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# THE PSYCHOLOGICAL TREATMENT OF CHILDREN AND ADOLESCENTS IN RESIDENTIAL CARE. CONTRIBUTIONS TO A SPECIFIC FIELD OF INTERVENTION

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*Psychological treatment is provided to a great number of minors fostered in residential centres of the child protection system; however, a deep and systematic analysis regarding the specific topics of this field has not yet been carried out. We analyse the ways of organizing units to attend children, taking into account three different options (general practice, specific practice in common settings, and specialized programs), and their advantages and disadvantages. We consider the role of the theoretical models, underlining the need for complexity and critical analysis, illustrated by reviewing three common models (the psychopathological, trauma-informed, and attachment models). Finally, we pay attention to the specificity of the technical interventions, calling for modified adaptations based on the characteristics of the minors, specific topics in this field, and some particular aspects of the context.*
**Key Words:** *Psychological treatment, Child protection, Child maltreatment.*

*Un gran número de menores acogidos en recursos residenciales del Sistema de Protección a la Infancia reciben atención psicológica sin que aún se haya abordado un análisis profundo y sistemático acerca de los aspectos específicos que delimitan este ámbito de intervención. Se analizan las posibilidades de organización de los dispositivos, considerando las tres grandes opciones de atención (genérica, específica en recursos comunes, y especializada) con sus correspondientes ventajas e inconvenientes. Se revisa el papel de los modelos de comprensión, cuya demanda de complejidad y de un análisis crítico es ilustrada con el repaso de tres perspectivas muy comunes (modelo psicopatológico tradicional, enfoques basados en el trauma, y teoría del apego). Finalmente, se considera la especificidad de las intervenciones técnicas, donde se demandan adaptaciones en función de las características de los menores, las temáticas propias de este campo, y algunos aspectos particulares del contexto.*
**Palabras clave:** *Intervención psicológica, Protección a la infancia, Maltrato infantil.*

## A VULNERABLE POPULATION AND ITS CARE NEEDS

The professionals responsible for the mental health of minors in residential resources in the care system face a challenge that has not yet been adequately analysed. Attention to this population requires changes at multiple levels, from the professional-patient relationship to the organization of care resources. This is a particularly vulnerable population and requires certain specificity with regard to the implementation of services and the technical requirements of psychological interventions. The purpose of this paper is to open a space for reflection, addressing three questions: a) the models for understanding the personal experiences that are typical for these children and adolescents; b) the institutional organization of the care that is provided to them; and c) the specificity of the interventions.

In our country there are in the region of 14,000 children and adolescents in residential care, i.e. around 170 per 100,000 children (Dirección General de Servicios para la Familia y la Infancia [General Council of Services for Families and Children], 2013). They are fostered in a large network of healthcare resources, where children grow up in the care of persons appointed by the Administration to replace their families. They reflect very different situations (babies born with drug withdrawal symptoms, children who have been beaten by their parents or suffered extreme neglect, young people driven from their homes in a situation of family break-up, etc.) and the units that serve them are a wide network of resources, from homes where 5-6 children live with caregivers to large residential centres. They include caregivers of very different kinds, from families that take on professionalized care, to large groups of professionals

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comprising a variety of occupational categories (social educators, early childhood educators, psychologists, etc.) (Galán, 2011).

A first approach presents us with a group that is at risk of suffering from emotional or behavioural difficulties, in that these children face three experiences with a potential pathogenic component:

- ✔ Maltreatment, which involves the beating/neglect/abuse/rejection which defines it, plus the underlying emotionally dysfunctional and damaging relationship, all in the most sensitive developmental period of a human being.
- ✔ A separation from home, which is usually experienced as terrible and catastrophic.
- ✔ An artificial environment of cohabitation, where the child who is being taken care of will be provided with necessary and valuable experiences, but this would still nevertheless be a poor substitute for the natural context of growing up and cohabitation. In the worst cases, a malfunction of the resource will mean exposure to the iatrogenic component of many institutional contexts.

This context leads us to consider that most of these children require special care, and that for many of them it will be necessary to assess the need for psychological care. In fact, the prevalence figures show that psychological disorders are more common in this population group than in the general population (Burns et al., 2004; Del Valle, Sainero & Bravo, 2011), and the change being produced in the profile of foster children is evident, where there is an increased need for therapeutic care for emotional problems and mental health (Bravo & Del Valle, 2009). Issues of concern arise regarding the type of assistance to offer and how it should be carried out, both at the level of direct care and the organization of units.

