

National child maltreatment reporting data for 2000 indicate that 19.3% of all confirmed maltreatment victims suffered physical abuse. After neglect (59.8% of victims), physical child abuse is the most prevalent form of child maltreatment, with 166,232 confirmed cases in the United States in 2000 (U.S. Department of Health and Human Services, 2002).

In responding to an allegation of physical abuse, first determine if the physical injury to the child is intentional. Factors that may prompt concern that a physical injury is intentional include:

- A history incompatible with the physical injury, conflicting histories, or bizarre explanations.
- Injury incompatible with child's developmental age.
- Injuries that appear older than the historical account.
- Unrelated soft tissue bruises, cuts, and scars, in different stages of healing, so that they could not all have occurred in the same incident.
- Old long bone or skull fractures found on X-ray.
- Specific skin injuries such as human bites, cigarette burns, puncture wounds, or missing hair.
- An adult unrelated to the incident seeking medical attention for the injured child or delay in seeking needed medical treatment.

(Filip, McDaniel, Schene, 1992; Jaudes & Mitchel, 1992).

Once it has been determined that a physical injury to a child is intentional, responding to physical abuse first involves determining the level of risk to the child. Even minor injuries can be serious if

there is a chronic or cumulative pattern of abuse or if injuries occur with increasing frequency. The age of the child is also a primary consideration in determining the urgency and immediacy of response that is needed. Infants and younger children are both more vulnerable to physical injury and less able to defend themselves against physical assault. Physical abuse can be divided into categories that have different dynamics and require different interventions.

Depending upon the circumstances of the injury and the history given, along with the age and vulnerability of the child (including any disability or special needs), the following guidelines may be used to generally classify physical injuries as major versus minor:

Physical abuse with major injury includes:

- Large burns; deep, serious burns, or multiple small burns.
- Central nervous system injury.
- Multiple fractures.
- Any life threatening injury.
- Any injury causing permanent damage to, loss of use of, or disfigurement to, body parts.
- Injuries requiring hospitalization.
- Chronic or cumulative minor injuries (especially to young children).

The following are examples of physical abuse with minor injury, (see that guideline):

- A small number of bruises, scratches, scars, or cuts.
- A few cuts or welts in areas of the child's body that do not pose a threat of serious injury or disfigurement, (e.g., a welt on the face may disfigure, a welt on the buttocks does not).

- A single minor burn.
- Small injuries in areas of the body that are not as sensitive to permanent injury or disfigurement (e.g., the limbs or buttocks).
- Those that do not require medical treatment.

Injuries that require brief medical treatment, such as numerous bruises or minor burns, or single fractures are considered moderate. Further risk assessment is needed to determine if this guideline or the guideline for physical abuse with minor injury should be followed.

For major injuries, medical treatment for the child is essential. Current federal law (The Adoption and Safe Families Act, 42 U.S.C. 671 (a) (15)) states that no reasonable efforts to preserve or reunite the family are required if the parent has assaulted a child or the child's sibling resulting in serious bodily injury. Otherwise, select therapeutic interventions, concrete services, and parenting education as needed based upon specific injuries, the case type, and the potential for building upon strengths to change parental behaviors. The goal should be to achieve child safety and specific positive outcomes for child and family.

These guidelines divide physical abuse into major and minor injuries. Your state may have more classifications, perhaps including a moderate injury category. Depending on the type of injury, try to determine whether the injury is major or minor using the examples provided. The major injury category would include all serious injuries and most moderate injuries, while the minor injury category includes only minor injuries.

The Guidelines are a product of the Casey Outcomes and Decision Making Project. Project partners: The Annie E. Casey Foundation; Casey Family Programs; Casey Family Services; American Humane Association, Children's Services; American Bar Association, Center on Children and the Law; Institute for Human Services Management. Guidelines developed and written by Tracey Feild, M.A. and Amy Printz Winterfeld, J.D.

Step 1. Assessment: Assess Seriousness of Abuse

Examples of Physical Abuse with Major Injury:

- An escalating cycle of injuries beginning with minor injuries to relatively invulnerable areas of the body, and proceeding to injuries to the head, neck, stomach, genitals, and/or other soft tissue injuries.
- Life threatening injury.
- Permanent injury or risk of permanent injury.
- Dangerous acts which could have resulted in serious injury (e.g., deliberate electrical shocks, holding child's head under water).
- Cruel and inhumane treatment (e.g., submerging toddler's head in toilet filled with feces).
- Loss of use of body parts.
- Disfigurement.
- Injury to the head.
- Injury requiring hospital care.
- Failure to provide treatment for injuries needing treatment.
- A sustained physical injury (e.g., a lost tooth, a broken bone, etc.).
- Multiple bruises or marks.
- Large burns, deep or serious burns, or multiple small burns.
- Minor injury, but child seems overly upset about and obsessed with the injury.
- Any suspicious injury with an inadequate explanation.

Examples of Physical Abuse with Minor Injury:

- No medical treatment needed.
- May need medical treatment, but immediate release afterwards.
- Injuries to areas not considered sensitive:
 - head, torso, except buttocks = sensitive.
 - limbs, buttocks = less sensitive.
- Minor injuries to children old enough to protect themselves.
- A single bruise or mark to a limb, or single small, superficial burn.



Go to guideline for
Physical Abuse – Minor Injury

Note: In cases of physical abuse with major injury, legal sanctions should be actively pursued. These cases may not be high priority for medical personnel, police or prosecutors. Without child welfare caseworkers actively pursuing completion of and

filing of reports, and prosecution, investigations may be dropped, and prosecutions not pursued. **Child welfare staff or police should photograph all injuries.**

Step 1. Assessment: Identify Case Type

There are six case types related to physical abuse with major injury. Each type is described below. Select the case type that best describes your case. (All case factors listed may not be present in your case.) There may be some level of overlap between case types. Any abuse resulting in a major injury to the child is serious, however, these categories are used to help you determine the best interests of the child, and the potential for changing the abuser’s behavior.

