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# Treatment of Child Abuse

*Common Ground for Mental Health, Medical, and Legal Practitioners*

EDITED BY

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## Chapter 22

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### Treatment-Resistant Families

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*Some families in which child abuse or neglect occurs must be classified as “treatment-resistant.” Contributing to this categorization is a constellation of factors—among them, sociological and psychological attributes and deficits, resistance to change or treatment and lack of readiness to change, and the necessary duration of treatment. These families are dangerous to the child, and the longer a child is in an abusive and neglectful environment, the greater the risk of physical and psychological harm. The parent who is young and who has the characteristics of early onset of violent behavior, antisocial personality disorder, substance abuse, social isolation, and poverty may be most dangerous and is least likely to be treated effectively. For treatment-resistant families, the intervention of choice is the termination of parental rights and a permanent placement outside the family for the child or children.*

#### GENERAL CONSIDERATIONS

In the three decades since the modern rediscovery of child abuse and neglect, the study and treatment of child maltreatment has gone through a variety of changes, even paradigm shifts. Kempe and colleagues’ benchmark article, “The Battered Child Syndrome,”<sup>9</sup> ushered in a period during which psychopathology was considered the main cause of abuse and neglect, while social factors were viewed as playing no important causal role. The 1970s saw the psychopathology model replaced by a variety of social and sociopsychological models that emphasized factors such as social disadvantage, distressed family functioning, social learning, and social and cultural approval of violence.<sup>9,10,14,24</sup>

When causal models changed, so did treatment and intervention. When child maltreatment was conceptualized as arising out of psychopathology, child welfare agencies tended to remove children from abusive or neglectful parents and provide counseling or psychotherapy for maltreating caretakers. When child maltreatment was envisioned as arising out of poverty, lack of education about child development, social isolation, and stress, children might still be removed from the home, but psychological services were augmented with support services, such as day care, homemakers, parenting classes, and other forms of hard and soft services designed to add resources to families while reducing or ameliorating stressors. By the 1980s there was an increased effort to keep children in the home while providing families and caretakers with social and psychological resources and services.

Throughout the transformation of the causal models, philosophies, and treatments, one philosophy seems to have persisted: that *all* abusive families can be helped. At the core of this philosophy is the cultural ideology that all parents are capable of being caring and loving. No matter how horrific the abuse or how fractured the family, according to this philosophy, the family can be treated and treatment can be successful if the quantity and quality of treatment are sufficient.

Consistent with this ideology, if treatment “fails” that is, the family or caretakers do not engage in or respond to the treatment process or they reabuse, renege, reinjure, or even kill their children, the failure is not attributed to the parents but to inadequate treatment. Failure is thought to be the result of insufficient resources, too few caseworkers, overworked caseworkers, undertrained caseworkers, or a failure to properly implement the intervention. Failure is rarely attributed to the family or caretakers’ being treatment-resistant.

In the child abuse and neglect literature, the premise is rarely found that some families who come into the child welfare system are “untreatable.” What portion of the more than one million substantiated cases of child maltreatment each year<sup>32</sup> are treatment-resistant? My best estimate is that between 10 and 15 percent of parents and caretakers engage in harmful behavior, are not even considering changing their behavior, and have a constellation of social and psychological attributes that would make them treatment-resistant according to the definitions that will be set forth in this chapter.

What are the characteristics of treatment-resistant families? First, the family or caretakers are dangerous. Second, they do not respond to the various types of intervention. The type of intervention, the intensity or “dose” of intervention, and the expertise of the provider do not affect the level of risk or danger in the family and do not decrease the abuse and neglect.

A treatment-resistant family may also be one that simply will not engage in the intervention. Here the issue is not so much that the family or caretaker does not respond to the proffered treatment but that they do not actually accept or become involved in the treatment *process*.

