EDICIONES COMPLUTENSE

Cuadernos de **Trabajo Social**
ISSN 1988-8295

ARTÍCULOS

Evaluation of Specialized Integral Intervention Programs for Children and Adolescents

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https://dx.doi.org/10.5209/cuts.96111 Enviado: 20/05/2024 • Aceptado: 06/02/2025

ENG **Abstract:** The concern for the violation of children's rights has increased in Chilean society. The following study seeks to evaluate the ways in which specialized comprehensive intervention programs (PIE) operate in response to therapeutically to various forms of rights violations against children. It uses a mixed methodology addressing critical elements linked to the design, process and results of the program, geographically located in the cities of La Calera, La Ligua, Ovalle and Los Vilos. It is concluded that the intervention models used are statistically effective but they present strong contradictions associated with an increasingly non-specific profile of the users, which translates into resistance and theoretical-methodological adaptations from the therapists.
Keywords: Rights violations; Childhood; Specialized Integral Intervention Programs (PIE); Therapy; Mixed methodology.

ES Evaluación de Programas de Intervención Integral Especializada hacia niños, niñas y adolescentes

Resumen: La preocupación por la vulneración de derechos de la infancia ha motivado el siguiente estudio que busca evaluar el funcionamiento de los Programas de Intervención Integral Especializada (PIE) a cargo de responder terapéuticamente a diversas formas de vulneraciones de derechos hacia la infancia. Utiliza una metodología mixta abordando elementos críticos vinculados al diseño, proceso y resultados del programa, geográficamente está situada en las ciudades de La Calera, La Ligua, Ovalle y Los Vilos. Se concluye que los modelos de intervención utilizados si bien son efectivos desde el punto de vista estadístico, presentan fuertes contradicciones asociados a un perfil cada vez más inespecífico de usuarias y usuarios, que se traduce en resistencia y adaptaciones teórico-metodológicas desde los terapeutas.
Palabras clave: Vulneración de derechos; Infancia; Programas de intervención integral especializada; Terapia; Metodología mixta.

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Como citar: Sotomayor López, F.; Concha Ríos, C.; Marques Oliveira, E. (2025). Evaluación de Programas de Intervención Integral Especializada hacia niños, niñas y adolescentes.. *Cuadernos de Trabajo Social 38(2)*, 335-345. https://dx.doi.org/10.5209/cuts.96111

1. Introduction

The persistence of child abuse in Latin America and the Caribbean, as well as in the United States, poses a major challenge to child protection systems, highlighting the need to strengthen public policies and

protection interventions. In 2020, in the United States, 3.9 million reports of child abuse were made involving 7.1 million boys and girls. Girls had higher rates (8.9 per 1,000) than boys (7.9 per 1,000) (Escalante-Barrios et al., 2020). In Latin America and the Caribbean, the presence of violent discipline in the home is a widespread problem deeply embedded in society. A UNICEF report from May 2022 reveals that nearly two-thirds of children between 1 and 14 years old experience violent discipline, underlining an alarming prevalence that reflects the urgency for interventions and public policies aimed at eradicating this violence (Bott et al., 2021).

The problem goes beyond the domestic sphere; it encompasses multiple contexts, from schools to public spaces, highlighting the pervasive nature of violence in children's daily lives. In Colombia, an analysis of 680 male-on-male sexual abuse cases between 2017 and 2018 reveals a high prevalence, mostly perpetrated by individuals known to the victims, characterized by high levels of violence (Escalante-Barrios et al., 2020).

This study, centered in Chile, uses a mixed-methods approach with qualitative and quantitative analyses to generate knowledge about the progress and results of current public policies and interventions. From a comprehensive perspective, it aims to identify pathways to improve the protection and well-being of children in the region (Pluck, 2021**).**

2. Child Abuse: Definition

Child abuse has been extensively studied from various perspectives, revealing its complexity and multifaceted nature. Perrone and Nannini (1997) highlight the importance of bonds with significant adult figures, noting that such bonds, which include care, affection, and protection, are crucial for the development of children and adolescents (NNA). Any form of abuse represents a significant break in these bonds, deeply affecting the social, emotional, and psychological development of the child or adolescent.

