

**“BABES – BOLYAI” UNIVERSITY  
FACULTY OF PSYCHOLOGY AND EDUCATIONAL SCIENCES**

**Aspects of clinical symptomatology of preschool  
abused children. Applications of a program that aims  
to improve the children’s socio-emotional skills.**

**- SUMMARY -**

**Scientific Advisor:  
Prof. Univ. Dr. Vasile Preda**

**PhD candidate:  
Sănduleac Irina**

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Keywords: abused children, children in institutions, psychiatric disorders, socio-emotional skills

## **Introduction**

Despite the fact that the phenomenon of child abuse has received considerable attention in recent years by social policies implemented by the state and the nongovernmental organizations, thousands of children continue to be abuse and neglected each year. In the past 20 years, the Romanian Child Protection System has seen considerable progress in terms of: providing psychological counseling services; reorganizing the residential centers and implementing the foster care system and adoption procedures.

In Romania, the legislation on the Child Protection is trying to clarify these issues and to provide a legal support for identifying and reducing the child abuse cases. Under this law, the state institutions are obliged to prevent and protect children from any act of violence, sexual or psychological abuse and neglect. The law prohibits any physical or humiliating punishment at home or in an institution which should deal with child protection or education. Complaints and referrals on child abuse can be made both by the child and/or by anyone near who has knowledge about a child being in a risk situation.

According to statistics presented by the Romanian National Authority for Child Protection at the end of year 2009, 11686 cases of abuse, have been referred to Child Protection Services. Neglect has the highest frequency, 8101 children. Also, there were reported 1326 cases of physical abuse, 1151 cases of emotional abuse, 572 cases of sexual abuse, 412 cases of child labor exploitation, 35 cases of sexual exploitation, and 89 cases of exploitation for crimes committing.

Present research is based on two studies. Their aim is first to identify mental disorders exhibited by abused children (physical abuse, emotional abuse, neglect and sexual abuse) and second, to optimize the level of socio-emotional skills of abused children living in a residential center.

Children placed in residential center face multiple emotional and behavioral problems caused by the pathological relationship with their parents and then due to the environmental changes. We believe that emotional and behavioral problems exhibited by children may be an obstacle for them to be accepted in future foster families or even in the natural family, where is possible.

## **PART I - Theoretical part**

### **CHAPTER I. Child abuse**

This chapter describes the types of child abuse and the legal aspects regarding child abuse in Romania. Also in this section are outlined the Romanian statistics concerning child abuse at the end of year 2009.

### **CHAPTER II. Theoretical aspects related to child abuse**

In this chapter there are discussed in detail the effects of child abuse. Also, this chapter contains aspects concerning the children living in institutions.

### **CHAPTER III. Child abuse, a risk factor for developing reactive attachment disorders**

Attachment disorders receive a special attention due to its increased rate of occurrence among abused children. Diagnostic criteria and manifestations of abused children who have reactive attachment disorders are discussed.

### **CHAPTER IV. Child abuse, a risk factor for attention deficit and hyperactivity disorder**

Attention deficit and hyperactivity disorder is one of the most frequently diagnosed disorders in preschool children. Studies show that child abuse is associated with attention deficit and hyperactivity disorder.

### **CHAPTER V. Child abuse, a risk factor for developing oppositional defiant disorder**

Chapter V aims to highlight the impact of parental style on the developing the oppositional defiant disorder.

### **CHAPTER VI. Emotional resilience**

Chapter VI describes emotional resilience within abused children and the impact of intervention programs on this component.

### **CHAPTER VII. Rational emotive behavioural therapy with children**

This section discusses the effects of REBT intervention with children and adolescents, from pointing that there is a mutual relationship between inappropriate behaviours and the environment.

### **CHAPTER VIII. You Can do It! Education Program**

This chapter focuses exclusively on describing the You Can do It! Education Program developed by Prof. Michael Bernard. This chapter discusses the theoretical foundations of the program and its practical applications.

## **PART II - RESEARCH**

### **CHAPTER XI. Study 1. The clinical symptomatology of preschool abused children**

#### **IX.1. Study objectives**

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Highlighting the types of disorders that are associated most commonly with a specific type of abuse.

Highlighting the association relationship between “the characteristics of abuse episodes” and the presence of reactive attachment disorder.

Highlighting the relationship between children's age of abuse onset and the current level of global functioning.

## **IX.2. Hypotheses**

1. It is hypothesised that, within the study group, there are differences regarding the type of mental disorder according to the type of abuse.
2. It is hypothesised that, within the study group, a higher frequency of abuse episodes is associated more commonly with reactive attachment disorders.
3. It is hypothesised that, within the study group, attachment disorders are associated with the person who committed the child abuse.
4. It is hypothesised that, within the study group, the age of abuse onset is associated with attachment disorders
5. It is hypothesised that, within the study group, there is a positive association relationship between the age of abuse onset and current level of global assessment functioning.
6. It is hypothesised that, within the study group, there is a causal relationship between the age of abuse onset and current level of global assessment functioning.

## **X.3. Methodology**

### **IX.3.1 Participants**

All 57 abuse cases were referred to Cluj Department of Child Welfare, by the local authorities, or any other person who had knowledge about children in critical situations. After the abuse was official documented, 57 children were screened by using the Structured Clinical Interview for DSM-IV.

The traumas included physical abuse by one or both parents (N=18, 31.6 %), sexual abuse (N=9, 15.8%), emotionally abused (N=15, 26.3%), and neglect (N= 15, 26.6%). Their ages ranged from 3 to 6 years (mean= 4.7 years, SD=1.13); 35 (61.4%) were male and 22 (38.6%) were female. Their ethnicity was: Romanian N= 32 (56.1%), Hungarian N= 4 (7%), Rroma N=

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21 (36.8%). 34 (59.6%) cases were from urban areas and 23 (40.4%) from rural areas. 20 children (35.1%) come from single parent families, 34 (59.6%) come from two parent families ( we specify that no account was taken of the fact that the parents were married or not), and in three cases (5.3%), children were living with a step parent.

Regarding the parents education, they have followed mainly primary education (42.2% of them have graduated more than 4 classes), also 26.3% of parents have a university degree, 10.5% have completed high school, and 21.1% have completed between 5 and 8 grades (years of study).

By the time of assessment, 28 children (49.1%) were attending some form of preschool education and 29 (50.9%) were not attending any form of education.

### **IX.3.2. Procedure**

We have used as assessment tools the diagnostic criteria of DSM-IV-TR, clinical observation. Disorders that have been diagnosed with a highest frequency are as follow: reactive attachment disorder disinhibited type, reactive attachment disorder inhibited type, ADHD and oppositional defiant disorder. We also used the Global Assessment Functioning Scale (GAF) for each child.

Children were brought for psychological assessment more often by the non- abusive parent or other person in the family or outside it, especially when both parents were abusive towards the child.

The evaluation was conducted over approximately 2.5 hours over three sessions, with each child. The evaluation results were recorded in individual assessment reports for each child. Other information such as frequency of abuse episodes, age of abuse onset, child's age, gender, ethnicity, was obtained from parents or from consulting official reports prepared by social workers.