A third type of impediment to treatment is the time factor. A family may engage in and actually respond to treatment but not do so within a time frame that is in the best interests of their children’s safety and development. Unlike substance abuse, alcohol abuse, mental illness, or other physiological or psychological problems or conditions, child maltreatment involves someone other than the individual with the condition or problem being treated. There is no real limit on how long it should take to treat alcoholism, drug abuse, or depression (aside from the limits set by managed care). Relapse is a normal and expected part of the change process. Although others may be affected by the relapse or lack of change, it is the individual in treatment who is most directly affected by the course of the treatment. Such is not the case for abuse and neglect treatment. If an abusive parent relapses or does not change, the child is the victim—both in terms of the harm inflicted by abuse and neglect and the harm that

results from a lack of permanent caretaking. The unique aspect of treatment for child abuse perpetrators is that the longer the treatment takes, the less likely a child is to have permanent caretaking. I will have more to say about this later in this chapter.

## HOW EFFECTIVE IS TREATMENT FOR CHILD ABUSE?

Before examining the issue of treatment-resistant families, it is useful to consider the effectiveness of the various treatments and combinations of treatments that are offered and provided to caretakers and families who maltreat their children. How effective are they? In fact, if we use the normal standards for scientific evidence in evaluation research to judge the effectiveness of treatments for abuse and neglect, our answer must be either, “we don’t know,” or “not very effective.”

Although there is a great deal of anecdotal evidence about the effectiveness of interventions, and some interventions indeed show promise, from a purely scientific point of view we have little hard evidence for the effectiveness of treatment. The National Academy of Sciences has convened two panels to examine child abuse and neglect. The first panel’s report, *Understanding Child Abuse and Neglect* (1993), stated that the fragmentary nature of research in this area inhibited the panel’s ability to evaluate the strengths and limitations of the intervention process.<sup>21</sup> A second panel, charged with assessing the effectiveness of family violence interventions in general, reviewed thousands of publications on family violence interventions and found 135 evaluations that met the panel’s standards for scientific evaluations.<sup>22</sup> Of these, most were evaluations of social service child maltreatment interventions, but few offered convincing evidence that these interventions were effective.

Among the better evaluations of an intervention is the evaluation research on home health visitors. David Olds and his colleagues looked at the effectiveness of a home-visiting family support program during pregnancy and for the first two years after birth for low-income, unmarried, teenage first-time mothers.<sup>23</sup> Nineteen percent of a sample of poor unmarried teenage girls who received no services during their pregnancy were reported for subsequent child maltreatment. In contrast, among poor, unmarried teenage mothers who were provided with a full complement of home visits by a nurse during pregnancy and for the first two years, 4 percent were the subjects of confirmed cases of child abuse and neglect reported to the state child protection agency.

Another review, of evaluations of 88 child maltreatment programs that were funded by the federal government between 1974 and 1982,<sup>3</sup> found that there was no correlation between a given set of services and the likelihood of further maltreatment of children. In fact, the more services a family received, the worse the family got and the more likely children were to be maltreated. This puzzling finding may result from the fact that the most difficult families received the most services, and these are the families that are least likely to change. Receiving a larger amount of services may actually increase a family’s level of stress and problems rather than ameliorating them. It is possible for families to receive more services than they can handle. Having to meet appointments for counseling, welfare benefits, and job training as well as having to adapt to an influx of home visitors and services may increase stress and actually reduce a family’s level of

functioning.

The evaluation reviewed indicated that lay counseling, group counseling, and parent education classes resulted in more positive treatment outcomes. The optimal treatment period appeared to be between 7 and 18 months. The most successful projects were those that separated children from abusive parents by placing them in foster homes or requiring the maltreating adult to move out of the house. Perhaps the success of these interventions was not in the treatment of the parents and caretakers but in separating the child from the abuser.

For a time, intensive family preservation services were thought to be the most promising interventions for treating child maltreatment. Intensive family preservation services are an alternative to the “business-as-usual” family preservation/family reunification child welfare casework used by child welfare agencies. The intensive family preservation services movement began in Tacoma, Washington, in 1974. Child psychologists David Haapala and Jill Kinney developed a program they called Homebuilders, with a grant from the National Institute of Mental Health. The goal of the program was to work intensively with families *before* a child was removed. There are now many variations of intensive family preservation services in use across the country. The core goal of such programs is to maintain children safely in the home or to facilitate a safe and lasting reunification. Intensive family preservation services were designed for families that have a serious particular crisis threatening the stability of the family and the safety of the family members.