From an analytical perspective, Bueno (1997) identifies four fundamental criteria for evaluating child abuse: the intentionality of the act or omission, its impact on the child, the community's ethical assessment, and the sociocultural patterns that influence this assessment.

Traditionally, four main types of child abuse are recognized: physical abuse, which involves non-accidental physical assaults that cause harm or expose the child to serious risk; psychological abuse, which includes habitual verbal harassment that degrades the child's self-esteem; neglect or abandonment, when the child's essential needs are not met; and sexual abuse, which involves any sexual activity with a minor under 18 years old without consent (Moltedo & Miranda, 2004).

Finkelhor (1979) warns about the reductive view that categorizing abuse can entail, emphasizing the importance of considering it within the framework of polyvictimization. This approach encompasses various forms of abuse and exposure to violence, emphasizing the power imbalance between the aggressor and the victim, which complicates both the identification and the intervention in such cases.

2.1. Impact of Child Abuse on Neurological and Socioemotional Development

The literature on the consequences of child abuse is extensive. In this article, we focus on the neurological and socioemotional dimensions to offer a biopsychosocial perspective of the phenomenon.

From a neurological standpoint, studies have shown that child abuse affects aspects such as intelligence, executive functions, and memory, as well as cognitive adaptation and flexibility, especially during adolescence (Fay-Stammbach, Hawes & Meredith, 2017).

Cohen Imach (2017) analyzed the intellectual performance of children and adolescents between the ages of 6 and 16 who were victims of psychological, sexual, or physical abuse. She found that 63% performed below the expected average. Other studies showed lower intellectual performance in victims of abuse and difficulties in reading and writing skills, even when controlling for variables such as age, gender, and socioeconomic status (Viezel et al., 2015; Pérez & Widom, 1994).

Regarding socioemotional consequences, research by Kaufman (1991) and Salzinger et al. (1993) indicates a higher prevalence of affective disorders—such as depression, self-harm behaviors, and lower socioemotional development—among abuse victims. Moreover, early traumatic experiences have been linked to difficulties in recognizing facial and bodily emotions, leading to dysregulation and adaptive issues in the school environment (Masten et al., 2008; Gruhn & Compas, 2020; Reyome, 2019).

Within the framework of complex trauma (López Soler, 2008), it has been observed that children exposed to multiple forms of abuse display more significant symptoms—anxiety, depression, and behavioral problems—compared to those who experience a single type of abuse (Ford et al., 2010). Furthermore, complex maltreatment can affect the capacity to establish healthy relationships and develop resilience in the face of adversity (Cyr et al., 2017).

2.2. Psychosocial Intervention in Child Abuse Contexts

The diverse psychosocial interventions for children who are victims of abuse can be divided into various approaches, each with specific techniques that may be used individually or complementarily in the therapeutic process.

Psychoeducation is a widely used intervention that can complement any therapeutic approach. It provides relevant information to help victims and significant adults understand the traumatic experience and develop protective resources for the future (Rigamer, 1986).

To address the immediate effects of abuse, crisis intervention is employed. This intervention offers victims the opportunity to express their feelings and receive emotional support. Generally limited to 2–3 sessions, it can be conducted individually or in groups across various settings (Gómez & Haz, 2008).

Grief therapy is adapted for children who have witnessed homicides, helping them accept the loss, express emotions, and maintain positive memories of the deceased (Cohen et al., 2002).

Play therapy, based on the interpretation of play as an indicator of internal conflicts, effectively facilitates communication about trauma and discussions on safety strategies (Gil, 2008). It is often used in combination with cognitive-behavioral approaches (Brown, Cohen & Mannarino, 2020).

Different family therapy models focus on improving family cooperation, developing positive communication, and resolving conflicts peacefully (Kolko, 1996). They have also been utilized to reestablish healthy boundaries, particularly in cases of domestic violence (Urquiza & McNeil, 1996). Studies such as those by Lieberman, Van Horn, & Ippen (2005) have focused on strengthening the parent–child relationship, especially in cases of physical abuse, to rebuild the child's perception of their caregivers.

These approaches provide various tools for addressing the complex needs of children who have experienced abuse, offering them emotional support, helping them process trauma, and promoting their overall well-being.