- **Case Type 1** (Excessive corporal punishment) and **Case Type 2** (Excessive corporal punishment with rejection of the older child) generally, but not always, occur with school-age children.

- **Case Type 3** (The battered child) generally occurs with pre-school age children.
- **Case Type 4** (The serial batterer) looks like a battered child case, but a history of the abuser reveals that the abuser has injured another child as well.
- **Case Type 5** (Extreme violence directed at a specific child) can occur with any age child, and occurs less frequently than the other case types.
- **Case Type 6** (Violence as a way of life) is a mixture of many issues, and may also include neglect.

Case Type 1: Excessive Corporal Punishment

- Is the child old enough to understand caregiver expectations for behavior, typically school age?
- Do caregiver expectations seem realistic?
- Was the punishment the result of misbehavior on the part of the child?
- Do all children in the household seem to receive excessive corporal punishment evenhandedly for their transgressions, even though one child may be described as more difficult to manage?
- Do caregivers give histories of being similarly disciplined or punished?
- Do caregivers seem concerned for the child, and express fears of possible future delinquency if behaviors are not stopped?
- Does caregiver admit that punishment may have been too severe?
- Does child admit that he or she did something wrong, yet not view him- or herself as bad?
- Is the punishment usually limited to whippings, even though serious injury may have resulted if a struggle caused a more vulnerable area to be hit? (Bowdry, 1990)

Step 1. Assessment: Identify Case Type

Case Type 2: Excessive Corporal Punishment with Rejection of the Older Child

These cases are typically characterized by children in the early elementary age range or in early teenage years, predominantly males. Children are referred for physical abuse, with injuries such as bruises, cuts, or welts. Initially, they may appear to be victims of misguided attempts at education (see Physical Abuse - Minor Injury guideline). A careful assessment of the issues should include:

For children in the younger age range:

- Does the caregiver reveal a history for this child that includes significant trauma and/or hospitalization, which could indicate child battering?
- Is the child perceived negatively by the parents or caregivers, and often by the siblings, and may this child be the family scapegoat?

- Does the child perceive him- or herself negatively, or describe him- or herself as “bad?”
- Does the caregiver request out-of-home placement of the child in order to “straighten the kid out?”

For children in the older age range, add the following:

- Does the child have severe behavior problems and/or antisocial conduct?
- Does the caregiver describe the child as cruel or harsh to younger children in the family or neighborhood, possibly with sex offenses?
- Does the caregiver reveal a history of placing this child outside the home for much of his (or her) life? (Bowdry, 1990)

Step 1. Assessment: Identify Case Type

Case Type 3: The Battered Child

- Is the child young, often under 4 years old?
- Are the caregivers immature emotionally?
- Do the caregivers have unrealistic expectations of the child and of parenting?
- Do the caregivers have histories of maltreatment in their own childhoods?
- Are the caregivers socially and emotionally isolated?
- Does the child have injuries that are unexplained or inconsistent with the explanation offered?

(Bowdry, 1990)

Case Type 5: Extreme Violence Directed at a Specific Child

- Do injuries reflect a deliberate effort to torture and inflict pain or to kill? (They may include branding, hanging, pulling out toenails or fingernails, deliberate starvation, etc.)
- Is the maltreatment sustained over several days or weeks?
- Does the abuser seem unable to empathize with the child?

Although the abuse may be *described* as “discipline,” it is clear that it is more closely linked to the desire to inflict pain.

(Bowdry, 1990)

Case Type 4: The Serial Batterer

Does this case have the same characteristics as Case Type 3, the battered child, except that the abuser or other source reveals that the abuser has injured another child in the past?
(Bowdry, 1990)

Case Type 6: Violence as a Way of Life

- Does this household experience regular or periodic episodes of domestic violence? **(If yes, use the “Domestic Violence and Abuse/Neglect” guideline.)**
- Is one or both of the caregivers a substance abuser? **(If yes, use “Substance Abuse” guideline as well as this guideline.)**
- Is the household enmeshed in the drug culture?
- Does the caregiver have a history of abusive relationships?
- Does the caregiver have a history of short-term, unstable relationships?
- Does the caregiver or do other adult household members have a history of childhood abuse or harsh discipline or corporal punishment?
- Does the household have a history of flight to avoid child welfare?
- Are there multi-generational abuse issues?
- Does caregiver violence appear related to mental illness?

Step 1. Assessment: Review Risk Factors

1. Pattern of Abuse: Reoccurrence of maltreatment is more likely:

- The greater the severity, frequency, or recency of the maltreatment.
- Once a person has been a perpetrator of maltreatment.

- The degree to which the functioning of the perpetrator is impaired by substance abuse or mental dysfunction.
- The degree to which a partner is an active participant, or does nothing to stop the maltreatment.

(Sigurdson & Reid, 1990)



2. Caregiver Response: Reoccurrence of maltreatment is more likely:

- If caregiver admits no guilt about the child's injury.
- If the caregiver does not view discipline as a developmental technique, but as a punishment for wrong deeds.
- If the caregiver believes that physical force or threats of violence are the only way to correct behavior.
- If the caregiver seems more concerned about what might happen to him or her, rather than to the child, as a result of the abuse.
- If the caregiver show little or no concern about the injury itself, the treatment, prognosis, or aftercare.
- If the caregiver or partner seems unable to protect the child.

- If the caregiver has little reaction to the injury.
- If the caregiver failed to adequately treat the injury.

(Sigurdson & Reid, 1990)

Factors associated with the most abusive behaviors are:

- Young age of abuser (18-30).
- Low income or poverty.
- Stressful life events.
- Social isolation and lack of social support.
- Experiencing or witnessing violence as a child.
- Alcohol and/or substance abuse.