Although there are many variations of intensive family preservation services, the essential feature is that such programs are short-term crisis intervention. Services are meant to be provided in the client’s home. The length of the sessions can be variable. Unlike traditional family preservation services, intensive family preservation services are available seven days a week, twenty-four hours a day. Perhaps the most important feature of intensive family preservation services is that caseloads are small—caseworkers may have only two or three cases. In addition, the length of time is brief and fixed at a specific number of weeks. Both hard and soft services are provided. Hard services include food stamps, housing, homemaker services; soft services include parent education classes and individual and/or family counseling.

The initial evaluations of intensive family preservation services were uniformly enthusiastic. The programs were claimed to have reduced the placement of children outside the home, reduced the cost of out-of-home placement, and, at the same time, assured the safety of children. Foundation program officers and program administrators claimed that families involved in intensive family preservation services had low rates of placement and “100 percent safety records.”<sup>1,8</sup> There have been at least 46 evaluations of intensive family preservation services of one form or another.<sup>16, 20</sup> Of these and of nearly 850 published articles on intensive family preservation, only 10 studies performed meaningful evaluations, included outcome data demonstrating effectiveness, and used a control group of some kind. In California, New Jersey, and Illinois, the evaluations used randomly assigned control groups, included outcome data, and had large enough samples to allow for rigorous evaluation. In all three studies, there were either small or insignificant differences between the group receiving intensive family

preservation services and the control group receiving traditional casework services. Even in terms of placement avoidance, there was no difference between the two groups, thus suggesting that earlier claims that intensive family preservation services were successful in reducing placement were because of the low overall rate of placement by child welfare agencies.

Most importantly, the outcome measures of most evaluations have not included data specifically designed to measure child outcome. Thus, it is also impossible to verify the claim of the safety record of intensive family preservation services. In summary, the empirical case for intensive family preservation has yet to be made.

There are numerous reasons why intensive family preservation services, specifically, and the broader range of efforts at family reunification, are not effective treatments. First, it is possible that intensive family preservation services, in and of themselves, are simply not effective. The theory behind the program may be faulty and the programs themselves, therefore, may not be addressing the key mechanisms that cause child abuse. Second, the programs may be effective but not being implemented properly by the agencies and workers that are using them. When the evaluation data for the Illinois Family First program were made public,<sup>30</sup> an initial reaction was that there was considerable variation in how intensive family preservation was being implemented at the different sites in Illinois and that the overall implementation was not true to the Homebuilders model of intensive family preservation. The lack of evidence of effectiveness was blamed on the programs' not being properly implemented. Third, the theory behind the intensive program may be accurate and the program itself may be appropriate, but the "dose" may be too small. It may be that more services are necessary or the length of the intervention should be increased. If this is true, however, it would partially negate the cost-effectiveness claims for intensive family preservation services.

Because even the most promising effort to treat abusive and neglectful caretakers has not demonstrated widespread effectiveness, both practitioners and policy makers need to be cautious in their assumptions about the effectiveness of treatment. Nonetheless, the fact that the case cannot be made for the effectiveness of treatment does not, in and of itself, support an argument that some or many families are untreatable. The following section suggests that one of the reasons why evaluations of treatment programs show either no or minimal effectiveness is that some families and caretakers are indeed resistant to treatment.

## **TYPES OF MALTREATERS**

Most current child welfare programs, including intensive family preservation services, assume that abuse and maltreatment are one end of a continuum of parenting behavior. The continuum model rejects a psychiatric or psychological "kind of person" explanation for maltreatment. Abusers and neglectors are not defective, deviant, or sick individuals; rather, they experience a "tipping point" or a "deficit" of parental skills and resources. In the former, stresses or problems pile up until a "tipping point" pushes parents from

carrying to maltreating. These stressors can be poverty, unemployment, marital conflict, alcohol or other substance abuse, social isolation, sexual difficulties, physical illness, or child-produced stressors such as colic, developmental delays, and delinquency. When the tipping point is reached, overstressed parents either actively lash out and physically abuse their children or passively neglect their children.

Alternatively, a “deficit” approach assumes that some parents lack the personal, social, or economic resources necessary to be effective parents. Inadequacy of resources is seen as the cause of abuse, so it is concluded that adding resources such as psychological counseling, parent education, treatment for substance abuse, or home visitors will help parents to meet their own needs and the needs of their children. Based on these models, the goal of most child welfare interventions is to add resources or remove stresses or both and to make the home safe again, so that children can be reunified with their parents.