Abuse was classified into four categories: physical, sexual abuse, emotional abuse and sexual abuse. Types of abuse considered for this study were classified by the social worker on the basis of severity of abuse.

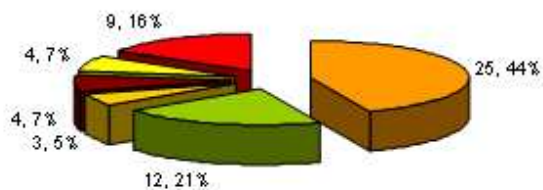
Frequency of abuse episodes were coded nominally, as it follows: single episode, one episode / week, 2-3 episodes / week and the episodes of abuse were repeated daily. Regarding the variable "the abusive person", several categories were found: mother, father, both parents and a person outside the family.



#### IX.4. Results and discussion

In order to verify the hypotheses, we used SPSS 13.0 and we used the following statistical tests: chi-square test, phi and Cramer V coefficient, linear correlation - Bravais-Pearson r, independent samples t test and simple linear regression.

The evaluation of children have revealed the presence of several types of symptoms



- reactive attachment disorder disinhibited type 25,44%
- reactive attachment disorder inhibited type 12,21%
- ADHD impulsive type 3,5%
- ADHD inattention type 4,7%
- Oppositional defiant disorder 4,7%
- The absence of disorders 9,16%

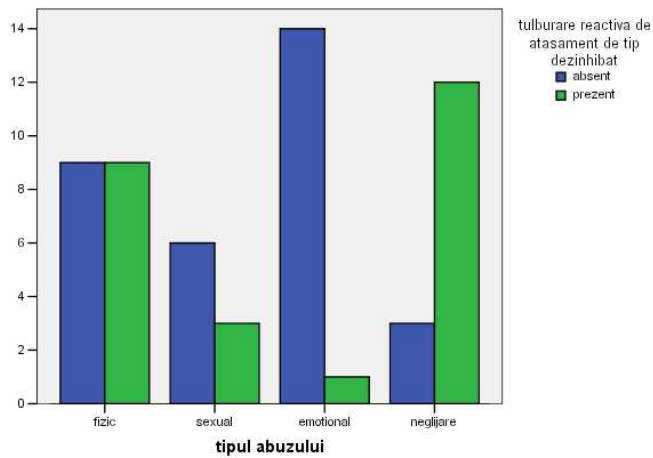
**Figure 1.** Main types of symptoms identified in study group

We found that attachment disorders are most frequently, this type of disorder was present in 37 cases (56%) from a total of 57 cases. 25 (44%) children shown symptoms of reactive attachment disorder disinhibited type and 12 (21%) children shown symptoms of reactive attachment disorder inhibited type, nine (16%) children did not show any symptoms which could be attributed to a diagnostic category, four (7%) children have ADHD diagnosis, inattention type and 3 (5%) children have ADHD symptoms, impulsive type, oppositional defiant disorder was found in four cases (7%).

**Hypothesis 1.** Within the study group, we suppose that there are differences regarding the type of mental disorder according to the type of abuse.

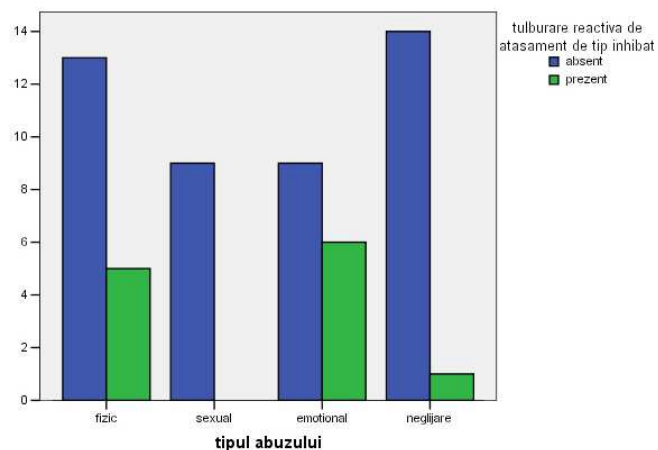
In study group, the frequency of specific symptoms of reactive attachment disorder, disinhibited type is higher within neglected children than within children who were victims of other forms of abuse ( $\chi^2=17.064$ ,  $p<0.01$ ).

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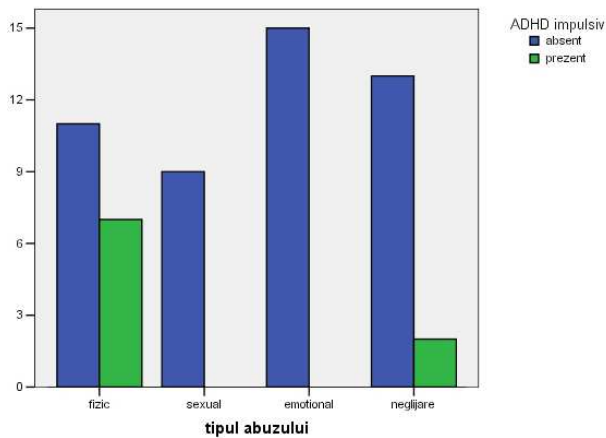
**Figure 2.** The frequency of reactive attachment disorder, disinhibited type and the type of abuse

In study group, the frequency of specific symptoms of reactive attachment disorder, inhibited type is higher within emotionally abused children than within children who were victims of other forms of abuse ( $\chi^2=7.998$ ,  $p < 0,05$ ).



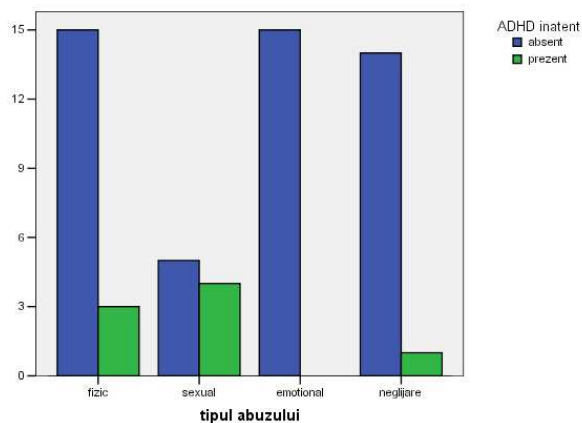
**Figure 3.** The frequency of reactive attachment disorder, inhibited type, and the type of abuse

In study group, the frequency of specific symptoms of ADHD impulsive type is higher within physically abused children than within children who were victims of other forms of abuse ( $\chi^2 = 11.791$ ,  $p < 0.01$ ).