## A HEALTHCARE ORGANIZATION PENDING CLARIFICATION

A tour of the different health care systems of our country shows great heterogeneity in the organization of psychological care for this population. To date no specific publications have carried out a nationwide review, and in the forums where the professionals responsible for this care meet there has not been a joint effort of clarification to analyse thoroughly what the work should entail or how it should be organized. Partial contributions (usually describing specific experiences of the professionals) offer a very mixed picture, with differences depending on which institution assumes responsibility (the care system itself or the health services), which professionals perform this task (public workers, professionals in private practice or private-public partnerships; psychologists from the institution itself or external agents), and the model used (direct intervention or support to the social-educational personnel). In a broader sense, there are three ways to implement this care:

1. Providing generic care, i.e., these children are treated the same as the rest of the population for all purposes, cared for in the network of the mental health services and sometimes supplementing with private practices where financial resources are available. This option has the advantage of its normalizing character (treating the children the same as the rest of the population) and it includes the children in a wide and comprehensive health care network, which facilitates complementary interventions (e.g., pharmacological prescription together with psychological intervention, neurological examinations, etc.) The disadvantages include the ignorance of the majority of health professionals regarding this population, in terms of both the psychological and administrative issues (legal concepts such as parental rights, lack of protection, guardianship, custody, foster care, etc.) Another encumbrance is the lack of resources, in the sense that some psychological areas to be worked with these children (for example, those relating to personal and family identity) require a dedication of time and effort that seems to be unfeasible for most health units.
2. Managing specific care within generic resources; i.e., these children are treated differentially, for example, considering them as priority cases, designating specific experts or implementing special programs (see for example the program of the Fundació Nou Barris per a la Salut Mental at www.f9b.org). This option is often the result of an agreement between the two care networks (health and child welfare), and has the aforementioned advantages of incorporating the minor into a complete healthcare network, while also advancing somewhat in the specialization of the professionals. Moreover, from a theoretical point of view, it situates the treatment of the children in an interdisciplinary field of mental health care that lies between the clinical and the social, and has its own specificity (Galán, Rosa & Serrano, 2011).
3. Providing specialized care, with professionals dedicated specifically to serving this population. Often this option has been used by the child protection services as a response to dissatisfaction with the care

provided in public health resources; agreements have been entered into with private entities to provide this care or professionals have been designated from the network itself to carry out this work. The major advantage is that it allows the implementation of highly specialized units that are extremely capable of integrating into the care network that attends to children (Aladro et al, 2010; Galán, 2012; Guerra, 2008). In addition, this specialization has revealed the specificity in terms of the concepts, knowledge and techniques required to work with the maltreated or abused population. The major disadvantage is that it involves, to some extent, the creation of a parallel health care network in relation to psychological care. Moreover, one of the most controversial aspects refers to whether these units should be part of the network of residential care (for example, as members of staff of the residential resources) or whether they should function as external entities; we note that in the first case there is a risk of the institutional dynamics invalidating the professional in the direct intervention with the child or adolescent.

One of the underlying issues in this problem is the relationship between the two care networks involved, those of child protection and health. While a dynamic of teamwork is necessary, it is rarely achieved, so there is a great deal of mutual ignorance and a fair amount of dissatisfaction. It is a difficult relationship to establish, as the two networks have different institutional settings (medical versus social), with languages and organizational cultures of their own, and also some relational asymmetry caused by the social perception of the two networks (the higher prestige of the health service). Within the current context of saturated care resources and economic constraints, these problems are even more acute.

## MODELS OF COMPREHENSION

Faced with the psychological difficulties of these children, the professional needs a conceptual framework to support their work, and a critical reflection is recommended regarding the fit and adequacy of the theoretical model that each one uses when working with such a specific population. In order to raise awareness in this regard, we take a brief look at three models of understanding which are very much present in the care of maltreated/abused children, adopting a critical perspective that allows us to underline the complexity of the problem we are addressing.