(Gelles, 1999)



3. Household Lifestyle: Reoccurrence of maltreatment is more likely:

- The greater the level of dysfunction within the family.
- The higher the level of stress experienced by the caregiver.

- The greater the disconnection of a caregiver from the family and the community.
- If the caregiver is violent in any context.
- The greater the acceptance of maltreatment within the family and/or community.

(Sigurdson & Reid, 1990)



Step 1. Assessment: Review Risk Factors

4. Child Risks: Reoccurrence of maltreatment is more likely:

- If the child is too young to be able to tell others of the abuse.
- If the child is too frightened or too intimidated to tell others of the abuse.
- If the child is isolated from contact with others due to his or her age, lack of extended family or community involvement, or location of the home.
- If the child has special needs (e.g., ADHD, developmental delay, special health problem, etc.).
- If the child is treated differently from others in the household, or singled out for abuse. (Sigurdson & Reid, 1990)



Remember:

- The more serious the injury, the more you should be concerned with who, what, when, and how the incident occurred.
- The more minor the incident, the more you should be concerned with the pattern of abuse and its impact on child safety.
- The more chronic the pattern of maltreatment, the more likely it is that other forms of maltreatment have occurred as well; assess for neglect and sexual abuse. (Wilson, 2000)

Step 2. Family/Cultural Issues: Assess Community, Family, and Cultural Issues

Assess community and cultural factors and your familiarity with them.

- Is it possible that community, cultural, or ethnic beliefs or practices that you are not familiar with are a factor in the caregiver's behavior? **Even if they are, remember that child safety is your first concern.**

No →

Go to **Next Page**

Yes ↓

- Find someone in your agency knowledgeable about the family's culture before proceeding. Develop your understanding of how the family's beliefs, values, interests, and concerns may differ from your own and affect their behavior before you assess needs or begin planning services. When you understand how your cultural views and the family's culture and beliefs affect your assessment of the family's issues and needs, it may also affect how you plan to remediate them.

- If no one is available within your agency to help you understand the family's culture and belief system, identify community or neighborhood representatives (e.g., community leaders, community-based organizations, religious leaders, etc.) who could assist you in assessing needs and planning for families within this culture and in understanding the values and beliefs of this cultural group.

- Are there community and cultural beliefs that can be reinforced to encourage positive parenting practices?
- Are there specific formal community or cultural programs, supports, or services that can be accessed to address the issues in this case?

- Does the family have informal community or cultural ties or resources, such as an extended kinship network or membership in a community of faith, which can be accessed to support positive family functioning?

Step 2. Family/Cultural Issues: Assess Community, Family, and Cultural Issues

Review family's assessment of reasons behind physical abuse.

- Are there factors or issues identified by the family that were not identified by you?
 - Is it possible that issues raised in the family's assessment of the situation could be partially responsible for the physical abuse?
 - Do they have any specific ideas about how to resolve the issues?
 - Do any of their ideas seem reasonable?
- Can family members (including extended family) help implement any of the ideas?
 - Can you help implement any of their ideas, either through development of the case plan goals, provision of services, or flexible funding?
 - To the extent that you can reasonably include any of the family's (including extended family) ideas in developing the case plan goals, services and interventions, you should do so as a high priority. **Remember they know each other better than you do.**

Identify and review family (including extended family) strengths:

- Identify the strengths that will help this family become independent from the child welfare system. (Include relationships, employment, education, personalities, skills, support systems, etc.)
 - If the family's issues and needs overwhelm their strengths, identify extended family members who could help support this family.
- Identify extended family strengths that could help this family become independent from the child welfare system.
 - Consider **all** of the strengths identified; both of the family involved in physical abuse and of the extended family, in developing the case plan goals, services, and interventions. Plan specific steps to use to bolster family strengths. **Rely on family strengths whenever possible to address issues. Remember the strengths that you successfully reinforce will remain with this family after the case is closed.**

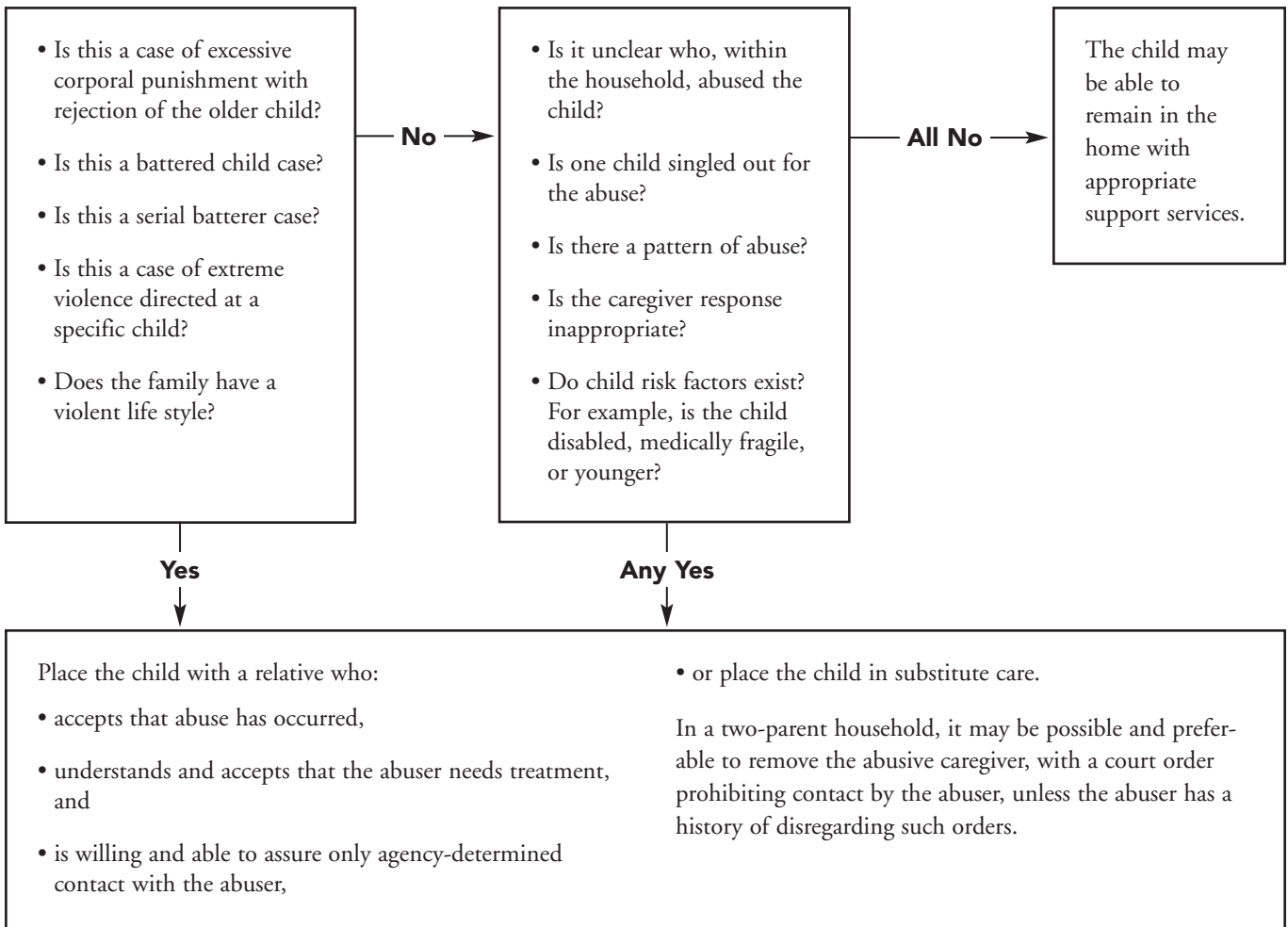
Step 3. Case Direction: Determine Case Direction