**Figure 4.** The frequency of ADHD impulsiv type and the type of abuse

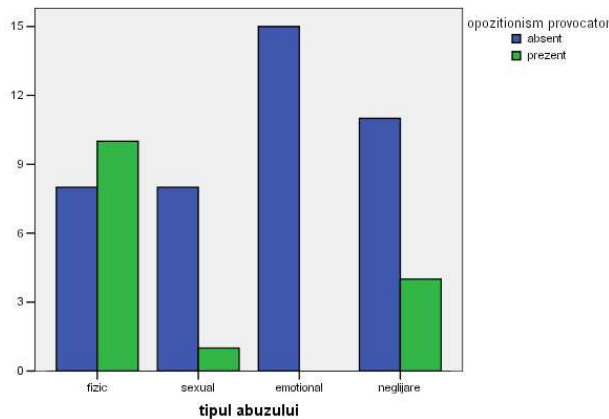
In study group, the frequency of specific symptoms of ADHD inattention type is higher within sexually abused children than within children who were victims of other forms of abuse ( $\chi^2=10.125$ ,  $p < 0.05$ ).



**Figure 5.** The frequency of ADHD inattention type and the type of abuse

In study group, the frequency of specific symptoms of oppositional defiant disorder is higher within physical abused children than within children who were victims of other forms of abuse ( $\chi^2 = 14.368$   $p < 0.01$ ).

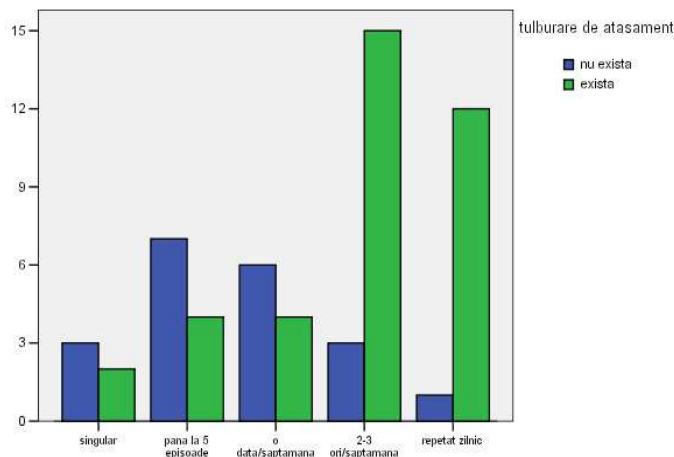
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**Figure 5.** The frequency of oppositional defiant disorder and the type of abuse

**Hypothesis 2.** It is hypothesised that a higher rate of abuse episodes is associated with a higher occurrence of reactive attachment disorder.

In the study group, the attachment disorders were significantly associated with the “repeated daily” type of abuse ( $\phi = 0,51$   $p < 0.05$ ).

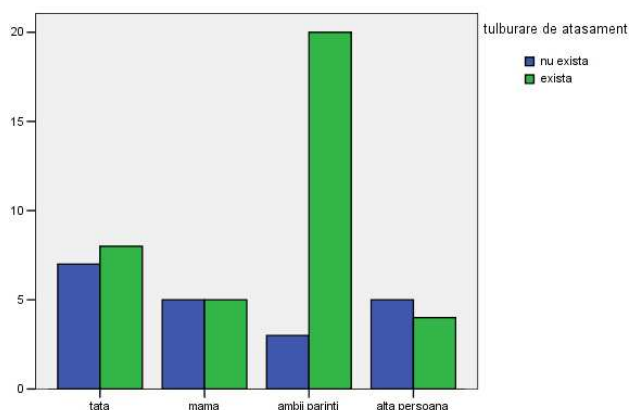


**Figure 7.** Reactive attachment disorder and frequency of abuse episodes

**Hypothesis 3.** It is hypothesised that the frequency of attachment disorders symptoms is associated with the person who exercised the abuse.

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The frequency of attachment disorder within children who have suffered a type of abuse was significantly associated with the person who committed abuse. When the abuse was committed by both parents ( $\phi = 0.38$   $p < 0.05$ ), a higher frequency of attachment disorders were observed.

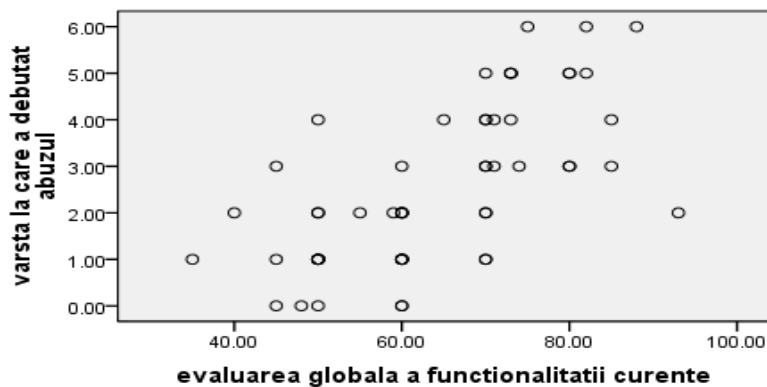


**Figure 8.** The frequency of attachment disorder and the person who committed child abuse

**Hypothesis 4.** There are significant differences regarding the presence of attachment disorder and the age of abuse onset.

Average age of the abuse onset is 3.35 years in the group of participants who did not exhibit attachment disorder and 2.1 years in the group of abused children who exhibit attachment disorders (t test value is 2.402,  $p = 0.23$ ). We can say that the average age of abuse onset is lower within children who have attachment disorders.

**Hypothesis 5.** It is hypothesised that, within the study group, there is a positive association relationship between the children's age at the time of abuse onset and current level of global assessment functioning.



**Figure 9.** Age of abuse onset and the level of current global assessment functioning

Examining Figure 9, we find a positive relationship between the linearity and homoscedasticity of the data. The data support the hypothesis ( $r = 0.65$ ,  $p < 0.01$ ), that there is a positive association relationship between the children's age at the time of abuse onset and the current level of global assessment of functioning.

More specifically, as the age of children at the moment of abuse onset is lower, the current level of global assessment functioning is lower.

**Hypothesis 6.** It is hypothesised that, within the study group, there is a causal relationship between the children's age at the time of abuse onset and current level of global assessment functioning.

We intended to analyze the causal relationship between two dimensions the children's age of abuse onset (predictor variable) and the level of current global functioning, GAF scores (criterion variable).

The value of  $R^2 = 0.42$ , shows that children's age of abuse onset explains 42% of current level of current global functioning and that  $F$  is statistically significant ( $F = 41.23$ ,  $p < 0.01$ ). Standardized regression coefficient  $\beta = .655$ ,  $t = 6.421$ ,  $p < .001$ , shows that there is a statistically significant causal relationship between predictor variable and criterion variable. Therefore, the age of abuse onset affects the intensity of current symptoms.

## IX.5. Conclusions

This study, made on children who suffered a type of abuse within their natural family, was able to reveal the existence of an association between types of abuse and certain psychiatric disorders. The specific symptoms of reactive attachment disorder disinhibited type were found to

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occur more frequently within children who were neglected than within children who were victims of other types of abuse. It was also noted that there is a significant difference in the presence of impulsive type of ADHD symptoms within physically abused children than within children who suffered another type of abuse. The presence of oppositional defiant disorder is more frequently associated with physical abuse than other types of abuse. The frequency of ADHD inattention type is more common with sexual abuse than other types of abuse. The frequency of specific symptoms of oppositional defiant disorder is higher within physically abused children than within children who were victims of other forms of abuse. In study group, the frequency of specific symptoms of reactive attachment disorder, inhibited type is higher within emotionally abused children than within children who were victims of other forms of abuse.

