

Interventions That Have A Reasonable Chance of Supporting Change in Physical Abuse of Children

There has been very little outcome research or progress in treatment approaches for physically abusive parent. Based on a review of largely disappointing results of demonstration projects in the 1980's, Cohn and Daro (1987) questioned the wisdom of pouring money into treatment of physical abuse, suggesting it was "too little, too late". In the years following, the study of treatment of physical abuse was largely abandoned; only a handful of studies were undertaken between 1983 and 2000.

"While physical abuse intervention research has been . . . dormant. . . [that] has not been the case for parent training programs in general. One of the better supported models is PCIT (Parent-Child interaction Therapy), which had been shown to be highly effective across a wide spectrum of behavioral and parent-child problems in a variety of populations" (Chaffin, et. al., 2002-3) PCIT treats parents with children and targets a limited number of behaviorally defined skills, which are directly coached and practiced in parent-child sessions, using a radio earphone in the parent's ear with a "live feed" from a skilled coach, observing the parent and child from behind a one-way mirror.

Following publication of a few small scale studies reporting "encouraging" results with physically abusive parents, Chaffin et al. studied 112 cases confirmed for physical child abuse. Families were randomly assigned to three intervention conditions: PCIT only, enhanced PCIT plus wraparound, and another community based didactic parenting skills and anger management training. Wraparound services included individual and marital/family therapy, domestic violence services, substance abuse services, psychiatric services and medication, and home visiting services.

Change was measured on the following variables:

- Parental distress and social support
- Parenting attitudes
- Parent-perceived child behavior problems
- Observed parent-child interaction

The study's significant findings included:

1. **PCIT and enhanced PCIT participants had significantly fewer subsequent physical abuse reports** (19% as compared to 49% in the standard community intervention group).
2. The **addition of additional wraparound services (enhanced group) did not improve physical abuse re-report outcomes**. There was a trend toward the opposite outcome, suggesting that receipt of additional services may have resulted in less attainment of the PCIT behavioral skills.
3. **Reductions in parental distress (including depression) and increased social support, reduction in rigid parenting attitudes, and fewer parent-perceived child**

behavior problems were not significantly related to positive outcome. Reduction in the targeted negative parent-child interactions was significantly related to outcome. This suggests that negative parent-child interactions are the correct target for change.

4. Although not the goal of the intervention, cases were also compared for subsequent reports of child neglect. There were no program effects.
5. PCIT was more costly than the standard community group (\$1,326 vs. \$371 per participant).

Measuring Change: Use of Proxy Variables in Cases of Child Physical Abuse and Parental Substance Abuse

One of the most difficult parts of the child welfare casework and supervision is predicting when it is safe for children to be allowed unsupervised visitation, or to be returned to their parents, or to terminate supervision and close the case. Making this kinds of predictions is especially difficult when the parent has not been allowed extended unsupervised contact with the child. Retrospectively, the researchers can study our decisions, and count the subsequent numbers of re-abuse and neglect reports, count the number of foster care re-entries and case re-openings. But we know the human cost of these decisions, and we want to be right the first time.

Based on her review of nearly 30 years of empirical research on treatment of child physical abuse (including the Chaffin study), treatment of substance abusing parents, and studies of successful and failed reunification, Professor Dee Wilson at University of Washington School of Social Work proposes some considerations, and some “proxy variables” for measuring risk reduction.

Wilson’s considerations when measuring risk reduction:

- Treatment for serious cases of child maltreatment requires several months (at least) of intensive treatment
- Probability of recurrence of maltreatment during the course of treatment is high, but not an indicator that treatment has failed or cannot succeed
- When children remain in home, incidents of child maltreatment should become less frequent and less serious
- Parental functioning should improve along these dimensions:
 - Attitudes, perceptions, behavior
 - Parent-child interaction
 - Parent’s ability to retain new skills or behaviors under stress is an indicator that positive changes are likely to be stable
 - Reversion to old habits under stress calls for additional support and/or time in services/treatment

You will see from the tables below that in developing proxy variables, Wilson combines measures of parent-child interaction, parent attitudes, the level of violence in the home, the parent’s response to relapse, and the parent’s social support networks into a couple of tables. You’ll also notice that she lists measures in both their positive and negative ways.