Most cases of physical abuse with major injury will result in removal of the abused child, and possibly other children in the household, particularly if:

- It is not clear who, within the household, abused the child;
- The abused child or siblings are younger than 6;

- The family falls within any case type **other than** excessive corporal punishment; or
- The caregiver’s response to the abuse has been inadequate.

If one child is singled out for the abuse, it may not be necessary to remove other children.



Step 4. Permanency Planning: For Native American Children, Keep ICWA Requirements in Mind as You Begin Planning

Determine the child’s Native American heritage — Is this child a member of a federally recognized Indian tribe, a child of a tribe member, or eligible for tribal membership?

No →

Go to **Next Page**

Yes ↓

Notify the tribal court that the child is the subject of an open child welfare case. Keep in mind that the Adoption and Safe Families Act (ASFA) requirements for timely

permanency **do not** supersede the requirements of the Indian Child Welfare Act (ICWA).

Regarding reasonable efforts:

ICWA requires that active efforts must be made to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family. Such efforts should “involve and use the available resources of the extended family, the tribe, Indian social services agencies, and individual Indian caregivers.” This requirement is for

Native Americans living both on and off of reservations. ASFA provides for efforts to prevent family breakup on a case-by-case basis. Your agency should consider ICWA legal standards for placement with extended family, other members of the child’s tribe, and other Indian families, before suspending active efforts to aid the family and before considering termination of parental rights (TPR).

Regarding termination of parental rights for American Indian children:

Parental rights may be terminated only where there is evidence beyond a reasonable doubt, including testimony of expert witnesses, that the continued custody of the child by the parent (or Indian custodian) is likely to result in serious emotional or physical damage to the child. Active

efforts to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family must have been made before a termination of parental rights may be sought. Remember that failure to adequately utilize appropriate tribal, extended family, and community resources could trigger the “failure to provide services” exception in the TPR filing requirement.

Make sure your agency attorney reviews ICWA before filing any actions with the court regarding permanency for this child. Remember that any permanency plan developed for a Native American child which provides for an out-of-home

placement, including an adoptive placement, would be subject to the placement preferences in ICWA (which include placement with extended family, other members of the child’s tribe, and other Indian families).

Step 4. Permanency Planning: Keep in Mind ASFA Safety and Permanency Goals and Required Timelines as You Begin Planning

For healthy development, children need consistent care and a feeling of belonging in a safe, permanent home. To help ensure permanency for children, the federal Adoption and Safe Families Act (ASFA), requires an initial focus on child safety, then development of a permanency plan for each child within 12 months.

- Can immediate child safety be assured only by placing the child outside the home?

No →

Go to next step

for identifying case goals and services. Ensure that plan includes supports for child safety at home. Include monitoring for child safety in plan.

Yes ↓

Begin permanency planning efforts immediately.

Develop a permanency goal and permanency plan for the child, in collaboration with the child’s parent(s).

- Involve the child’s parents, the child (generally if the child is 14 or older, and/or able to understand the situation), other relatives, or persons important to the child in the planning process.
- Do “concurrent” planning, that is, plan at the same time for the possibility of reunification of child and parent or finding an alternate permanent home for the child with relatives, through guardianship, or by adoption.
- Focus on child safety as the paramount goal, but make reasonable efforts to return the child home, unless the

parent has assaulted, seriously injured, or killed a child or another child of the parent or there are “aggravated circumstances” such that the child’s safety would be endangered by reunification. “Aggravated circumstances” not requiring reunification efforts include any listed in your state’s law and the following as defined by federal ASFA law: abandonment, torture, chronic abuse, or sexual abuse.

- Ensure that the child’s permanency plan includes: protection of the child’s health and safety, type and appropriateness of the child’s placement (see the Placement Level of Care guideline), any services to be provided to the child and the reason, services to be provided to the child’s biological parents, foster parents, and identified permanency family.

Under the ASFA, federal law requires compliance with the following timelines to ensure permanency for children in the custody of state child welfare agencies. State law timelines may be more restrictive.