However, there are situations in which have been identified related disorders. For example, ADHD impulsive type was noted as primary diagnosis in three cases, and in six cases it is co morbid with other diagnosis, without being significantly associated with a particular disorder . Also ADHD inattention type was noted in four cases as primary disorder, and in four cases the symptoms appear to be associated with other disorders, but did not correlated statistically significant with a particular diagnosis. The oppositional defiant disorder was identified as another common disorder associated significantly with reactive attachment disorder.

This study revealed also the existence of positive associations between certain characteristics of the abuse episodes and the presence of attachment disorders. The frequency of attachment disorders in children who have suffered a type of abuse tends to increase in situations where abuse is exercised by both parents. Another variable that has been identified to associate positively with attachment disorders in abused children is in cases where abuse has been exercised daily. Significant differences were noted within children who exhibit abnormal attachment than within those who do not exhibit attachment disorders in terms of age at the time of abuse onset. The age of children at the time of abuse onset, particularly the period 0-2 years, is associated with later attachment disorder, also the age at the time of abuse onset predicts the current level of functioning such as if the age at the time of abuse onset is lower, the current level of functioning is lower.

## **IX.6. Limitations and future research**

The limits of this study are primarily due to a small number of participants, then to the assessment instrument and the lack of investigation of parent-child relationship. Investigation of more complex parent-child relationship has not been possible due to poor cooperation of the parents with the child protection institution. Another limit is that the types of abuse were taken into account in a distinctive manner although in many cases some types coexisted. This classification was taken from each child's file classification.

For this study were not taken into account subjective factors that might predispose to the emergence of certain symptoms. Moreover, we consider being necessary to introduce variables related to psychosocial characteristics of parents (history of child abuse, substance abuse, socio-economical status, educational level).

Also, as a future investigation we find useful to consider making a comparative study that takes into account several age groups in a larger sample, to take account of internal factors and have a control sample.

## **CHAPTER X. Study 2. Applications of a program for optimising socio-emotional skills of abused and neglected children living in a residential center.**

This study design is a quasi-experimental one, this type of design was used because of ethical reasons related to the inability to study a control group formed by abused children placed in a residential center, without performing psychological intervention. Also, we could not randomize the participants and the initial findings have produced different results from group to group. The design type is pre-test - post-test design for non-equivalent groups.

### **X.1 Objectives**

1. Highlighting the differences of the socio-emotional skills level (confidence, persistence, organization, getting along and resilience) of children who have suffered a form of abuse and have been institutionalized in different environments (in a residential center and in foster care).



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2. Optimising the level of socio-emotional skills (confidence, persistence, organization, getting along, resilience) of the children who have been abused in their natural families and had been institutionalized in a residential center.

## **X.2 Hypotheses**

1. We suppose that, abused children who are institutionalised a residential center have a lower level of socio-emotional skills (confidence, persistence, organization, getting along, resilience) than the level of socio-emotional skills of abused children placed in foster care.

2. We suppose that the level of socio-emotional skills (confidence, persistence, organization, getting along, resilience) of children living with natural non abusive families, is higher than the skills level of abused children placed in foster care.

3. We suppose that the level of socio-emotional skills (confidence, persistence, organization, getting along, resilience) of abused children placed in residential center is significantly higher after the application of You Can Do It! Education Program.

## **X.3. Methodology**

### **X.3.1 Participants**

This study involved a total of 35 children, aged between 3.5 and 7 years. Groups can be described as follows: 10 children who have been abused in their biological families, and for at least one year they have been living in a residential center, 13 children who have been abused by their natural parents and for at least one year they have been living in foster care, 12 children living with their natural non abusive families. 6 children from the residential center are boys and four are girls aged between 4 and seven years, 6 have suffered physical abuse and 4 have been neglected.

Regarding the group of abused children placed in foster care, their age is between 3.5 and 7 years, 5 children have been physically abused, seven children have been neglected and a child has been sexually abused.

### **X.3.2. The quasi-experimental design**

The quasi-experimental design is a pre-test-post-test one for non-equivalent groups.

1. Pre-test: setting the level of socio-emotional skills in the two groups of children: group consisting of abused children in their natural families and who have been placed in residential

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center and the group composed of abused children in their natural families and who have been placed in foster care. Also, we compared the level of socio-emotional skills of children abused in their natural families placed in foster care with the level of socio-emotional skills of children living in non abusive families.

2. Post-test: retesting socio-emotional skills of two groups of children, abused children who have been placed in residential center and abused children placed in foster care after the application of the program for children living in the residential center.

### **X.3.3. The evaluation and intervention procedure**

To evaluate the level of socio-emotional skills there was used the assessment procedure from the YCDI program (You Can Do It! Education) designed by Prof. Michael Bernard.

Evaluation datasheets were completed by: 1. the parents for children living in natural families; 2. the foster parent for children placed in foster care and; 3. the caregiver for children living in residential institutions.

The evaluators received clear instructions regarding the procedure for evaluating and rating the items. They were asked to observe behavioural aspects contained in the five dimensions in a variety of situations, for three weeks. After this, the evaluators were asked to complete the evaluation sheets.

The procedure involves five data sheets designed to assess the dimensions considered essential for social and emotional skills. According to Michael Bernard B. (2004a, 2006), the dimensions are:

a. Confidence: means knowing that you will likely be successful at many things. It means not being afraid to make mistakes or to try something new. Accepting Myself. Not thinking badly about yourself when you make a mistake. Taking risks. Thinking that it's good to try something new, even though you might not be able to do it. Being Independent. Thinking that it's important to try new activities and to speak up even if classmates think you're silly or stupid.

b. Persistence means trying hard and not giving up when schoolwork feels like it's too difficult or boring. I Can Do It. Thinking that you are more likely to be successful than you are to fail. Giving Effort. Thinking that the harder you try, the more successful you will be. Working

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Tough. Thinking that in order to be successful in the future, sometimes you have to do things that are not easy or fun in the present.

c. Organization means setting a goal to do your best in your school work, planning your time so that you are not rushed, having all your supplies ready, and keeping track of your assignments' due dates. Setting Goals. Thinking that setting a goal can help you be more successful at a task. Planning My Time. Thinking about how long it will take you to do the schoolwork and planning enough time to get it done.

d. Getting Along means working well with teachers and classmates, solving problems without getting too angry, and following the rules of the classroom. Being Tolerant of Others. Not making overall judgments of people's character based on their differences or behaviour. Thinking First. Thinking that when someone treats you badly, you need to think about different ways you can react and the impact of your actions on the other person's feelings. Playing by the Rules. Thinking that by following important school and home rules, you will live in a better world where everyone's rights are protected. Social Responsibility. Thinking that it is important to be caring, honest, and respectful, a good citizen, and to help build a world with fairness and justice for all.

e. Emotional Resilience means knowing how to stop yourself from getting extremely angry, down, or worried when something "bad" happens. It means being able to calm down and control your behaviour.