2.3. Intervention Models in Chile's Protection Policy: From Repair to Re-Elaboration

Since the 1990s, Chilean policies addressing child abuse have had a reparative focus, aiming to alleviate suffering and facilitate victims' recovery. According to Dussich & Pearson (2008), reparative therapy focuses on restoring dignity through respect, validation, and recognition. This approach is implemented through different therapeutic models.

Although multiple theoretical perspectives are acknowledged in Chilean programs, in practice, parental competency models prevail, contrasting with the broader ecological approaches adopted internationally (Contreras, Rojas & Contreras, 2015).

Venegas (2011) highlights that the concept of "reparation" has undergone several phases and theoretical debates. Initially associated with the notion of harm, it later evolved into a constructivist view of "co-construction." However, tensions arose around this framework, which led to the proposal of a "re-elaboration" model focusing on narratives that emphasize how abuse affects both the present and future of those affected.

The term "restoration of rights" has also gained relevance, acknowledging that sexual abuse violates fundamental rights (Sinclair & Martínez, 2006). It is understood that child abuse in all its dimensions alters a child's perception of self, others, and the world, requiring a broader ecological approach to reparation.

For Capella et al. (2021), child abuse, particularly sexual abuse, is a traumatic event whose integration is crucial so that the person can express and work through their feelings without being defined by them in the future. This approach seeks the re-elaboration of trauma, allowing recovery and future development of the individual.

2.4. Specialized Integral Intervention Program (PIE)

In Chile, PIE programs, established under Law 20.032 of 2005, focus on the physical and psychological recovery and social reintegration of children and adolescents who are victims of abandonment, exploitation, or abuse. Executed by accredited collaborating agencies (OCAS) and subsidized by the Servicio Mejor Niñez (formerly SENAME), these programs last 18 months and aim to repair the harm caused by serious rights violations. Additionally, they develop competencies in responsible adults and provide psychosocial and therapeutic interventions for the affected individuals. Though called "projects," they are technically considered programs with implementers subject to ongoing evaluation and potential reassignment (Servicio Nacional de Protección Especializada a la niñez y adolescencia, 2018).

PIE includes therapeutic alliances, assessments, and the development of an Individual Intervention Plan (PII). Each quarter, the process is evaluated, and based on the results, a decision is made regarding case closure or coordination with other programs. The model of care, called the multidimensional approach for chronic rights violations (MVCD), relies on a psychosocial-educational strategy featuring a multidisciplinary team of tutors, social workers, and psychologists. Table 1 summarizes the intervention dimensions established in its technical guidelines.

Table 1. Dimensions and areas of reparative intervention (based on technical guidelines)

Dimensions	Areas
Individual Dimension: Position of the child or adolescent who is a victim of physical, psychological, or sexual assault.	**Protection:** Related to creating a safety context for the child or adolescent by mobilizing legal resources.
Family-Relational Dimension: Disposition of the significant adult to fulfill their protective role and the relational context.	**Reparation of Socioemotional and Physical Harm:** Visualization and adoption of alternative practices to violence through recognizing it on individual, family, and contextual levels (crisis).
Contextual Dimension: Presence of the child or adolescent's support network (social, community, or institutional).	**Development Area:** Development and/or strengthening of family, individual, and contextual competencies and resources that contribute to validating protective relationships and parenting styles.

Source: Author's own, 2024.

2.5. Evaluation of Intervention Programs in Child Abuse Contexts

Multiple authors (Cantón & Cortés, 1999; Gómez & De Paúl, 2003; Finkelhor, 1980; Glaser & Frosh, 1997; Smith & Bentovim, 1994) have highlighted the importance of enhancing the evaluative practices of intervention programs. In Chile, the evaluation of child-focused policies has primarily centered on symptom reduction, assuming a linear relationship between symptoms and child abuse. However, authors like Castro (2011) and López Soler (2008) emphasize the complexity of the therapist–patient relationship, which gives rise to a range of non-linear symptoms. Hence, evaluations should expand their information sources (children, parents, teachers, clinicians, etc.), timeframes (disclosure, treatment, follow-up), environments (home, school), and methods (self-reports, questionnaires, direct observation, interviews).