Proxy Measures of Change

from Wilson, D., "How do I Measure Risk Reduction?" in Dubowitz, H. and DePanfilis, D., Handbook for Child Protection Practice, Sage Publications (2000)

Positive Measures

- Increased empathy and responsiveness to child
- Increased enjoyment of contact with child
- Increased ability to set limits on child without hitting, yelling, ignoring or abandoning
- Increased reliability in keeping appointments, fulfilling promises, and visiting child
- Increased recognition of past history of child abuse and neglect
- Increased contact with persons supportive of positive changes
- Absence of violence in interpersonal relationships
- Increased motivation to change following relapse
- Increased self-esteem

Negative Measures

- Little or no empathy with child
- Little or no enjoyment of child
- Little or no ability to set limits on child without hitting, yelling, ignoring or abandoning
- Not reliable in keeping appointments, fulfilling basic responsibilities and visiting child
- Little or no recognition of child abuse or neglect
- Parent is isolated or maintains extensive contact with persons discouraging positive change
- Recurrent violence in interpersonal relationships
- Relapse followed by abandonment of treatment program
- Low self-esteem

Parental Attitude Toward Child

Positive Attitude

- Parent expresses appreciation, love and caring about child through verbal and nonverbal behavior
- Parent demonstrates patience with and understanding of child's misbehavior
- Parent expresses pride in child's development and achievement
- Child is treated fairly compared to siblings
- Parent forgives child following disciplinary incidents ("lets go" of anger)
- Parent perceives child accurately
- Parent demonstrates concern with child's physical pain or emotional distress

Negative Attitude

- Parent displays little affection or regard for child
- Parent blames child for personal or family misfortune
- Parent views child as embodiment of despised parent or spouse
- Parent attributes bad or evil motives to child
- Parent emotionally abuses child with insults, demeaning behavior, or comments
- Parent does not let go of anger toward child
- Parent demonstrates little concern for child in pain or emotional distress

24 Treatment Approaches for Child Sexual and Physical Abuse

As rated by the National Crime Victims Research and Treatment Center and
Center for Sexual Assault and Traumatic Stress

Child-Focused Interventions

Received rating of 1 (highest) rating: 1 program

Trauma-focused Cognitive-Behavioral Therapy (CBT)

Received rating of 3: 7 programs

Cognitive Behavioral Play Therapy for Children with Sexual Behavior Problems and their
Caregivers

Cognitive Processing Therapy

Eye Movement Desensitization and Reprocessing (EMDR)

Individual Child and Parent Physical Abuse-Focused Cognitive Behavioral Treatment

Resilient Peer Training Intervention

Therapeutic Child Development Program

Trauma-Focused Integrative-Eclectic Therapy (IET)

Received rating of 4: 1 program

Trauma-Focused Play Therapy

Parent, Parent-Child, and Family Focused Interventions

No programs received ratings of 1 or 2

Received rating of 3: 6 programs

Behavioral Parent Training Interventions for Conduct-Disordered Children

Family Focused, Child Centered Treatment Interventions in Child Maltreatment
(Focused Treatment Interventions or FTI)

Multisystemic Therapy (MST) for Maltreated Children and their Families

Parent-Child Education Program for Physically Abusive Parents

Parent-Child Interaction Therapy (PCIT) *note others rated this higher

Physical Abuse-informed Family Therapy

Received rating of 4: 6 programs

Attachment- Trauma Therapy

Family Resolution Therapy (FRT)

Integrative Developmental Model for Treatment of Dissociative Symptomatology

Intensive Family Preservation Services (e.g., Homebuilders)