Psychometric properties of the assessment scale of socio-emotional skills: the internal consistency and correlation between half (Spearman, Guttman) are presented in Table 1.

**Table 1.** Psychometric properties of the assessment scale of socio-emotional skills

Scale/ subscale	Alpha Cronbach	Nr. items	Guttman (split-half)	Spearman (split-half)	level
<b>Confidence</b>	<b>.877</b>	<b>3</b>	<b>.759</b>	<b>.872</b>	<b>Good</b>
<b>Persistence</b>	<b>.894</b>	<b>2</b>	<b>.894</b>	<b>.894</b>	<b>Good</b>
<b>Organisation</b>	<b>.897</b>	<b>4</b>	<b>.877</b>	<b>.878</b>	<b>Good</b>
<b>Getting along</b>	<b>.934</b>	<b>5</b>	<b>.894</b>	<b>.946</b>	<b>Excellent</b>
<b>Resilience</b>	<b>.927</b>	<b>2</b>	<b>.927</b>	<b>.927</b>	<b>Excellent</b>

The values obtained show that scale has good internal consistency and the subscale for "getting along" and "resilience", the internal consistency is excellent.

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The items are clearly formed and were not difficult to assess. Therefore the instrument is valid and we can rely on results obtained from its application.

After the initial assessment, the program started. Its aim was to optimise the level of social-emotional skills of the abused children placed in residential center. The program lasted for five months and it consisted in weekly sessions of 40-50 minutes. The program involved the use of materials like: sheets, puppets, songs, and pre established activities from the program.

The program involves the application of five units: confidence, persistence, organization, getting along and resilience, in total according with specifications made by Michael Bernard (2004 b). Each of the unit consists in five modules, each containing a series of activities whose content can be delivered in several ways. The sequences of activities within each unit are as follows:

1. Activities providing children the definition of the ability and providing examples of that ability.
2. Activities involving the children practicing the behaviours that exemplify the ability and encouraging the children to practice positive self-verbalization.
3. Activities involving the use of self-verbalization on children as they carry out behaviours that reflect learned skills.
4. Activities in which children will have to identify different situations that might apply the behaviours they have learned.
5. Activities in which children, regardless of carer support will have to apply skills learned in different circumstances, seeking help only when they can not handle the situation.

#### **X.4. Results and discussion**

Data processing was done through SPSS 13.0. We have used the following statistical tests: Mann-Whitney test and Wilcoxon test.

Hypotheses 1.

We suppose that, abused children who are institutionalised in a residential center have a lower level of the socio-emotional skills (confidence, persistence, organization, getting along, resilience) than the level of socio-emotional skills of abused children placed in foster care.

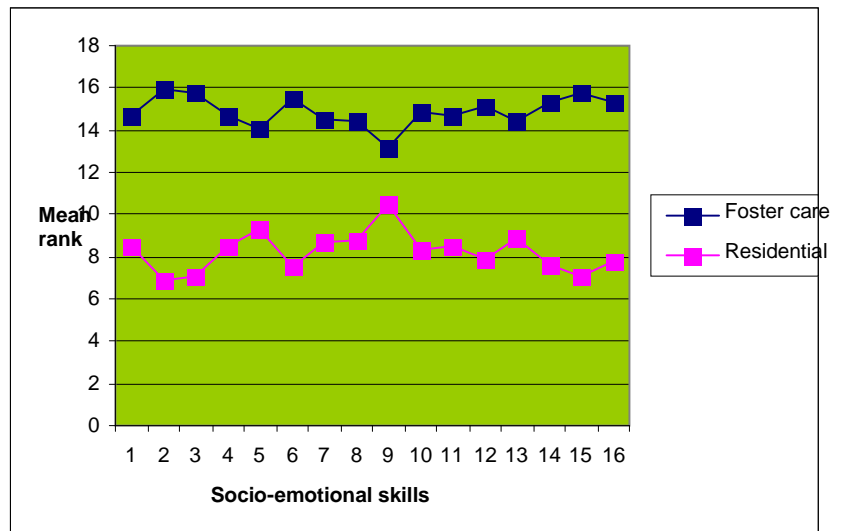
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**Table 2.** The Mann Whitney test values

Socio-emotional skills	Mann-Whitney U	Asymp. Sig. (2-tailed)
Being independent post-test - being independent pre-test	30.5	.022
Taking risks post-test - taking risks pre-test	14	.001
Accepting myself post-test - accepting myself pre-test	16	.001
Working through post-test - working though pre-test	30	.022
Giving effort post-test - giving effort pre-test	38	.079
Setting goals post-test - setting goals pre-test	20	.004
Active listening post-test - active listening pre-test	32	.034
Planning my time post-test - planning my time pre-test	33	.039
Take care of things post-test - take care of things	50	.325
Interaction with other kids post-test - interaction with other kids pre-test	28	.016
Playing by the rules post-test - playing by the rules pre-test	30	.024
Conflict management post-test - conflict management pre-test	24	.008
School positive outcome post-test - school positive outcome pre-test	34	.037
Social responsibility post-test - social responsibility pre-test	21	.005
Emotional self control post-test - emotional self control pre-test	16	.001
Outcome self control post-test - outcome self control pre-test	22,5	.005

**Socio-emotional skills**

- 1-being independent
- 2-taking risks
- 3-accepting myself
- 4-working though
- 5-giving effort
- 6-setting goals
- 7-active listening
- 8-planning my time
- 9-take care of things
- 10-interaction with other kids
- 11-playing by the rules
- 12-conflict management
- 13- school positive outcome
- 14-social responsibility
- 15-emotional self control
- 16-outcome self control



**Figure 1.** Graphic representation of the average ranking levels of socio-emotional skills of children who were abused in their natural families and were placed in residential centers and of those placed in foster care

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Analyzing the results of Mann-Whitney test, we see that the socio-emotional skills level differ significantly from abused children placed in foster care and those placed in residential center ( $p < 0.05$ ,  $N_1 = 10$ ,  $N_2 = 13$ , U value is lower than the critical  $U=35$ ). Socio-emotional competence level is higher at children placed in foster care than the level of those placed in a residential center. However, the dimension "to take care of things" and the "giving effort" is not significantly different from the same variable level presented by abused children were placed in residential center.

Hypothesis 2. We suppose that the level of socio-emotional skills (confidence, persistence, organization, getting along, resilience) of children living with natural non abusive families, is higher than the skills level of abused children placed in foster care.

