when in fact it is a normative response. Similarly, it may be comforting to the victims of child abuse to know that the vast majority of children in this study were described as engaging in many AE behaviors at least some of the time. Therapists might consider sharing the memoirs of adults who were abused as children to help bring these findings to life (Burns 2001). Hearing other victims of abuse talk about how hard they worked to connect with the maltreating parent may create an opening for the child to recognize and understand those feelings within him- or herself.

Likewise, clinicians working with this population can provide corrective feedback to the child victim of physical abuse that sometimes minimization and self-blame can occur. In our study, many children tended to minimize the harm done to them, blaming themselves for the bad behavior of their parents. This is important information for both the children and the clinicians to know because it means that the children themselves may not be reliable reporters regarding the harm caused to them by the abuse. Clinicians may want to create a space for children to re-evaluate their perception of harm and blame over the course of treatment by introducing such issues in the course of treatment. The goal is for the child to have a balanced and accurate view of the impact of the abuse on their behavior and on their understanding of their worthiness of being treated with kindness and respect. Of course, minimization and self-blame allow the child to preserve the fantasy of the good parent and this cannot be taken away from a child before s/he is ready to face the painful reality that their parent has hurt them. One way to facilitate this is to allow for the possibility that the parent has good intentions and loves the child while at the same time engaging in harmful behaviors. Hearing other victims of abuse talk about how hard they worked to see the parent as good and how they downplayed the pain and suffering inflicted on them, may help the child see the parallels with their own experience.

There are currently a number of empirically validated as well as promising therapeutic interventions for adult and child victims of childhood trauma (Baker et al. 2014; Kolko and Swenson 2002). In many of these approaches, there is an important place for the victim to tell his or her story. According to trauma expert Bessel van der Kolk (1989), putting a traumatic event into a narrative format moves the memories from the sense memory part of the brain – where the trauma can be activated as presently felt sensations and emotions – into the prefrontal cortex where the trauma can reside as a memory of a past event. Through the trauma narrative, abuse victims can adjust some of their cognitive distortions. All of this falls into the category of psychoeducation about the nature of trauma and the effect on the individual. According to Briere and Scott (2015) psychoeducational activities can be useful to abuse survivors both at the beginning and throughout the therapeutic process, although Resick and Schnicke (1992) suggest that corrective statements alone are usually not sufficient for reworking the trauma. They suggest that activation of the emotional memory should also pay a role.

Clinicians should also note that many children have an intense desire to preserve their fantasy of the perfect parent. As Fairbairn noted, children would rather be a "sinner in a world ruled by God than a saint in a world ruled by the devil" (1952, p. 66–67), by which he meant that it was preferable to see *themselves* as bad rather than see their *parents* as bad. In therapy, some children strongly resist any attempt to help them to recognize that they have been harmed by a parent. Accepting that a parent is abusive is "perhaps the most difficult and painful psychological task a human being can be called on to face" (Peck 1983, p. 130). And yet, Miller (2001) described the psychological toll when a child denies the harm caused by a parent. Thus, powerful mental mechanisms exist that both foster a child's tendency to idealize an abusive parent and to minimize that parent's flaws. By recognizing that many abused children have a powerful tendency to maintain and cultivate attachment relationships with their abusive parents, therapists can help such children to develop a more realistic, constructive, and healthy view of their past experiences and current circumstances.

The findings also have implications for those who work with abusive caregivers, especially those who might be all too eager to believe their children when they minimize the harm and/or blame themselves for the abusive behavior of the parent. This would be relevant, for example, to clinicians working with the child welfare system providing reunification treatment, some of whom provide eclectic treatment and some provide evidence-based models such as AF-CBT (Kolko and Swensen 2002). The purpose of these efforts is to help repair the attachment by fostering the caregiver's ability to be safe, loving, and available to the child, the essence of a secure attachment (Bowlby 1969). The data from the current study suggest that one impediment to this work could be the parent and child's collusion in the distortion that the abusive behavior was not that harmful and/or was deserved. As long as this belief is held by the abused child and the abusive caregiver, the reparation of the attachment will be impeded.

The survey study has a number of strengths including a large sample size, a high response rate, an ability to compare both severely and moderately abused children, and data collected about specific children as well as children in general. While the sample was primarily female social workers working in agency settings, this is most likely the prototype of the mental health clinician working with abused children. One obvious limitation is that the parents themselves were not interviewed about the behavior of their children, although it is likely that they would not be as objective as the therapists were, they certainly would have had a base of observation that was both wider and deeper.

One direction for future research could involve a replication which would be to have the clinicians rate the children's behaviors at the *end* of the treatment process. In the current study the time frame for the rating was not specified. Presumably, children's attitudes toward the maltreating parent change over the course of treatment, perhaps to become more nuanced and reality based, e.g., as the children become better able to tolerate negative feelings about the maltreating parent. If the clinicians completing the survey had focused more on the attitudes expressed at the end of treatment rather than at the beginning of treatment, the findings presented here may over-represent the AD behaviors because they may be more prominent at the end of treatment when the child is better able to express anger and hurt toward the maltreating parent. If so, then perhaps the findings would be even more extreme with the children even less likely to exhibit the AD behaviors. It would also be interesting to survey clinicians about changes in children's attitudes over the course of treatment. Likewise, recall bias might have come into play as the clinicians were asked to report on behaviors that they had observed at some point in the past. A future modification of the study could entail clinicians rating their current cases on an ongoing basis so that the data are collected in real time. Clearly more work needs to be done to further understand the nature of the interactions between abused children and their attachment figures.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Informed Consent All participants were provided with written informed consent statement that described the study, the sponsors of the study, the nature of confidentiality, and any perceived risks and benefits from participating.

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