This study revisits the ideas of authors such as Llanos & Sinclair (2001), who advocate the integration of new perspectives by considering the intervention model design, the organization and management of teams, network articulation, and outcomes (symptom reduction, activation of judicial protection mechanisms).

3. Method

The main objective of this study was to evaluate the implementation process of two PIE programs. We employed effectiveness evaluation models (Castro, 2011) and process evaluation models (Santos Guerra, 1993) to generate knowledge. Both approaches integrate the intervention context into their analysis and are not limited solely to the symptom reduction resulting from the abuse experience. Moreover, they allow us to address the heterogeneity in the characteristics of the children and adolescents served[1], the responsible therapists, and the overall intervention framework. We decided to integrate both approaches through models proposed in the specialized project evaluation literature (Arancibia, 2018). The study results are presented across three levels: (a) Design; (b) Organization and management; and (c) Intervention results.

This study is grounded in a mixed-methods approach, combining qualitative and quantitative analyses to comprehensively explore the design, organization, and management dimensions, as well as the symptomatic impacts of Specialized Integral Intervention Programs (PIE) in the Valparaíso Region. A comparison was made between non-random groups of long-term programs, facilitating the identification of critical elements that influence their effectiveness. Central to this approach was the implementation of a case study, which allowed immersion into the operation and results of both programs, thus enabling a detailed evaluation of the interventions and their effects over time. This mixed-methods method ensured a comprehensive understanding of the phenomenon, from the initial conceptualization to the assessment of post-intervention results, aligning with rigorous research standards.

Regarding rigor criteria, credibility was addressed by employing data triangulation techniques and peer review. Auditability was ensured through detailed documentation of the research process, allowing other researchers to examine and verify the study's methodology and findings. For confirmability, strategies were adopted to minimize researcher bias, such as critical reflection on personal assumptions and open discussion with other researchers. Transferability was strengthened by thoroughly describing the context and participants, providing the basis for applying the results to similar settings (Guba & Lincoln, 1989).

For processing and analyzing qualitative data, thematic content analysis was used, enabling the identification and exploration of significant patterns related to participants' experiences and program dynamics (Braun & Clarke, 2006). This methodology was complemented by specialized qualitative analysis software, which increased efficiency and accuracy in managing the collected data.

From the quantitative perspective, we extracted a sample of 88 cases, all served between January 2022 and June 2023, distributed as 58 children and adolescents from center "A" and 30 from center "B." This difference is due to the timing difference in the tender processes for both technical proposals, and thus their implementation of the multidimensional approach for chronic rights violations (MVCD). To maintain methodological consistency in our sample and results, we included only those intervention processes framed under this model. The study design is non-experimental and longitudinal in nature.

For the qualitative sample, a non-probabilistic, discretionary sampling was used, comprising 19 in-depth interviews, following a typology of roles within the program's operations. For the children, adolescents, and their families, a categorization based on ideal types was used, seeking deeper insight into cases of high effectiveness and lower effectiveness. In summary, the sample included: 1 developer of the PIE intervention model; 2 program directors; 6 direct intervention professionals (psychologists/social workers); 2 linking agents; representatives from the institutional networks associated with PIE; 4 children and adolescents served by PIE; and 4 significant adults participating in PIE. For the quantitative phase, a non-probabilistic or intentional census-type sampling was employed with a total of 88 cases, consisting of all children between 4 and 18 years of age admitted to one of the two programs.

For pre- and post-intervention measurements, the instrument titled "Instrumento para Elaboración de Plan de Tratamiento Individual e Indicadores de Situación" (Instrument for Individual Treatment Plan Development and Situation Indicators) was used. It supports a longitudinal pre- and post-intervention perspective and utilizes an assessment scale. According to Himmel, Olivares, and Zabalza (1999), such instruments adequately identify behavior. Table 2 provides a summary of the variables included in the instrument.

[1] La totalidad de los casos provienen derivados de tribunales o Ministerio Público, instancia que opera con lógicas no necesariamente técnicas de diferenciación por gravedad de la sintomatología producto de la experiencia abusiva.