### *A. The traditional psychopathological model*

It seems necessary to reflect on this model due to its large presence in clinical settings and because its ability to explain the psychological problems is currently under question. It is undeniable that certain influences on development lead to specific ways of behaving, feeling, thinking and suffering, and these sometimes "crystallize" into certain well-defined configurations which we call "disorders" (psychological, psychiatric, mental, etc.) But this perspective is a partial approach that calls for the introduction of some critical questioning, which would focus on three points:

- ✔ the weakness of the psychopathological models
- ✔ the precariousness of the nosotaxies
- ✔ the paralysing effect that this perspective can have on some professionals

The dominant psychopathological perspective has considerable conceptual and technical background that has supported the development of psychiatry and clinical psychology, and the health systems responsible for serving the mentally ill. However, there are a number of proposals that recommend decoupling the psychopathological perspective from the so-called mental disorders, proposing alternative models for understanding human behaviour (González & Pérez, 2007; López & Costa, 2013). It is argued that the psychopathological perspective is a way of viewing anomalous behaviour that is a legacy of classical medicine, and it resorts to models of human pathology (searching for the seat and cause of the disease within the body). In this system, we find certain behaviours and thoughts, we label them as symptoms and we refer to an underlying abnormality in the individual's interior (in the brain). When this model was adopted by psychology, the brain was replaced (if only for methodological purposes) with the hypothetical constructs that are the supposed cause of the symptoms (for example, "depressogenic schemas"). It is the same pattern that we would use for conditions such as diabetes, asthma or an infection, although the field of psychological difficulties would be different. This difference between the two areas has been defined as a distinction between "natural entities" and "interactive entities" (Gonzalez & Perez, 2007). The basic mistake is to define mental disorders based on behaviours, to be treated later as if they were real entities, and finally to explain the behaviours based on the presence of the mental disorder, giving rise to circular reasoning. As an alternative to this model, it is proposed that behaviours should be defined as they are, i.e., as

behaviour in context. Therefore, the symptoms would include mainly the behaviour, and as such: a) they belong to the person; b) they occur within a context; and c) they have a meaning.

This is not the place to engage in this complex (and enriching) debate, but we must point out that we address the dilemma from a practical angle and framed in a constructivist view of reality (Feixas & Villegas, 2000). From this viewpoint, we do not understand the models as unquestionable realities, but as tools that we human beings use to manipulate reality. In this sense, the fundamental criteria for us are the utility, the coherence, the consistency and the elegance (in the sense of harmony and contextualization) of this way of understanding the clinical facts. Whilst still recognizing the important background of the classical psychopathological perspective, this is a model that fails to fully grasp the difficulties of these children. Although it seems useful in addressing many of the difficulties that characterize the maltreated/abused child, when working with these children and adolescents we should necessarily come closer and work with daily lives, experiences, modes of relationship, etc. for which the classic psychopathological model (with its symptoms, syndromes and alleged underlying causes) is clearly insufficient. A more phenomenological (in the sense of understanding the experiences based on the encounter), biographical, contextual and constructivist perspective is more useful.

Related to the above, the debate arises about the classifications of mental disorders. The study of psychopathology has led to the development of nosotaxies, i.e. classifications of mental disorders. The prevailing model is categorical and consensual, firmly rooted in classical psychopathology, and clearly represented by the classifications of the American Psychiatric Association (DSM) and the World Health Organization (ICD). Its usefulness is undeniable, but its limitations force us to question whether there are more productive and enriching ways of understanding the suffering and the emotional and behavioural maladjustment of human beings. The prevailing model is related to the choice of a medical model of psychological problems, and we saw earlier that it entails some basic weaknesses. In addition, these criticisms are amplified when applied to the field of children and adolescents because the characteristics of mental illness in children give it a specificity that requires a different form of classification. Among these characteristics we would include (Rodríguez-Sacristán, 1995) the symptomatological nonspecificity (the symptoms are very polyvalent and are present in very different clinical conditions), the capacity for self-regulation, reversibility and mutability (the pathology does not appear in such a rigid way as in adults), the time-dependent character (the same disorder can have very different expressions depending on age), the individual differentiability (the same disorder can have very personal manifestations for each child), the comorbidity (few mental disorders appear alone) and the psychopathoplasty of the context (the disorders are highly influenced by the environment).

Undoubtedly there are alternatives, such as dimensional models or transdiagnostic approaches. In fact, the more specific approaches to child psychological illness have resulted in some concrete formulations, such as developmental psychopathology, one of whose fields of application has been the very field of abuse (Toth & Cicchetti, 2013). As opposed to the categorical view of mental disorders, with the mode of diseases that are differentiated from each other, and a clear separation between health and disease, it is argued that psychopathology would not be a state in itself and differentiated from normality, it would be subject to a dynamic process of evolution (in close relation to its context), it would not be based on simple relationships between "etiological" factors and outcomes, it would attend to the interaction between biological, psychological and social systems, and it would also include the protective factors (Lemos, 2003). We can also consider the structural perspective of the mind; based on the psychoanalytic tradition, we find updated viewpoints, such as the proposal by Kernberg (Kernberg, Weiner & Bardenstein, 2001) or the French Classification of Mental Disorders in Children and Adolescents (CFTMEA-R-2000). These alternatives show that there are very productive ways to approach infant distress beyond the more formalized systems. What they have in common is that they introduce richness and complexity, and they also require a more individualized approach to the patient, which could be basic requirements for attending to psychopathology in maltreated/abused children and adolescents.