**Table 3.** Mann Whitney test values

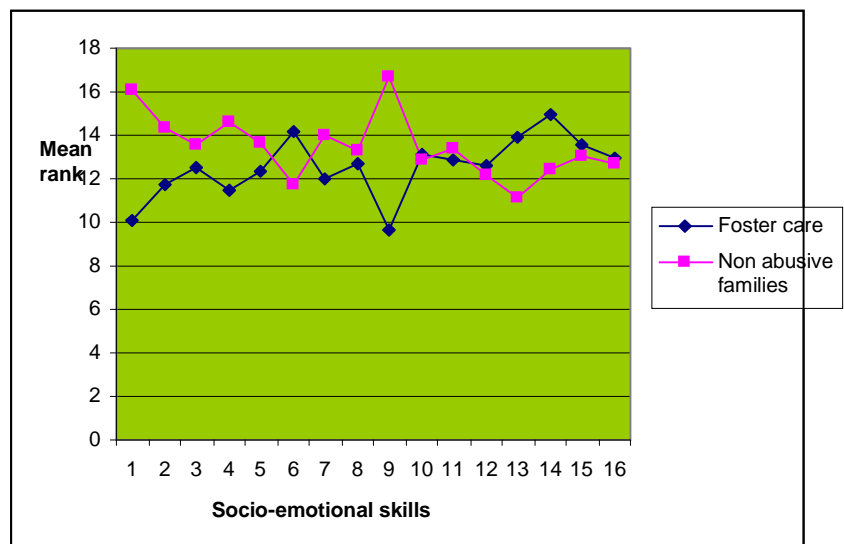
Socio-emotional skills	Mann-Whitney U	Asymp. Sig. (2-tailed)
Being independent post-test - being independent pre-test	40.5	.032
Taking risks post-test - taking risks pre-test	61.5	.323
Accepting myself post-test - accepting myself pre-test	71.5	.700
Working through post-test - working though pre-test	58.5	.257
Giving effort post-test - giving effort pre-test	70	.647
Setting goals post-test - setting goals pre-test	63	.388
Active listening post-test - active listening pre-test	65.5	.473
Planning my time post-test - planning my time pre-test	74	.817
Take care of things post-test - take care of things	34	.011
Interaction with other kids post-test - interaction with other kids pre-test	76	.903
Playing by the rules post-test - playing by the rules pre-test	73	.772
Conflict management post-test - conflict management pre-test	67	.543
School positive outcome post-test - school positive outcome pre-test	54	.165
Social responsibility post-test - social responsibility pre-test	71	.672
Emotional self control post-test - emotional self control pre-test	77	.952
Outcome self control post-test - outcome self control pre-test	74	.816

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Analysis of the data in the two groups of abused children placed in foster care for at least one year and children from non abusive families shows that the only difference between the mean ranks is at the competence “to take care of things” ( $p = 0.01$ ,  $N_1 = 13$ ,  $N_2 = 12$ ,  $U$  value is 34, is lower than the critical  $U$ -35). Children placed with foster care have a higher level at the dimension “setting goals” than children from natural families. Otherwise, no statistic significant results were found in the two groups.

**Socio-emotional skills**

- 1-being independent
- 2-taking risks
- 3-accepting myself
- 4-working though
- 5-giving effort
- 6-setting goals
- 7-active listening
- 8-planning my time
- 9-take care of things
- 10-interaction with other kids
- 11-playing by the rules
- 12-conflict management
- 13- school positive outcome
- 14-social responsibility
- 15-emotional self control
- 16-outcome self control



**Figure 2.** The socio-emotional skills mean ranks for both groups

**Hypotheses 3.** We suppose that the level of socio-emotional skills (confidence, persistence, organization, getting along, resilience) of abused children placed in residential center is significantly higher after the application of You Can Do It! Education program.

To highlight the differences between initial and final level of socio-emotional skills, Wilcoxon test was used.

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**Table 4.** Wilcoxon test values

Socio-emotional skills	Z	Asig,Sig. (2-tailed)
Being independent post-test - being independent pre-test	-2.762	0.006
Taking risks post-test - taking risks pre-test	-2.919	0.004
Accepting myself post-test - accepting myself pre-test	-2.919	0.004
Working through post-test - working though pre-test	-2.972	0.004
Giving effort post-test - giving effort pre-test	-2.810	0.005
Setting goals post-test - setting goals pre-test	-2.859	0.004
Active listening post-test - active listening pre-test	-2.85	0.004
Planning my time post-test - planning my time pre-test	-2.889	0.004
Take care of things post-test - take care of things	-2.739	0.006
Interaction with other kids post-test - interaction with other kids pre-test	-2.428	0.015
Playing by the rules post-test – playing by the rules pre-test	-2.598	0.004
Conflict management post-test - conflict management pre-test	-3.051	0.002
School positive outcome post-test - school positive outcome pre-test	-3.162	0.002
Social responsibility post-test - social responsibility pre-test	-2.598	0.004
Emotional self control post-test - emotional self control pre-test	-2.762	0.006
Outcome self control post-test - outcome self control pre-test	-2.919	0.004

After implementing the program, the levels of socio-emotional skills of abused children institutionalized in a residential center differ significantly from the initial assessment. Rank mean difference is significant ( $p < 0.05$ ), the level of the competences is higher after the application of the program. Z scores are lower than the critical value (8) for  $N = 10$  and  $\alpha = 0.05$



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3.1. The assessments results of the abused children placed in foster care

**Table 5.** Wilcoxon test values

<b>Socio-emotional skills</b>	<b>Z</b>	<b>Asig.Sig. (2-tailed)</b>
Being independent post-test – being independent pre-test	-2.000	.046
Taking risks post-test - taking risks pre-test	-1.000	.317
Accepting myself post-test - accepting myself pre-test	-1.000	.317
Working through post-test - working though pre-test	-2.000	.046
Giving effort post-test - giving effort pre-test	-1.732	.083
Setting goals post-test - setting goals pre-test	-1.414	.157
Active listening post-test - active listening pre-test	-1.000	.317
Planning my time post-test - planning my time pre-test	.000	1.000
Take care of things post-test - take care of things	-2.000	.046
Interaction with other kids post-test - interaction with other kids pre-test	.000	1.000
Playing by the rules post-test – playing by the rules pre-test	-1.000	.317
Conflict management post-test - conflict management pre-test	-1.414	.157
School positive outcome post-test - school positive outcome pre-test	-1.414	.157
Social responsibility post-test - social responsibility pre-test	-1.000	.317
Emotional self control post-test - emotional self control pre-test	-1.000	.317
Outcome self control post-test - outcome self control pre-test	.000	1.000

In three dimensions (being independent, working though, take care of things) the results shows significant differences between pre-test and post-test although the children placed in foster care were not include in the program. In the case of other dimensions, differences between initial and final assessments were not statistically significant.

3.2. In **Table 6** are presented the results of the socio-emotional skills level of children living in the residential center at the end of the program (post-test) and children living in foster care who have not been included in the program (post-test ).