Table 2. Abbreviated variable operationalization matrix

Dimension	Nominal Definition of the Dimension	Sub-Dimension
A. Protection	Understood as creating a safe environment for the child or adolescent who is a victim of severe abuse and their family.	**A.1.** Identification of safety resources that promote protection for the child/adolescent and their family. **A.2.** Mobilization of safety resources that create protective conditions for the child/adolescent and family. **A.3.** Absence of new assaults.
B. Crisis	Understood as the process of examining the abusive relationships present in the maltreatment/ abuse experiences of the child or adolescent.	**B.1.** Recognition of the abusive relationships present in the victimization experiences of the child/adolescent. **B.2.** Generation of premises to denaturalize abusive relationships present in the child/adolescent's experiences. **B.3.** Recognition of the need for individual and family support (a facilitating dimension).
C. Socioemotional Harm	Understood as the specific socioaffective manifestations linked to the experience of abuse/ maltreatment.	**C.1.** Integration of the abuse/maltreatment experience into life history. **C.2.** Reduction in manifestations of socioemotional and physical harm associated with the abuse/maltreatment experience.
D. Development	Understood as the creation or strengthening of individual, family-relational, and contextual resources oriented toward the integral well-being of the child/adolescent.	**D.1.** Identification of individual, family-relational, and contextual resources. **D.2.** Mobilization of individual, family-relational, and contextual resources.

Note: This instrument was developed by the NGO hosting this research and was administered during the 2022–2023 period.

Quantitative data were processed using the SPSS (Statistical Package for the Social Sciences) software. Normality tests were conducted (Kolmogorov–Smirnov / Shapiro–Wilk), followed by paired-sample t-tests, independent-sample t-tests, the homogeneity of variance test or a one-factor ANOVA, multiple comparisons using Tukey's HSD, and Pearson's r correlation test. A significance level (p) of less than or equal to 0.05 was accepted.

4. Results

The qualitative results are organized around three dimensions. First, regarding the methodological design of the intervention proposal; second, the impressions related to organization and management; and finally, the results and effectiveness of reparative therapy.

4.1. On the Methodological Design of PIE

The findings reveal significant criticisms regarding the conditions surrounding the technical design of the PIE intervention model. First, the intervention teams expressed a notable demand for designer involvement in implementing this modality. Distances were identified between the direct intervention teams and those who were in charge of the model's technical design.

An example of this issue is the program's geographic location and dispersion, as well as problems accessing the children and their families. These first two elements appear to reflect a tendency toward operational over-standardization, emphasizing centralized efficiency grounded in a reality that is both centralist and urban. Ultimately, it is questioned that the original design of PIE features contradictions typical of an operational task-standardization process that fails to meet the teams' need for immediate response.

However, regardless of these design-related issues, the teams noted that a significant strength of PIE lies in its multidimensional nature. In this sense, those professionals with more time in the organization and experience with a previous technical proposal highlight the advantages, indicating an affinity with the work approach used in other more complex programs, such as Abuse Repair Programs (PRM).)[2]. Nevertheless, they point out that the instruments used to evaluate progress, which are borrowed from other types of programs like PRM, do not meet the needs or objectives of PIE, as PIE has a broader scope of complexity levels, exacerbated in rural contexts where specialized responses are limited due to a scarcity of programs.

[2] Programas de reparación de Maltrato Grave, que tiene como objetivo una recuperación integral de niños(as) y adolescentes que han sido víctimas de graves vulneraciones de derechos, ya que han sufrido maltrato físico o psicológico grave y agresión sexual, situaciones que Ley n° 19.927 califica constitutivo de delito, y que involucran daño a nivel físico, social, emocional y/o del desarrollo sexual que ponen en riesgo su inserción social.

Accordingly, the profiles of children entering these programs are increasingly broad and complex, forcing the same team to respond equally to highly diverse issues requiring advanced technical competencies, such as child labor and sexual exploitation, or children with sexually abusive behaviors (PAS), among others.

The interviews indicate that, after several years of implementing this design, there has been a process of customizing the technical proposals via a diagram based on four identified tensions: model implementation, technical response, user profile, and geographic location. Each PIE project has tailored its approach depending on how these tensions have been addressed.

4.2. On the Implementation and Management of the Model

At this level of analysis, several advantages in implementing the PIE intervention model were noted, including the energy, commitment, and youth of the professionals involved. Interviews with network partners (courts, educational institutions, healthcare centers, etc.) highlight the team's capacity to work with complex cases and their willingness to engage in interinstitutional collaboration.