Continuing with the critical contributions to the traditional psychopathological model, we should point out that day-to-day experience shows us that this diagnosis can have a paralysing effect on non-clinical professionals. Consider, for instance, a common diagnosis such as "conduct disorder" formulated by a clinical unit. The solutions to be implemented in this context will be

psychopharmacological prescriptions and psychological interventions, which can be predicted to have a positive effect on the child's difficulties. Interestingly, the criteria that define the clinical condition are not just the symptoms, but also the intervention objectives of any psychosocial-educational program (whether it is a family intervention program through social services, or in the context of residential care for children in foster care). For the psychologist of the family intervention program, or the educator in a care centre, there is a temptation to retreat into the background of the intervention because the behavioural manifestations are the subject of a clinical intervention. We have chosen this example because most likely the treatment of choice is psychosocial-educational action in the context of living with others (in this case, in a residential environment), rather than other interventions; and therefore the clinical actions should serve as support for this other action, and not vice versa. But the weight given to the clinical diagnosis (among other things due to the prestige of the health service, but also due to the essentialist character of the classical psychopathological model), has a paralysing effect on other professionals who easily reinforce the tautology that underlies some diagnoses.

### *B. Models based on trauma*

Many approaches to abused children are based precisely on the element that defines them as a group: a traumatic experience. A very representative sample is found in the USA, where one of the most ambitious initiatives to advance the development of interventions with abused children is the National Child Traumatic Stress Network, a large network of research resources, supported by a congressional initiative, which seeks to implement resources based on the concept of trauma.

When using this concept in children, we must take into consideration that, in addition to its perturbing effect on wellbeing, trauma in children adds a distortion to their developmental process. This specificity explains the debates about how to label the traumatic experiences and limit their effect. Unlike traumatic models in adults (the paradigm for which is post-traumatic stress disorder, PTSD), in many children that are maltreated/abused in the family we will only find rarely: a) concrete experiences, which are truncated in terms of time and space; b) some distance with regards to the experience, so it is presented as a traumatic experience in itself. More common are traumatic situations that are fully amalgamated within life functioning, which makes it difficult to define and analyse the events from a distance. Obviously there are exceptions; for example, when moving into adulthood it is more feasible to establish distance from the abusive experiences and analyse them as such; in the same way, even with small children, it is possible to isolate certain traumatic experiences, especially when these were not part of their daily lives (for example, the action often referred to in the professional terminology as "removal", meaning the moment when the child is removed from the home and transferred to a residential setting).

These particular characteristics make it difficult to apply the diagnostic category PTSD. This category provides a very intuitive vision, because when we think of those who have suffered a car accident, a violent attack or a natural disaster, it is easy to identify these symptoms and understand their meaning. It is different when the situation is persistently maintained over time, and when the source is a person with whom the patient has a significant relationship. The symptoms of PTSD do not fit well to the trail that these experiences can leave behind. For example, dissociative experiences, demoralization and depressive symptoms are more frequent. These differences uphold, for example, the distinction between type I and type II traumas, which would correspond to these two different situations (Pérez-Sales, 2009). Moreover, in adults we are considering an already formed psychic structure, on which the stressor impacts. However, the disturbing potential in a child is much greater, and the growth process after the trauma will have to be carried out on top of the damage caused. Therefore, sometimes it seems as though we should talk of "traumatic lives" rather than "trauma."

This difference underlies conceptual or diagnostic contributions such as complex posttraumatic stress disorder (CPTSD) or "complex trauma", or developmental trauma disorder (Van der Kolk, 2005). These suggest that multiple or chronic exposure to interpersonal traumas associated with development will generate emotional distress but also produce symptoms in very different domains of personal functioning (attachment, emotional regulation, self-concept, functional impairment, etc.). These seem to cover practically the whole person, and require a comprehensive treatment of the individual as a whole.