- If reasonable efforts to return a child home are not being made due to aggravated circumstances, a court permanency hearing must be held within 30 days of placement.
- For every child in an out-of-home placement (including placement with relatives), a court permanency hearing must be held within 12 months of the date of the child’s first placement out of the home to determine the child’s permanency plan.

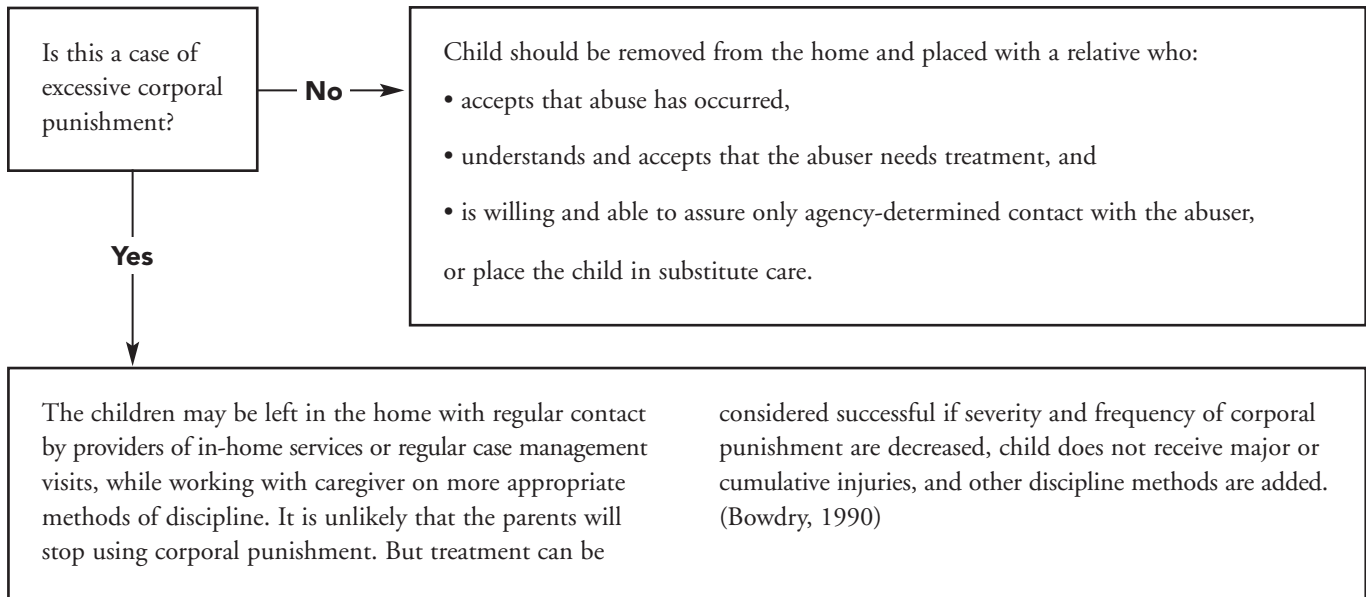
- If a child has been in placement for 15 out of the last 22 months, a court petition to terminate parental rights must be filed, unless:

1. A relative is caring for the child.
2. There is a documented compelling reason that termination of parental rights is not in the child’s best interests.
3. The state failed to provide the family with services, unless reasonable efforts to reunify the family were not required for the reasons listed above.

Step 5. Goals and Services: Identify Goals and Services

Goal 1

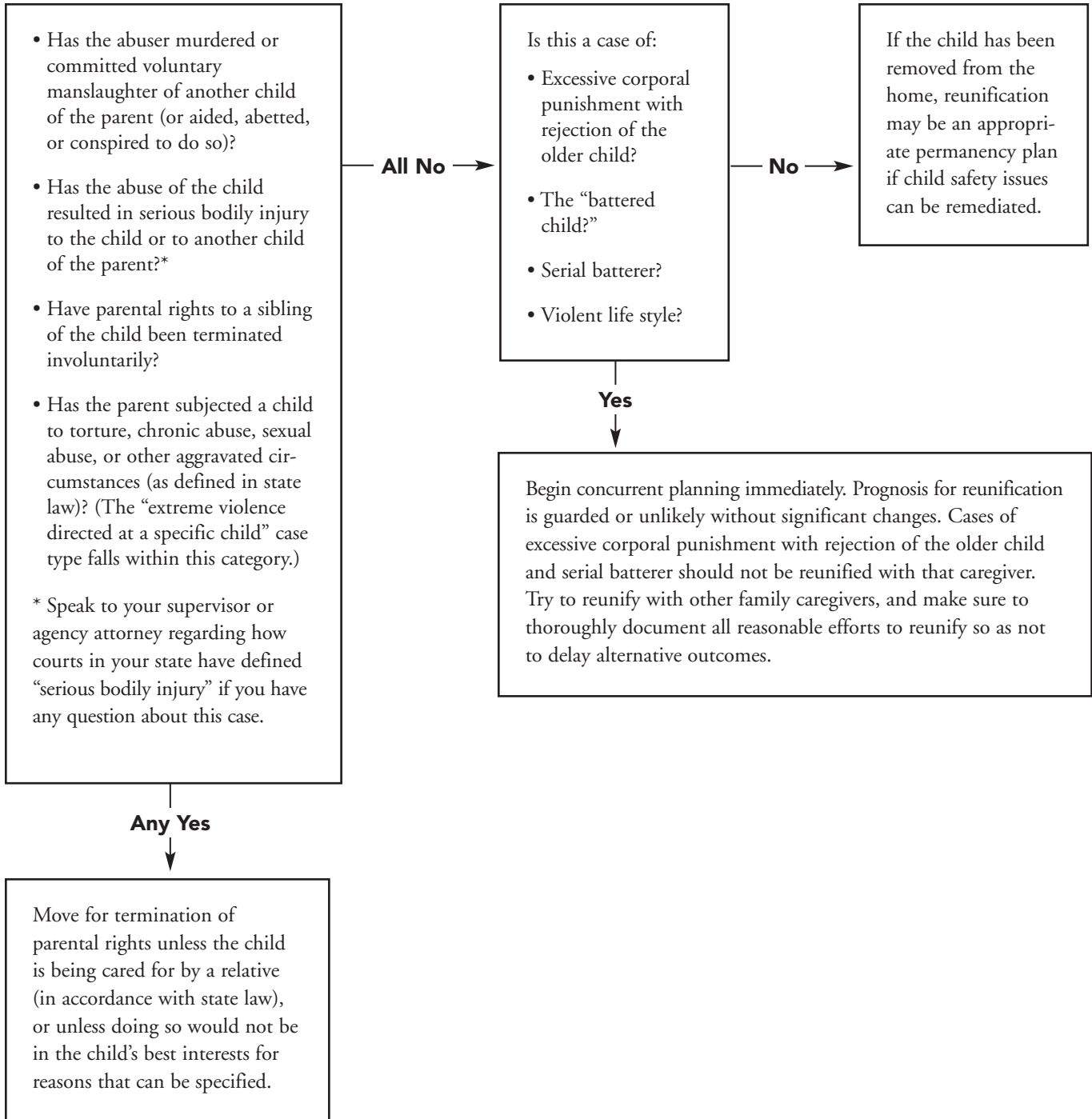
Protect the child.