However, concerning the organization and management of the intervention model, the transcripts and descriptions illustrate a complex situation, particularly in the relationship between support entities (financial and administrative) and the work teams, as well as the internal tensions in project execution. Table 3 features a few excerpts.

Table 3. Excerpts from professional team interviews

Excerpts from professional teams	Center "A"	Center "B"
Selected quotes	"...with the previous model, we were kind of on our own, each person on their own, it was exhausting because it was just one of us." "Regardless of the time or day, there was always someone who could receive the child or adolescent at some point during the day... now we also had the whole administrative aspect (...) how do we address SENAME's requests." "We argued a lot... we were upset. Now that I think more reflectively, I understand it wasn't so bad, but at the time we were resistant." (Linking agent) "When they told us we would have more cases but there would be three of us, I thought, well, that's fine. But now I see it was a mistake. I'm not sure if it's the model or that these new contracts allowed more cases per professional. You can't complete administrative tasks."	"It's not possible for the same team member to be in charge of linking, evaluating, intervening, reconnecting, going out to find them, and doing home visits." "We work in combined triplets. It's very efficient... I think that all of us, in addition to being professionals, are linking agents on paper, but in practice, that doesn't happen." "The linking agent shouldn't go to hearings because they have a different role to maintain the relationship. They shouldn't go to complicated hearings." "Having a professional in the education field has been essential—there's permanent support for the kids."

Source: Author's own, 2024.

Firstly, as centers located in peripheral areas of the Valparaíso region, there is a tension between the need for greater technical support and the desire for autonomy in applying the strategy model, in dialogue with the situated nature of the interventions. This tension suggests a disconnect between expectations and the actual needs of the field team.

One key characteristic of the intervention model is the phased approach to intervention and the prescribed sequence for addressing the abuse or maltreatment situation of a child or adolescent. Resistance to the modular logic and the introduction of a Linking Agent indicates tension between the greater freedom enjoyed under previous therapeutic frameworks and the possible constraints introduced by this new model. Administrative and contractual elements also emerge in the interviews with team members and directors, revealing the need for careful planning and management to balance technical and economic demands.

4.3. Results of Intervention Effectiveness Measurement

In both projects, the male population predominates. Center "A" has 36.64% (34 cases) male and 27.27% (24 cases) female. Meanwhile, center "B" has a slightly higher distribution of 23.86% (21 cases) male and 10.23% (9 cases) female. Regarding a potential correlation between gender and intervention effectiveness, correlation tests yielded a p-value of 0.229, which is above 0.05, indicating no statistically significant relationship between the gender of participants and the effectiveness of the intervention.

Concerning the dimensions evaluated, we begin with the protection dimension. Table 4 shows progress in four sub-dimensions. Notably, A-1 exhibits an increase of +11.3, representing a 30% improvement over the initial condition of the cases at the time of intervention. Among all the sub-dimensions evaluated in

the instrument (across both centers), "A" yields the most prominent results in identifying safety resources. Statistical analysis using paired t-tests shows bilateral significance values of 0.00. This confirms that both centers are statistically effective in this dimension, even though, compared to other dimensions, the proportional improvement here is relatively lower.

Table 4. Summary of results for the protection dimension

Center	Identification of safety resources that foster protection for the child/adolescent and their family (A-1)	Mobilization of safety resources that generate protective conditions for the child/adolescent and their family (A-2)	Absence of new transgressions from the child/adolescent (A-3)	Absence of new violations against the child/adolescent (A-4)
A	**Pre** A-1 = 26.6 **Post** A-1 = 39.0	**Pre** A-2 = 15.5 **Post** A-2 = 21.6	**Pre** A-3 = 2.6 **Post** A-3 = 3.5	**Pre** A-4 = 2.68 **Post** A-4 = 4.12
	Difference = **+12.39**	Difference = **+6.08**	Difference = **+0.82**	Difference = **+1.44**
B	**Pre** A-1 = 32.23 **Post** A-1 = 41.43	**Pre** A-2 = 17.76 **Post** A-2 = 21.56	**Pre** A-3 = 3.03 **Post** A-3 = 4.43	**Pre** A-4 = 2.76 **Post** A-4 = 4.10
	Difference = **+9.2**	Difference = **+3.8**	Difference = **+1.4**	Difference = **+1.33**
TOTAL AVERAGE	**+11.3**	**+5.31**	**+1.02**	**+1.40**

Source: Author's own, 2024.