An alternative to the continuum model is the conceptualization that there are different types of abusers.<sup>11,13</sup> Rather than seeing abuse and neglect as arising out of a surplus of risk factors or a deficit of resources, this model supposes that there may be distinct psychological and social attributes of caretakers who inflict serious or fatal injuries compared to caretakers who commit less injurious acts of maltreatment. If there are different types of maltreaters and different underlying causes for different types of abuse, it is reasonable to assume that a “one size fits all” intervention or policy would not be effective. Moreover, there may be types of abusers or neglectors who are not amenable to treatment.

Research on men who abuse women and on youthful violent offenders is more supportive of a typological conceptualization of violence than a continuum model.<sup>6,7,15,17,18</sup>

In the case of child abuse, the factors that correlate with the most abusive behaviors are:

- young age (between 18 and 30),
- low income or poverty,
- stressful life events,
- social isolation and lack of social support,
- experiencing or witnessing violence as a child, and
- alcohol and/or substance abuse.<sup>13, 21, 22</sup>

Although men are more violent in and outside the family, the relationship between sex and child abuse is more complex. Biological mothers are the most likely abusers and murderers of children under 1 year of age, while men are more likely to injure and abuse older children. Men who are not biologically related to children in their care are more likely to injure and kill the children than are biological fathers.<sup>2, 13, 32</sup>

Although there is not a consistent profile of parental psychopathology related to serious child maltreatment, researchers do find that perpetrators with antisocial personality disorders have the highest rates of serious abuse and violence.<sup>21</sup> Research on seriously violent offenders finds that offenders whose onset of violent behavior began before the age of 12 are the least likely to desist in their violent acts in their late 20s and early 30s.<sup>7</sup>

While these factors are correlates of abuse, injury, and even fatal child maltreatment, they cannot be considered predictors of serious abuse, fatal abuse, or dangerousness. The low rate of serious and fatal abuse and the modest correlations between these factors and serious or fatal abuse means that we do not have a set of risk factors that can accurately predict dangerous behavior. However, we do know that the early onset of violent behavior, young age, and antisocial personality disorder, combined with substance abuse, social isolation, and poverty may indicate a type of individual who is more dangerous and is less likely to be treated effectively.

## **READINESS TO CHANGE**

Behind the notion that anyone can abuse a child and all families can be treated, if adequate personal and social resources are available, is the assumption that change is a two-step process, that individuals move directly from engaging in inappropriate, deviant, or dangerous behavior to not engaging in the behavior. Interventions, simply stated, instruct the individual “don’t do that” or “do this.” Social interventions are designed so that the client “does not do that” or acquires the resources to “do this.” The assumption is that any reasonable person does not want to “do that” and simply needs help to “do this.”

Research on behavioral change clearly demonstrates, however, that change is not simply a two-step process. Rather, changing behavior is a dynamic, ongoing process that progresses through a number of stages. Research also has found that there are cognitive aspects to behavioral change that can be measured.<sup>25-28</sup>

One of the reasons child welfare interventions have such modest success rates may be that they require action of the client but are often provided to individuals and families who are not ready to make active change, maybe not even to consider it. Prochaska and his colleagues call these the “contemplation” and “precontemplation” stages of change. Others have described individuals in these stages as “denying” or “ambivalent” about the need for change.

I have discussed the application of Prochaska’s transtheoretical model of change to child maltreatment fully elsewhere.<sup>12, 13</sup> The virtues of this instrument for child maltreatment assessment are that it can classify caretakers into one of the five stages of change (precontemplation, contemplation, preparation, action, and maintenance) and that the main constructs of the model (decisional balance, self-efficacy, and the processes of change) can be assessed.