Step 5. Goals and Services: Identify Goals and Services

Goal 2

Make initial determination of permanency goal.



Step 5. Goals and Services: Identify Goals and Services

Goal 3

Address child’s treatment needs.

Case Type 1: Excessive Corporal Punishment

Typically, since the child does not see him or herself as “bad,” but simply as having done something wrong, which caused the punishment, therapeutic services will not be needed, and the child can remain in the home, with

appropriate treatment for the parents and instruction in more appropriate discipline methods. If the child appears overly withdrawn or anxious, or acting out, refer for evaluation.

Case Type 2: Excessive Corporal Punishment with Rejection of the Older Child

- Child should have complete health check-up and a psychological evaluation.
- Therapy should focus on helping the child make peace with the past, and realize he or she is still lovable, even though the child did not get that love from parents.

- For the elementary age child, provide extensive therapy and an accepting environment. Child may continue to have attachment problems.
- For the older child, provide emotional support and a secure environment. These youth may do better in a group setting, offering emotional space, and which does not require the intimacy of a family setting. (Bowdry, 1990)

Case Type 3 & 4: The Battered Child and the Serial Batterer

- Children should have a complete developmental screen, health check-up, and a psychological evaluation to

determine the need for additional treatment or therapies.

Step 5. Goals and Services: Identify Goals and Services

Case Type 5: Extreme Violence Against a Specific Child

- The child should have a complete developmental screen, health check-up, and psychological evaluation to determine the need for additional treatment.
- The child should be removed permanently from the home of the abuser.

Case Type 6: Violent Life Style

The children should have complete developmental screens, health check-ups, and psychological evaluations to determine the need for additional treatment or therapies.

Step 5. Goals and Services: Identify Goals and Services

Goal 4

Address abusive parenting behaviors, if reunification is the goal.

The motivation of the abuser should be carefully assessed to determine the therapeutic interventions that should be provided, and the long-term prospects for reunification. The four case

types identified below discuss typical motivations of child abusers and the prognosis for treatment, with types 2 and 3 being most prevalent.

1. Negative Affect Toward the Child:

- Has strong negative feelings about the child, child may be a scapegoat.
- Negative feelings toward a spouse, partner, self, or other may be displaced onto the child.
- The child may be blamed for being dependent and immature and not nurturing the caregiver.

- If the caregiver is incapable of ambivalent feelings, he or she may exaggerate the negative feelings toward the child.

Treatment success is possible if abuser can be made to see who he or she is really angry at, or if abuser can become more confident in managing the child. Parenting classes may help, *but only* if abuser has a real problem managing the child. **Therapy for the parent is recommended.** (Salter, Richardson & Martin, 1985)

2. World View that Rationalized the Abuse:

- The caregiver feels that the child deserves to be beaten or abused because of the child's behavior.
- Minor infractions may be blown out of proportion and described as personal affronts toward the caregiver.
- The abuse is seen as the only way to control the child for as long as possible, because once the child has grown, the child may "turn" on the caregiver.
- The caregiver may not see any reason to control his or her impulses when provoked by a child who cannot fight back.

- The caregiver sees the world as a tough place to live, and others are out to do him or her in, so he or she has the right to beat or abuse this child.
- The caregiver makes no attempt to control his or her impulses because he or she perceives his or her actions to be reasonable.

These caregivers are resistant to change and they are manipulative. Treatment success is possible **only** if the abuser can begin to understand and face the fact that he or she really thinks that hurting a child is justifiable. Parenting classes or anger management classes **will have little impact** on changing this behavior. (Salter, Richardson & Martin, 1985)

Step 5. Goals and Services: Identify Goals and Services

3. Inability to Control Impulses:

- The caregiver becomes overwhelmed by his or her impulses and cannot weigh pros and cons accurately.
- The caregiver may express guilt or confusion about his or her behavior and promise to “do better.”

Treatment success is linked to the abuser’s belief in external controls, since the abuser cannot rely on internal controls

to control his or her impulses. External controls may not always work, if the abuser sees only minor consequences to his or her impulsive behaviors. Highly motivated abusers may be able to develop and rely on internal controls to abusive behaviors. Anger management classes may help, but **therapy should be provided** as well. (Salter, Richardson & Martin, 1985)

4. Payoff:

- The abusive act may relieve the caregiver of emotions that are unpleasant (e.g., warding off depression through anger, discharging impulses rather than tolerating them).
- The abusive act may distract a caregiver from interpersonal or other problems.