### *C. The attachment model*

Attachment is a fundamental dimension in the development of human beings, and the experience of

abuse directly impacts it. This explains why attachment theory has become the basic framework of reference for many professionals who treat abused children. In addition, the intuitive nature of its basic idea, the major background research supporting it, and the possibility that it offers of directing a more positive vision to the development of human beings, have strongly boosted the interest in this framework of understanding. However, as with the previous models that we have analysed critically, we find gaps and deficiencies which show once again the need for more comprehensive and incisive reconsiderations of the ideas upon which we base psychological care for vulnerable children.

We should start with the lack of precision with which the concept of attachment is often used, confusing it with other concepts and giving it an excessively explanatory nature for all human relationships (Galán, 2010). While we have multidimensional models that place attachment within a greater complexity of human functioning, there still persist very simplistic visions of emotional ties. Similarly, despite the theoretical and methodological power of attachment theory, there is a gap in its projection to the clinical space, both in terms of evaluation and treatment. This has allowed many practices inspired by attachment theory to unite contributions from different backgrounds, which has sometimes resulted in well-integrated proposals but has also produced combinations that are worthy of criticism. And at the more serious extreme, we find highly questionable practices whose scientific and ethical status has been questioned by professional groups such as the American Professional Society on the Abuse of Children (Chaffin et al., 2006).

In the field of psychopathology, attachment theory offers us the possibility to obtain a different reading of the traditional diagnostic categories, as Bowlby did, for example with phobias (Bowlby, 1998). But also, attachment as a basic dimension of the mental and relational life of human beings may be directly affected, and here we are talking about attachment disorders. Clearly, by these we refer to a coherent domain of severe behavioural and relational problems (Chaffin et al., 2006) and follow-up studies suggest that it is a very persistent condition, so simply placing the child in a healthy care setting will not achieve significant change. But from the critical perspective argued here, we should highlight the abuse of this notion, to the extent that in some contexts it has become an excessively explanatory diagnosis and the central focus of intervention that should perhaps go primarily in another direction (Nilsen, 2003).

If we limit ourselves to the rigorous proposals, we find a debate on how to define the different ways an attachment disorder can occur. Probably the most widespread proposals are those that defend the international classifications of mental disorders (DSM and ICD, Diagnostic Classification 0-3), but there is dissatisfaction with these classifications. For example, specifically addressing the proposal of the DSM, objections appear such as those by Boris and Zeanah (1999) or Chaffin et al. (2006), stressing the conceptual and methodological weaknesses of these criteria. But above all, we should highlight the lack of precision, which means that difficulties in managing relationships lead to the classification of "attachment disorder", disregarding the enormous clinical complexity that this concept encompasses.

With this critical analysis of the three very common models in this area, we aimed to demonstrate that we are situated in a context of high complexity, and the knowledge in this area has made great progress, but where the frameworks of understanding cannot be simple or accepted uncritically. Furthermore, the model that each professional decides to use to attend to the maltreated/abused population should contemplate:

- ✔ the high degree of suffering involved in the personal reality of these children and adolescents;
- ✔ the great technical and emotional effort required of the professionals; and
- ✔ the handicap that certain experiences impose on healthy and successful development.

## THE SPECIFICS OF THE TECHNICAL INTERVENTION

To understand the large gap that exists between the time a working model is designed and its widespread implementation, the Chadwick Center for Children and Families (2004) noted how four stages can be identified in the field of child abuse (common to other clinical areas): the use in the specific population of interventions used in the general population, the subsequent appearance of prominent figures who provide the keys to the particular field which are adapted by some professionals, the development of validated formats of treatment, and finally the dissemination and generalization of these. Most of the professionals in our country are in the first two stages, as there are barely any validation studies for specific formats of treatment, except those by the research group at the University of Murcia (http://www.cop.es/infocop/pdf/1602.pdf); and of course these are not widespread.

Awaiting the development of such treatment models, the professionals have a responsibility to include, in their generic formats of care, some specific knowledge and skills. The inspiration can be found in different places. Outside our country there are a variety of models that have been specifically developed for working with maltreated/abused children, which have also not escaped the current drive towards evidence-based practice. We can point to recent reviews, such as Leenarts et al. (2013), Rosa-Alcázar, Sánchez-Meca and López-Soler (2010), the special edition on Child Maltreatment in 2012 (Volume 17), or the review by the National Child Traumatic Stress Network on empirically supported treatments (http://www.nctsn.org/resources/to¬pics/treatments-that-work/promising-practices).

Beyond these standardized formats, there are concrete proposals that are especially inspiring for many professionals in our country, in the "prominent figures" we mentioned earlier, and among which we might include the Centro per il bambino maltrattato e la cura della crisi familiare (CBM) in Milan, Jorge Barudy and Juan Luis Linares (Barudy, 2001; Cirillo, 2012; Cirillo & Di Blasio, 1991; Linares, 2002).