Regarding crisis management, sub-dimensions B-1 and B-2 show relatively low admission scores but experience considerable improvements of +9.90 and +10.94, respectively, representing roughly 30% effectiveness by the end of the psychosocial process. According to Table 5, in sub-dimensions B-1 and B-2, related to recognizing the risk of re-victimization and creating premises for validating rights, center "A" differs significantly from center "B." T-test results confirm that both projects' effectiveness is statistically significant.

Table 5. Results for the crisis dimension

Center	Recognition of individual, family-relational, and contextual resources; social inclusion (B-1)	Mobilization of individual, family-relational, and contextual resources (B-2)
A	**Pre** B-1 = 10.01 **Post** B-1 = 24.00	**Pre** B-2 = 15.21 **Post** B-2 = 34.45
	Difference = **+13.98**	Difference = **+19.24**
B	**Pre** B-1 = 24.7 **Post** B-1 = 31.33	**Pre** B-2 = 30.50 **Post** B-2 = 37.53
	Difference = **+6.63**	Difference = **+7.03**
TOTAL AVERAGE	**+7.26**	**+9.39**

Source: Author's own, 2024.

With respect to the emotional harm experienced by children and adolescents, Table 6 shows that the difference between pre- and post-intervention scores for C-1 is consistent with the average improvement observed in the instrument (8.1 points). However, for C-2, progress is modest, with an increase of only +4.67, marking it as one of the sub-dimensions with the lowest degree of improvement. Notably, in project "A," out of the 57 cases evaluated initially, only 33 had subsequent assessments, which could potentially overrepresent its effectiveness in C-2. In C-1, both projects show similar improvements but with considerable dispersion in the results, reflecting the diverse conditions of the children at admission. The t-test confirms that effectiveness in this dimension is statistically significant.

Table 6. Results for the emotional harm dimension

Center	Integration of the abuse/maltreatment experience into life history (C-1)	Reduction of socioemotional and physical harm manifestations linked to the abuse/ maltreatment experience (C-2)
A	**Pre** C-1 = 15.36 **Post** C-1 = 23.69	**Pre** C-2 = 19.73 **Post** C-2 = 28.51
	Difference = **+8.32**	Difference = **+8.77**
B	**Pre** C-1 = 13.86 **Post** C-1 = 23.10	**Pre** C-2 = 15.73 **Post** C-2 = 17
	Difference = **+9.23**	Difference = **+1.26**
TOTAL AVERAGE	**+8.56**	**+4.67**

Source: Author's own, 2024.

In the dimension of resource development (Table 7), significant progress of 7.26 and 9.39 points was observed in sub-dimensions D-1 and D-2, respectively, with similar and complementary patterns across both. In D-1, identifying individual, family, and contextual resources seems to be a precursor for their subsequent mobilization in D-2. Center "B" admits children and families with higher baseline scores and maintains elevated figures at discharge. However, in terms of effectiveness, center "A" stands out, doubling the difference in scores. This suggests that the "A" team is capable of focusing on the resources, not just weaknesses or barriers. For D-2, "A" again proves superior, displaying a substantial 20-point improvement from its starting point. Paired t-test results confirm that both centers are statistically significantly effective in this dimension, with bilateral significance values of 0.00.

Table 7. Results for the resource development dimension

Center	Identification of individual, family-relational, and contextual resources; social inclusion (D-1)	Mobilization of individual, family-relational, and contextual resources (D-2)
A	**Pre** D-1 = 10.01 **Post** D-1 = 24.00	**Pre** D-2 = 15.21 **Post** D-2 = 34.45
	Difference = **+13.98**	Difference = **+19.24**
B	**Pre** D-1 = 24.7 **Post** D-1 = 31.33	**Pre** D-2 = 30.50 **Post** D-2 = 37.53
	Difference = **+6.63**	Difference = **+7.03**
TOTAL AVERAGE	**+7.26**	**+9.39**

Source: Author's own, 2024.