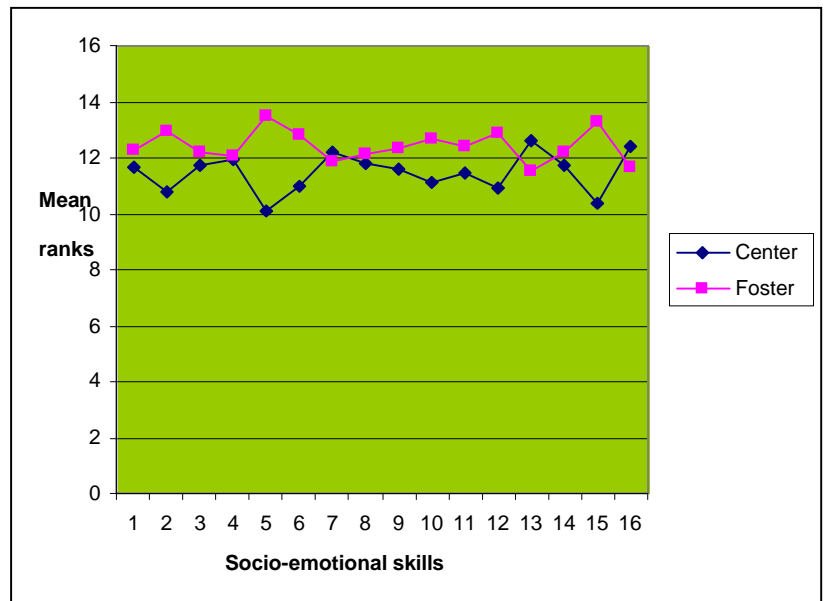
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**Table 6.** Mann Whitney test values

Socio-emotional skills	Mann-Whitney U	Asymp. Sig. (2-tailed)
Being independent post-test - being independent pre-test	61.500	.813
Taking risks post-test - taking risks pre-test	53.000	.392
Accepting myself post-test - accepting myself pre-test	62.500	.864
Working through post-test - working though pre-test	64.000	.946
Giving effort post-test - giving effort pre-test	46.000	.207
Setting goals post-test - setting goals pre-test	54.500	.484
Active listening post-test - active listening pre-test	63.000	.894
Planning my time post-test - planning my time pre-test	63.000	.892
Take care of things post-test - take care of things	61.000	.792
Interaction with other kids post-test - interaction with other kids pre-test	56.000	.542
Playing by the rules post-test - playing by the rules pre-test	59.500	.719
Conflict management post-test - conflict management pre-test	54.000	.468
School positive outcome post-test - school positive outcome pre-test	59.000	.645
Social responsibility post-test - social responsibility pre-test	62.500	.866
Emotional self control post-test - emotional self control pre-test	48.500	.239
Outcome self control post-test - outcome self control pre-test	61.000	.785

**Socio-emotional skills**

- 1-being independent
- 2-taking risks
- 3-accepting myself
- 4-working though
- 5-giving effort
- 6-setting goals
- 7-active listening
- 8-planning my time
- 9-take care of things
- 10-interaction with other kids
- 11-playing by the rules
- 12-conflict management
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- 15-emotional self control
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**Figure 3.** Graphic representation of the mean ranks of socio-emotional skills levels

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Mean ranks levels of socio-emotional skills do not differ significantly between groups although children placed in residential center participated at the program and the children placed in foster care did not. Although differences are not significant it can be seen that the average skill level of children placed in residential center socio-emotional is lower than that of children placed in foster care. Abused children placed in foster care for more than a year, reached a developmental level of socio-emotional skills close to that of children from non abusive families.

We conclude that the program, used for optimising the level of socio-emotional skills of abused children placed in residential center, was useful. The results show a statistically significant difference of the results after the appliance of the program. Nevertheless, the results were not significantly different when comparing the mean ranks of children placed in residential center who received the intervention and the mean ranks of children placed in foster care, who did not participated in the intervention program.

## **X.5. Conclusions**

The results obtained support the research hypothesis that abused children, institutionalized in residential centers (more than one year), present deficits in terms of socio-emotional skills comparing to abused children that are placed in foster care (more than one year). The developmental level of socio-emotional skills of children placed in foster care did not differ significantly from the developmental level of socio-emotional skills of children living with their natural families.

As shown in previous studies, many abused children manifest behavioural problems. Abused children who are institutionalized in residential centers also face serious problems of lack of attachment to one person, as this may grow the initial problems.

Also, the internalising or externalising behavioural problems that arise as a result of abusive treatment, may lead to the establishment of transfer measures from a residential center to another, and at some point these changes may constitute itself triggers of new behavioural disturbances that overlap the existing ones (Newton Litrownik and Landsverk, 2000). The disturbances manifested by children before they enter the welfare system are components of other disturbances that arise in response to the experience of being in the welfare system.

Problems in the care and welfare system, including lack of residential stability and psychotherapeutic limited resources, combined with lack of parental support, often delay the

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process of assessment and appropriate intervention on mental health problems (Arcelus, Bellerby, Vostanis, 1999; Barber Delfabbro, Cooper, 2001).

This program aimed to optimise the social and emotional skills level of abused children placed in residential center. As is shown in terms of significant differences between pre-test and post-test assessment, the results appear to confirm that the goal of this study was achieved. However, the results were not significantly different when comparing the mean ranks of children placed in residential center who received the intervention and the mean ranks of children placed in foster care, who did not participated in the intervention program.

We can say that children placed in foster care have different situation in that they have the possibility of developing a secure type of attachment to the main carer who provides adequate support for the development of child's socio-emotional skills. Furthermore this type of care involves learning a model of behavioural patterns specific to a functional family.

#### **X.6. Limits and future research**

The sample taken into account is limited in terms of number of participants, which does not allow taking into account certain factors related to the type of abuse. Another limit is that there weren't made multiple measurements by different carers of the same child with the same instrument.

Also in this chapter we note that there may appear confused variables relating in particular to foster care perception of the child, in which they may consider that the child's skills level is due to his/her intervention. We did not reveal the factors that contributed to higher results at post-test within children placed in foster care, but we specify that children placed in foster care received, when needed, psychological intervention during this time. Also the foster parent contributed to this positive growth by moderating the child behaviour or emotional state.

We believe that it was not an ethical approach in which children have not benefited from intervention as long as they needed. One future research direction is the periodic assessment of children who have taken part of the program to highlight if the effects persist over time and to engage the parents if the situation allows it.

### **CHAPTER XI. Case studies**

#### **X.1. Iulia, 4.5 years of age**

- Iulia witnessed violence between her parents.

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- Iulia is left in her father's care who is a frequently alcohol consumer and who commonly use a high tone and inappropriate language towards her.
- Iulia's mother is very busy running a business and she experiences severe financial difficulties.
- Iulia was brought for evaluation by her father. She left his side easily, once entered in the evaluation room she began asking questions like: "Is this your house? Can I stay here until my mom comes to pick me up?"
- In terms of behaviour, Julia shows anger and aggression when her emotional needs are not satisfied, or when her mother's behaviour is contrary to her wishes (e.g.: Mom wants to leave the toys room).
- During the evaluation Iulia showed symptoms of ADHD (symptoms confirmed by the psychiatrist).

Iulia's Mother acknowledged that the negative behaviour and emotional manifestations of her daughter are triggered by the family's tensions, so she decided to leave Iulia's father and to take Iulia with her. After the psychological counselling procedure was finished, they leaved the country.