- The abusive act actually may make the caregiver feel better, by relieving stress or tension.

Treatment success is linked to the abuser finding alternative ways to achieve the same payoff, or to interfere with the ability of the abuse to generate a payoff. **Intensive anger management training and therapy are recommended.** Parenting classes are not likely to help. (Salter, Richardson & Martin, 1985)

Each of the abuser categories listed above requires significant therapeutic treatment to address the abusive behaviors. Important to the treatment process is the **motivation of the abuser to eliminate the abusive behavior.** Without caregiver motivation to eliminate the abusive behavior, and

without the caregiver taking responsibility for the abuse, treatment may not be successful within the timelines dictated by federal and state laws. Concurrent planning will become more important to achieving timely permanency.

Abusive parents are very difficult to treat, and treatment should be undertaken by clinicians *who have experience with abusive parents*, and who are able to distinguish between genuine motivation to change one’s behavior versus an effort to manipulate the clinician. Chronic abusers are often described as having “poor impulse control.” For some, their actual motivation is to **express their impulses**

without negative consequences. They see their children as appropriate objects of their frustrations, and therapeutic contacts as a way to stay out of jail (Salter, Richardson & Martin, 1985). The serial batterer falls within this category, is very resistant to change, and as such, should be considered very dangerous to the safety of young children.

Step 5. Goals and Services: Identify Goals and Services

Goal 5

Address violent lifestyle (if case is type 6 - "violence as a way of life").

Refer caregiver and partner, separately, to domestic violence counseling or mental health counseling for power, control, or victimization issues as warranted. (Also see the Domestic Violence or Substance Abuse Guidelines if appropriate.)

Refer to other social services, such as housing referral agencies, if needed. Determine if caregivers have an interest in developing a safe environment for their children.

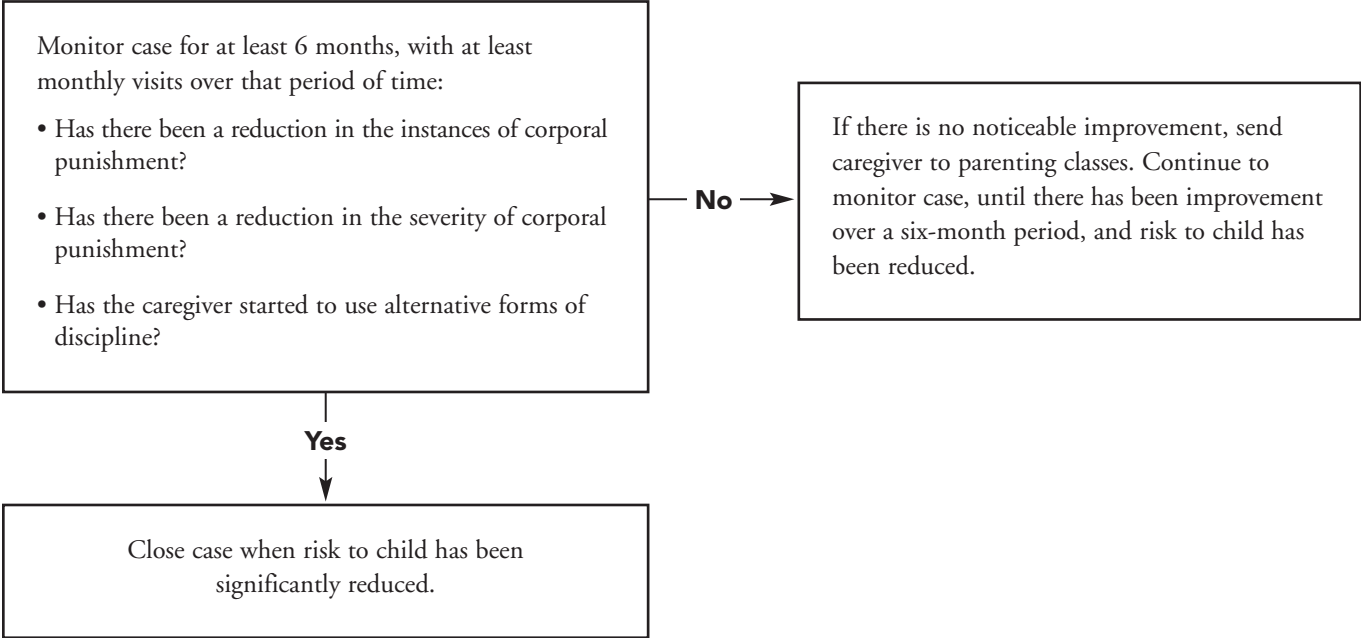


Monitor case to assure that violence issues are being adequately addressed in treatment. **Issues must be under control without relapse for 6 months before reunification can be considered.** (This should be determined through monitoring of police reports,

active participation in treatment, random drug screens (if warranted) etc.) Regular random home visits, at least monthly, throughout this period should be undertaken to assure that issues are being addressed.

Step 6. Achieve Permanency: Assure Permanency and Family Stability

**Case Type 1
Excessive Corporal Punishment**



**All other case types except Case Type 1:
Excessive Corporal Punishment**

Abused children, particularly preschoolers, need significant individual attention to overcome the effects of abuse on their development and view of their world. Abused children may be aggressive because they are under-socialized or have learned negative behaviors. They should have ongoing, specialized services to overcome these deficits. Seek special needs day care programs for preschoolers. (Salter, Richardson & Kairys, 1985)

Step 6. Achieve Permanency: Assure Permanency and Family Stability

To consider reunification, the caregiver must:

- Recognize and acknowledge his or her abusive behavior.
- Be able to recognize stress and develop effective means for dealing with it.
- Engage in treatment and demonstrate progress from treatment.

- Demonstrate affection for the child.
- Have an understanding of the child’s needs and behaviors.