A sensitive and technically correct approach will lead us to consider issues specific to this population. For example, in relation to the characteristics of children, attention is often drawn to their resistant nature, although sometimes their behaviour seems contradictory. Psychotherapy provides a significant interpersonal relationship, causing resistance in a person who has had at least one double failure in the most important meaningful relationships in their life. However, emotional deprivation may involve at the same time a search for interpersonal bonds, giving rise to an ambivalent attitude towards the professional, which demands patience, sensitivity and sometimes a great deal of creativity on the part of professional, in order to establish a minimal emotional contact to initiate and/or continue the intervention. Another example is the frequent presence of what might be called "deficit pathology" in the sense of mental functions that it has not been possible to develop, causing a number of limitations. An example of this could be in the management of emotions (feeling them, acknowledging them, expressing them, controlling them, etc.), which requires of the professional "emotional education" work in the psychotherapeutic context, but also an effort to allow the unblocking of the mental functioning. In the same line limitations may appear in the symbolic management, implying that some instruments that are frequently used to access other children (pictures, stories and role play) are not readily available, at least in the early stages; and this can frustrate the professional who expects a certain richness of communication, to which he would respond with elaborate verbal interventions.

Moreover, an in depth intervention will eventually find some very specific issues (or common ones that will adopt specific features), such as abandonment, care, family loyalty, traumatic events, identity, personal history or stigma. They appear in some way, sometimes as symptoms and other times as background that only comes to the fore if a dedicated intervention is carried out and/or the professional directs attention towards them. This consideration will lead the therapist to work systematically with the life trajectory of these children, where traumatic experiences, conflicts and gaps appear, which must be addressed.

Finally there are specific elements of the context of the intervention. With many children we encounter difficulties in emotional contact and relationships on a close one-to-one basis, which force us to search for mediating activities, provide well-regulated frameworks for containing the relationship, etc. Likewise, it should be kept in mind that these children are being cared for by people who assume a dual role in their lives (as caregivers and professionals), which will also apply to the psychologist, and it may be difficult to find the optimal distance that enables us to harness their emotional involvement at the same time as not considering them as "patients."

It is also important to place the psychological intervention in a much broader context. These cases transcend the space of the consultancy, bringing countless variables into play with legal, institutional, psychological, social, and family aspects, etc. This complexity, together with the diversity of views that are external to psychotherapy itself, constitutes a challenge for some practitioners of psychological intervention, who find it difficult to handle this diversity of perspectives, the inter-institutional relations, and even just the logistics of participating in such a wide network.

A final point to consider is the determination of the outcome measures. The criteria for symptomatic reduction is unavoidable, although shown to be limited when the reasons underlying the derivation barely adjust to a psychopathological vision; when an

intervention is requested due to the confusion shown by a child in understanding his/her life situation, difficulty in relating to family in a mature way, or a tendency to clash in their different relationships, it is difficult to establish efficacy criteria based on the classic symptoms. This brings us back to the questioning of the tradition of measuring the efficacy of psychological therapy only in terms of symptoms, when it would be more relevant to promote psychological flexibility, self-awareness, the clarification of personal decisions, the empowerment of resources, or the ability to solve problems. This position brings us to the definition of mental health by the WHO, which views it as a state of being in which the individual is aware of his own attitudes, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community (World Health Organization, 2001).

These elements do not exhaust the specificity of this field, but show the complexity and idiosyncrasies of this area of intervention, with the consequent need to adjust the concepts and techniques used.

## NECESSITIES

In addition to the organizational, theoretical and technical issues we have mentioned, there are also requirements in the social and ethical fields. Appropriate psychological treatment for abused/ maltreated children requires that enhanced visibility is given to this population, which would allow a better understanding of the particularities of their administrative situation and the life challenges they face.

Secondly, a mental attitude is required that facilitates integrative views at the professional level, which can account for the complexity of these life situations and of the administrative and institutional situations; and in addition, a change of perspective might be considered regarding the designing of interventions, so that we move from a formulation based on the problem to a care provision that is adapted to the necessities.

Finally, none of the above is valid if there is no ethical commitment to these children and adolescents faced with extremely difficult experiences, precisely at the time when their efforts need to be concentrated on the growth process itself. These children face challenges of great magnitude, and while some give us a lesson on how to take advantage of growth potential in the worst circumstances, others show us how certain life experiences can hinder the development of a human being.

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