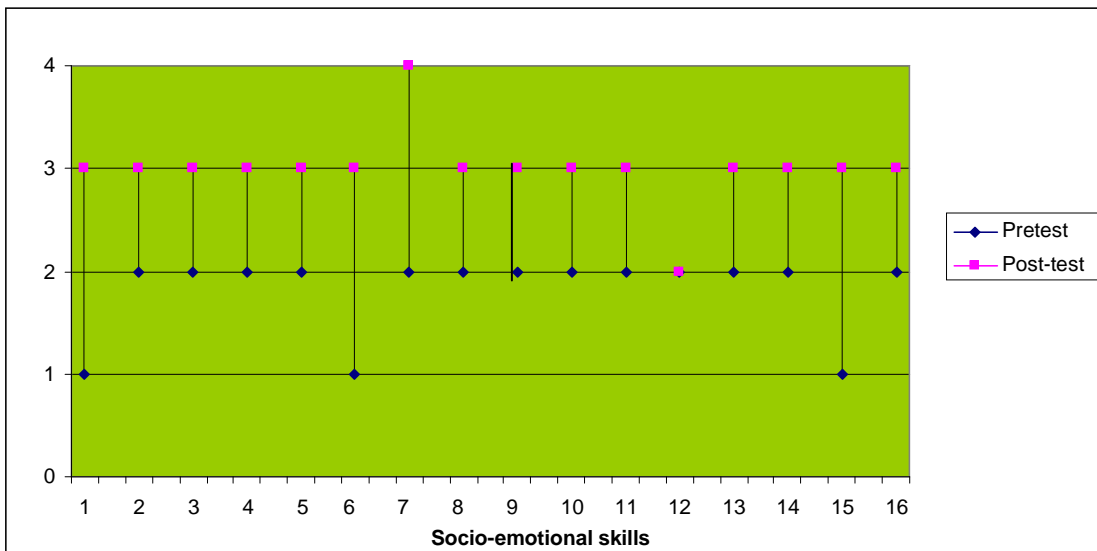
#### XI.2. Elena, 7 years of age

- Elena was physically abused by her mother's boyfriend.
- Both mother and her boyfriend have expressed the willing to leave Elena in the Child Protection Care System. They both are alcohol consumers.
- Elena's father is also a heavy drinker and a violent man; he has two other children in care institutions.
- Elena stayed with her mother; she had multiple relationships ended due to domestic violence and alcohol consumption.
- Elena was left alone for a long period of time, her mother worked at various farms. Lately, Elena, was taken care by an old lady, previous to that Elena was in her aunt's care.
- Her mother said that she is determined to give Elena away because she can not manage Elena's aggressive behaviour.
- Elena's teacher said that she is aggressive towards the other children and she can not keep up with school requirements.
- Elena was taken in foster care.

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- After establishing the placement, Elena apparently accepted easily the family rules. Later, the foster carer described the following issues: at school, she hit a colleague and expressed her intention to destroy her things; she was furious when she failed in academic tasks. Another problem identified by the foster carer was that Elena refused to recognize her guilt when she hit a girl in the park.
- The foster carer was extremely concerned that Helen may be taken away by anyone as Elena shows indiscriminate sociability to all persons that come into contact with her, even with strangers.
- The foster carer tried to reduce this behaviours using direct intervention during Elena's crisis, but this type of intervention nurtured Elena's anger.
- Elena and the foster carer were included in a counselling program but the foster carer had resigned from the institution.
  
- Elena was placed in a residential center and she was included in the You Can Do It! Educational Program.

Figure 1. Graphical representation of the results obtained by Elena



- During the program, Elena was responsive to the intervention and she made efforts to deal with activities and program requirements.

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- Elena has reached a positive development of her socio-emotional skills level. Only in terms of “conflict management”, the level remained the same, but this can also be on behalf of many conflict situations that appeared among children.
- In one situation Elena improved her competencies reaching from a "development in progress" stage to a "strongly reinforced" stage (to take care of things). This competency she has acquired is also due to the fact that no high cognitive or emotional effort is required and the immediate result was reinforced by others not involved in the program (caregiver, cook).
- Helena and other children participated in individual counselling sessions, in which the psychologist has applied techniques used in the program and has given the feed-back indicated by the program.
- Helen's emotional and behavioural problems may recur especially in the context in which a person to give her care will be found, therefore, the program continues, and Helen will continue to receive individual counselling.
- We believe that an emotionally stable environment and especially the presence of a primer care giver would reduce both the intensity and frequency of undesired behaviours.
- We continue to seek a solution for providing a stable environment for the child.

### XI.3. Conclusions

Children described in these case studies have experienced highly pathogenic care situations, being exposed to many development challenges. These symptoms are not included in the diagnostic criteria for reactive attachment disorder, but are shown by most children exposed to trauma. These atypical symptoms have posed a diagnostic dilemma. There were used more diagnoses attached to the reactive attachment disorder diagnosis (ADHD, oppositionist defiant disorder).

It is the researcher's duty to determine whether there is a multitude of symptoms that contribute to a single explanation or whether in fact these children have multiple diagnoses on Axis I.

Since there are cases of inadequate care on a continuum from lack of experience to severe abuse by parents, it is imperative that the research demonstrates the relevance and usefulness of keeping the etiology. The question of developmental researchers is that these children suffer from attachment disorder or a syndrome of abuse. From their perspective, the defining feature of attachment disorder is a profound disturbance of parent child relationship (Zeanah et al., 2001).

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Zeanah (2001) proposed a set of criteria for attachment disorders, so the diagnosis requires an assessment of child-parent relationship. This orientation is different from the current DSM criteria, which focus on disorders of social networking and pay little attention to child-caregiver relationship. In Elena's case, this relationship can not be investigated. However, hetero-aggressive behaviours have tried to be reduced by implementing the You Can Do It! program and to some extent it has been done. In Iulia's case the investigation of the type of parent child relationship was possible and interventions have been made in order to change this relationship.

## **GENERAL CONCLUSIONS**

This research made on preschool children who suffered child abuse was able to reveal the existence of a positive association between types of abuse and certain psychiatric disorders (reactive attachment disorder, ADHD, ODD). Also, the studies revealed the existence of a positive association between the abuses exerted by both parents and / or the children's age of 0 to 2 years at the abuse onset and the presence of attachment disorders. The children's age at the abuse onset was proven to be a predictor for the current global level of functioning of the children. Such as the children's age at the onset is lower, the current level of functioning is lower.

Starting from revealing the behavioural problems of the abused children, particularly those placed in residential centers and the fact that they need to be more successful in cognitive tasks, and to reach a higher level of emotional well being, we decided to optimize their socio-emotional skills by including them into Michael Bernard You can do It! Educational Program. From the statistical and practical point of view the results were significant.

In conclusion we consider that these studies brought a positive approach for clinical psychologists who work with abused children by providing information about clinical symptoms of abused children and by showing a working model of intervention meant to improve children's socio-emotional skills.



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