Regarding overall comparisons between the two centers, the validity of our hypothesis was tested using two statistical methods. First, effectiveness (the difference in total pre- vs. post-intervention indices) at centers "A" and "B" was confirmed through the paired t-test. The results show a statistically significant difference between conditions at admission and discharge in both centers ($p < 0.05$), consistent with the observations across the four dimensions discussed. Relevant improvements were demonstrated in both centers, backed by the t-test. It is crucial to determine whether the differences in effectiveness between centers are statistically significant. An independent-sample t-test was applied to compare pre-/post-intervention differences across the four dimensions (Table 8).

Table 8. Summary of statistically significant differences

Dimension	Statistical results
Protection	No statistically significant differences found between "A" and "B" ($p > 0.05$).
Crisis	Statistically significant difference favoring center "A" ($p < 0.05$).
Socioemotional Harm	Center "A" shows significantly higher effectiveness compared to center "B" ($p < 0.05$).

Dimension	Statistical results
Resource Development	Although "A" shows remarkable effectiveness, it is not statistically significant compared to "B" ($p > 0.05$).
Protection Dimension	No statistically significant differences found between "A" and "B" ($p > 0.05$).

Source: Author's own, 2024.

5. Discussion

Recent literature stresses "reparation" as a process of restoring dignity, rooted in respect and validation (Dussich & Pearson, 2008; Ravazzola, 1997). However, the PIE implementation has drawn criticism for its over-standardization and lack of local adaptation (Contreras, Rojas & Contreras, 2015). There is a tension between therapeutic models based on parental competencies and broader ecological approaches (Llanos & Sinclair, 2001).

Outcomes from interventions for children and adolescents who are victims of abuse have varied, with differentiated techniques applied at different stages of therapy (Foa et al., 2009). Nevertheless, there is a disconnect between the PIE's technical design and its practical implementation, possibly linked to a trend toward standardization and efficiency (Gómez & Haz, 2008).

Adequate evaluation is critical for these interventions, but there is a lack of training and resistance to the modular model (Rigamer, 1986). Although centers "A" and "B" demonstrate improvement in certain dimensions, there are notable differences, likely related to challenges and tensions in implementation (Castro, 2011).

The lack of significant differences by gender suggests that the intervention may be adaptable regardless of gender (Hien et al., 2010). Identifying and mobilizing safety resources appear to be positive aspects, even though emotional harm remains a challenge (Schofield & Beek, 2005; Ross, Russotti, Toth, Cicchetti & Handley, 2023). Both centers show strengths and areas for improvement, with notable differences in crisis intervention effectiveness and emotional harm (Castro, 2011). The lack of complete data in some cases indicates the need for more comprehensive evaluations in future research.

6. Conclusions

This research shows that while the Specialized Integral Intervention Program (PIE) is conceived as a multidimensional approach to address the needs of children and adolescents (NNA) whose rights have been violated, it faces considerable challenges stemming from over-standardization. This issue leads to a lack of adaptability to local realities, creating a gap between the actual needs of the children and adolescents and the proposed interventions. Nonetheless, PIE's strength lies in its ability to incorporate multiple intervention dimensions, highlighting its potential to address complex cases in an integrated manner.

Difficulties in PIE implementation and management stand out as critical elements. The lack of training and the disconnect between program designers and implementers hinder effectiveness. Quantitative results indicate progress in both centers under study, but with variations in effectiveness across program dimensions. The absence of significant differences related to gender suggests that PIE can be effective regardless of participants' gender.

Differences in crisis management between the centers highlight the need for customized strategies. However, addressing emotional harm requires additional attention in both centers, suggesting a need for more specialized and ongoing therapies.

To enhance the effectiveness of future interventions, it is essential to adopt more ecological and adaptive approaches. Ongoing training and consideration of local needs are key factors. Ethical evaluations of programs should prioritize accountability to participants, using a wide range of informational sources to strengthen effectiveness and ensure respect for the dignity and fundamental rights of the children and adolescents served.

7. References

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Research Funding

This study was financially supported by the Interdisciplinary Center for Political Culture, Memory, and Human Rights (CEI-CPMDH) at the University of Valparaíso.