Stage of Change	Severity of Risk	
	High	Low
Precontemplation	No reunification High likelihood of terminating parental rights	Parent education classes
Contemplation		
Preparation		
Action	Family preservation only with close monitoring	Family preservation
Maintenance		Reunification recommended

Figure 22.1 Two Dimensions of Risk Assessment for Child Abuse and Neglect  
Source: Adapted from Prochaska et al.<sup>25-28</sup>

With regard to precontemplation and contemplation, Prochaska and his colleagues found that, for a set of 15 different health and mental health problems, 40 to 60 percent of a representative sample of 6,000 people who were still engaging in problem behaviors (i.e., not yet in the action stage of change) were in the precontemplation stage and the rest were in the contemplation stage.<sup>29</sup> It is reasonable to assume that similar percentages of abusive families in the child welfare system are in the precontemplation or contemplation stage for changing their abuse and neglect of their children.

What I believe makes these individuals and families treatment-resistant is the combination of high risk, early stage of readiness to change, and long duration of time before change will occur (see figure 22.1).

Caretakers who do not recognize or admit to the harm they have inflicted on their children, by acts of either omission or commission, are not going to respond to an action-oriented intervention such as intensive family preservation, a parenting class, additional social resources, or even psychotherapy. Precontemplation- or contemplation-stage abusers remain risks to their children. They are also unlikely to respond to conventional interventions or treatments.

The transtheoretical model of change would argue that clinicians should match interventions to an abuser's readiness to change and have a goal of moving a precontemplative caretaker to contemplation. However, such a course of intervention takes time. As noted earlier, while time may not be a critical issue for smoking cessation or drug or alcohol abuse, it is critical for child safety and health. The longer a child is in an abusive and neglectful environment, the greater the risk of physical and psychological harm. Moreover, the older a child gets, the less likely a child is to be adopted. Thus, while child welfare agencies struggle to engage a high-risk,

precontemplative caretaker in an intervention, the probability decreases that an adoptive home for the child will be available if treatment fails.

Thus, the last component of a classification of “treatment-resistant” is how long it is likely to take to successfully intervene with a maltreating caregiver. For those caretakers in the upper left cell of figure 22.1, high-risk precontemplators, the likelihood of change within 12 to even 18 months is low (based on research on the process of change for other behaviors). From the eyes of the child, and using a child’s sense of time and need for permanence, treatment of these families and caretakers is impractical.

## **CONCLUSION**

A portion of parents and caretakers who maltreat their children are treatment-resistant. They have engaged in behavior that is so harmful and so dangerous that they should be considered at high risk to engage in such behavior again. Psychometrically sound risk assessment and assessments of dangerousness notwithstanding, the best predictor of an individual’s future behavior is past behavior.

Some parents and caretakers are resistant to treatment because they have a combination of psychological and social attributes that suggests a low likelihood that interventions will be effective. Individuals who have begun their violent behaviors at young ages, are diagnosed with antisocial personality disorders, have alcohol or other substance abuse problems, and who are young, poor, and disengaged from social networks tend to continue their violent careers for longer periods of time than other perpetrators of violent and abusive behavior.

Also, some parents and caretakers are at such an early stage of readiness to change their behavior that treatment, if it could be effective, would have to be provided over a long period of time. Most importantly, precontemplators, who do not believe that they have a problem that requires change, are unresponsive to action-based treatment programs.

Finally, decisions to treat perpetrators of abuse must take into account the permanence interests of the children involved. Decisions about treatment or intervention should be made with a child’s sense of time and a child’s need for permanence as the main criteria for choice of intervention. For treatment-resistant families, the intervention of choice would be to terminate parental rights and seek a permanent placement for the child or children.

Finally, a caveat: it is not possible to predict who will be treatment-resistant without knowing the parents’ or caretakers’ actual behavior toward their children. There is no way of assessing who is or is not going to respond to treatment without a complete knowledge of their caretaking behavior.