Parents United (Child Sexual Abuse Treatment Program)

Parents Anonymous

Received rating of 6 (Lowest rating = “concerning treatment”): 1 program

Attachment Therapy

Offender Focused Interventions

No programs received ratings of 1 or 2

Received rating of 3: 2 programs

Adult Child Molester Treatment

Adolescent Sex Offender Treatment

University of Iowa School of Social Work – National Resource Center for Family Centered Practice
“Committed to Excellence Through Supervision,” USDHHS Grant # 90CT0111

© Copyright 2009 The University of Iowa

Module IV – Clinical Practice Supervision

Child Abuse – Page 5

Treatment Protocol Classification

From *Child Physical and Sexual Abuse: Guidelines for Treatment (2004)*

1 = Well-Supported, Efficacious Treatment (Highest Rating)

1. The treatment has a sound theoretical basis in generally accepted psychological principles.
2. A substantial clinical-anecdotal literature exists indicating the treatment's value with abused children, their parents, and/or their families.
3. The treatment is generally accepted in clinical practice as appropriate for use with abused children, their parents, and/or their families.
4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
5. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.
6. At least two randomized, controlled treatment outcome studies (RCT) have found the treatment protocol to be superior to an appropriate comparison treatment, or no different or better than an already established treatment when used with abused children, their parents, and/or their families.
7. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

2 = Supported and Probably Efficacious Treatment

1. The treatment has a sound theoretical basis in generally accepted psychological principles.
2. A substantial clinical-anecdotal literature exists indicating the treatment's value with abused children, their parents, and/or their families.
3. The treatment is generally accepted in clinical practice as appropriate for use with abused children, their parents, and/or their families.
4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
5. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.
6. At least two studies utilizing some form of control without randomization (e.g., matched wait list, untreated group, placebo group) have established the treatment's efficacy over the passage of time, efficacy over placebo or found it to be comparable to or better than an already established treatment.
7. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

3 = Supported and Acceptable Treatment

1. The treatment has a sound theoretical basis in generally accepted psychological principles.
2. A substantial clinical-anecdotal literature exists indicating the treatment's value with abused children, their parents, and/or their families.
3. The treatment is generally accepted in clinical practice as appropriate for use with abused children, their parents, and/or their families.
4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
5. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.
6.
 - a. At least one group study (controlled or uncontrolled), or a series of single subject studies suggest the efficacy of the treatment with abused children, their parents, and/or their families, OR
 - b. The treatment has demonstrated efficacy with other populations, has a sound theoretical basis for its use with abused children, their parents, and/or their families, but has not been tested or used extensively with abused populations.
7. If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

4 = Promising and Acceptable Treatment

1. The treatment has a sound theoretical basis in generally accepted psychological principles.
2. A substantial clinical-anecdotal literature exists indicating the treatment's value with abused children, their parents, and/or their families.
3. The treatment is generally accepted in clinical practice as appropriate for use with abused children, their parents, and/or their families.
4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
5. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.

5 = Innovative or Novel Treatment

1. The treatment may have a theoretical basis that is an innovative or novel, but reasonable, application of generally accepted psychological principles.
2. A relatively small clinical literature exists to suggest the value of the treatment.
3. The treatment is not widely used or generally accepted by practitioners working with abused children.
4. There is no clinical or empirical evidence or theoretical basis suggesting that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
5. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.

6 = Concerning Treatment (Lowest Rating)

1. The theoretical basis for the treatment is unknown, a misapplication of psychological principles, or a novel, unique, and concerning application of psychological principles.
2. Only a small and limited clinical literature exists suggesting the value of the treatment.
3. There is a reasonable theoretical, clinical, or empirical basis suggesting that compared to its likely benefits, the treatment constitutes a risk of harm to those receiving it.
4. The treatment has manual or other writing that specifies the components and administration characteristics of the treatment that allows for implementation.