## REFERENCES

1. Barthel J. *For children's sake. The promise of family preservation*. New York: Edna McConnell Clark Foundation. 1991.
2. Daly M, Wilson M. *Homicide*. New York: Aldine de Gruyter. 1988.
3. Daro D, Cohn AH. Child maltreatment evaluations efforts: What have we learned? In Hotaling GT, Finkelhor D, Kirkpatrick JT, Straus MA (eds.), *Coping with family violence: Research and policy perspectives*, 275—287. Newbury Park, CA: Sage Publications. 1988.
4. Daro D, Gelles R. Public attitudes and behaviors with respect to child abuse prevention. *J Interper Viol* 1992;7:517—531.
5. DiClemente CC, Prochaska JO, Gibertini M. Self-efficacy and the stages of self-change of smoking. *Cogn Ther Res* 1985;9:181-200.
6. Dutton DG, Golant SK. *The batterer: A psychological profile*. New York: Basic Books. 1995.
7. Elliott DS. Serious violent offenders: Onset, developmental course, and termination (American Society of Criminology Presidential Address.) *Criminology* 1994;32:1—21.
8. Forsythe P. Homebuilders and family preservation. *Child Youth Serv Rev* 1992;14:37—47.
9. Garbarino J. The human ecology of child maltreatment. *J Marr Fam* 1977;39:721—735.
10. Gelles RJ. Child abuse as psychopathology: A sociological critique and reformulation. *Am J Orthopsychiatry* 1973;43:61 1—621.
11. Gelles RJ. Physical violence, child abuse, and child homicide: A continuum of violence or distinct behaviors? *Hum Nature* 1991;2:59—72.
12. Gelles RJ. "Using the transtheoretical model of change to improve risk assessment in cases of child abuse and neglect?" Roundtable presented at the 4<sup>th</sup> International Family Violence Research Conference, Durham, NH, 1995.
13. Gelles RJ. *The book of David. How preserving families can cost children's lives*. New York:Basic Books. 1996.
14. Gil D. *Violence against children. Physical child abuse in the United States*. Cambridge: Harvard University. 1970.
15. Gondolf LW, Fisher ER. *Battered women as survivors: An alternative treating learned helplessness*. Lexington, MA: Lexington Books. 1988.
16. Heneghan AM, Horwitz SM, Leventhal JM. Evaluating intensive family

- preservation programs: A methodological review. *Pediatrics* 1996;97:535—542.
17. Holtzworth-Munroe A, Stuart GL. Typologies of batterers: Three subtypes and the differences among them. *Psycho! Bull* 1994;16:476—497.
  18. Jacobson NS, Gottman JM, Waltz J, Rushe R, Babcock J, Holtzworth-Munroe A. Affect, verbal content, and psychophysiology in the arguments of couples with a violent husband. *J Consult Clin Psychol* 1994;62:982—988.
  19. Kempe CH, Silverman FN, Steele BF, Droegemueller W, Silver HK. The battered child syndrome. *JAMA* 1962;181:107—112.
  20. Lindsey D. *The welfare of children*. New York: Oxford University Press. 1994.
  21. National Research Council. *Understanding child abuse and neglect*. Washington, DC: National Academy Press. 1993.
  22. National Research Council. *Assessing family violence interventions*. Washington, DC: National Academy Press. 1997.
  23. Olds DL, Henderson CR Jr, Tatelbaum R, Chamberlin R. Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics* 1986;77:65—78.
  24. Parke RD, Collmer CW. Child abuse: An interdisciplinary analysis. In Hetherington M (ed.), *Review of child development research*, vol. 5, p. 102. 1975. Chicago: University of Chicago Press. 1975.
  25. Prochaska JO, DiClemente CC. Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice* 1982;19:276—288.
  26. Prochaska JO, DiClemente CC. Stages and processes of self-change in smoking: Toward an integrative model of change. *J Consult Clin Psycho!* 1983;5:390—395.
  27. Prochaska JO, DiClemente CC. *The transtheoretical approach: Crossing traditional boundaries of change*. Homewood, IL: Dow Jones/Irwin. 1984.
  28. Prochaska JO, Norcross JC, DiClemente CC. *Changing for good*. New York: Morrow. 1994.
  29. Rossi JS. *Stages of change for 15 health risk behaviors in an HMO population*. Paper presented at the meeting of the Society of Behavioral Medicine, New York, 1992.
  30. Schuerman J, Rzepnicki TL, Littell JH. *Putting families first: An experiment in family preservation*. New York: Aldine de Gruyter. 1994.
  31. U.S. Advisory Board on Child Abuse and Neglect. *A nation's shame: Fatal child abuse and neglect in the United States*. Washington, DC: U.S. Department of Health and Human Services. 1995.

32. U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect. *Child maltreatment 1995: Reports from the states to the National Center on Child Abuse and Neglect*. Washington, DC: U.S. Government Printing Office. 1997.