You should undertake a complete safety assessment using your agency’s tools and format before considering reunification.

(Bowdry, 1990)

- Generally, cases of excessive corporal punishment with rejection of the older child, serial batterer, and extreme violence against a specific child should not be reunified with the abuser. Alternative permanency for the child is recommended.
- Extreme caution should be used in reunifying children with a passive partner of the abuser. Adult domestic violence victims should be assisted to achieve safety for

themselves and their children whenever possible, however, not “punished” by the removal of the children. If the child is reunified with the passive partner, the case should be kept open and monitored regularly for at least 6 months to make sure the abuser has not returned to the household.

(See the guideline on Domestic Violence and Abuse/Neglect for suggestions on how to protect the child by ensuring the safety of the adult domestic violence victim.)

Reunified cases should be monitored for at least 6 months to assure the child is safe. Community services (such as

child day care, homemaker, parent aide) should be provided to monitor the child’s safety as well.

Notes

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National child maltreatment reporting data for 2000 indicate that 19.3% of all confirmed maltreatment victims suffered physical abuse. After neglect (59.8% of victims), physical child abuse is the most prevalent form of child maltreatment, with 166,232 confirmed cases in the United States in 2000 (U.S. Department of Health and Human Services, 2002). In general, younger children, under age 7, are more often victims of this type of maltreatment. Victims of physical maltreatment may also be teenaged youth, however, with a victimization rate of 2.2 per thousand males and 3.1 per thousand females, age 12 to 15 in the U.S. child population (U.S. Department of Health and Human Services, 2002).

In responding to an allegation of physical abuse, first determine whether or not the physical injury to the child is intentional. Factors that may prompt concern that a physical injury is intentional include:

- A history incompatible with the physical injury, conflicting histories, or bizarre explanations.
- Injury incompatible with child’s developmental age.
- Injuries that appear older than the historical account.
- Unrelated soft tissue bruises, lacerations, and scars, in different stages of healing, so that they could not all have occurred in the same incident.
- Old long bone or skull fractures found on X-ray.

- Specific cutaneous injuries such as human bites, cigarette burns, puncture wounds, or missing hair.
- An adult unrelated to the incident seeking medical attention for the injured child or delay in seeking needed medical treatment.

(Filip, McDaniel, Schene, 1992; Jaudes & Mitchel, 1992).

Once it has been determined that a physical injury to a child is intentional, responding to physical abuse, even what may be considered minor injuries, first involves determining the level of risk to the child. Even minor injuries, such as a small burn, can be serious if there is a chronic or cumulative pattern of abuse or if injuries occur with increasing frequency. The age of the child is also a primary consideration in determining the urgency and immediacy of response that is needed. Infants and younger children are both more vulnerable to physical injury and less able to defend themselves against physical assault.

Physical abuse can be divided into categories that have different dynamics and require different intervention.

Depending upon the circumstances of the injury and the history given, along with the age and vulnerability of the child (including any disability or special needs), the following guidelines may be used to generally classify physical injuries resulting from abuse as minor versus major:

Physical abuse with minor injury may include:

- A small number of bruises, scratches, scars, or cuts.
- A few cuts or welts in areas of the child’s body that do not pose a threat of serious injury or disfigurement, (e.g., a welt on the face may disfigure, a welt on the buttocks does not).
- A single minor burn.
- Small injuries in areas of the body that are not as sensitive to permanent injury or disfigurement (e.g., the limbs or buttocks).
- Those that do not require medical treatment.

Injuries that require brief medical treatment, such as numerous bruises or minor burns, or single fractures are considered moderate. Further risk assessment is needed to determine if this guideline or the guideline for physical abuse with major injury should be followed. (If in doubt, follow the guideline for Physical Abuse - Major Injury.)

The following are examples of physical abuse with major injury, for which the separate guideline “Physical Abuse - Major Injury” should be followed:

- Large burns, deep, serious burns, or multiple small burns.
- Central nervous system injury.
- Multiple fractures.
- Any life threatening injury.
- Any injury causing permanent damage to, loss of use of, or disfigurement to body parts.

- Injuries that require hospitalization.
- Chronic or cumulative minor injuries (especially to young children).

Even for minor injuries, therapeutic intervention, concrete services, medical

treatment, and parenting education all may be needed to respond. Services should be selected in partnership with the family based upon the paramount concern for child safety, the nature of the specific injuries, the potential for

building upon strengths to change parental behaviors, and the ultimate goal of achieving specific positive outcomes for the child and family.

The Guidelines are a product of the Casey Outcomes and Decision Making Project. Project partners: The Annie E. Casey Foundation; Casey Family Programs; Casey Family Services; American Humane Association, Children's Services; American Bar Association, Center on Children and the Law; Institute for Human Services Management. Guidelines developed and written by Tracey Feild, M.A. and Amy Printz Winterfeld, J.D.

Step 1. Assessment: Assess Seriousness of Abuse

Examples of Major Abuse:

- An escalating cycle of injuries beginning with minor injuries to relatively invulnerable areas of the body, and proceeding to injuries to the head, neck, stomach, genitals, or other soft tissue injuries.
- Life threatening injury.
- Permanent injury or risk of permanent injury.
- Dangerous acts which could have resulted in serious injury (e.g., deliberate electrical shocks, holding child's head under water).
- Cruel and inhumane treatment (e.g., submerging toddler's head in toilet filled with feces).
- Loss of use of body parts.
- Disfigurement.
- Injury to the head.
- Injury requiring hospital care.
- Failure to provide treatment for injuries needing treatment.
- A sustained physical injury (e.g., a lost tooth, a broken bone, etc.).
- Multiple bruises or marks.
- Large burns, deep or serious burns, or multiple small burns.
- Minor injury, but child seems overly upset about and obsessed with the injury.
- Any suspicious injury with an inadequate explanation.

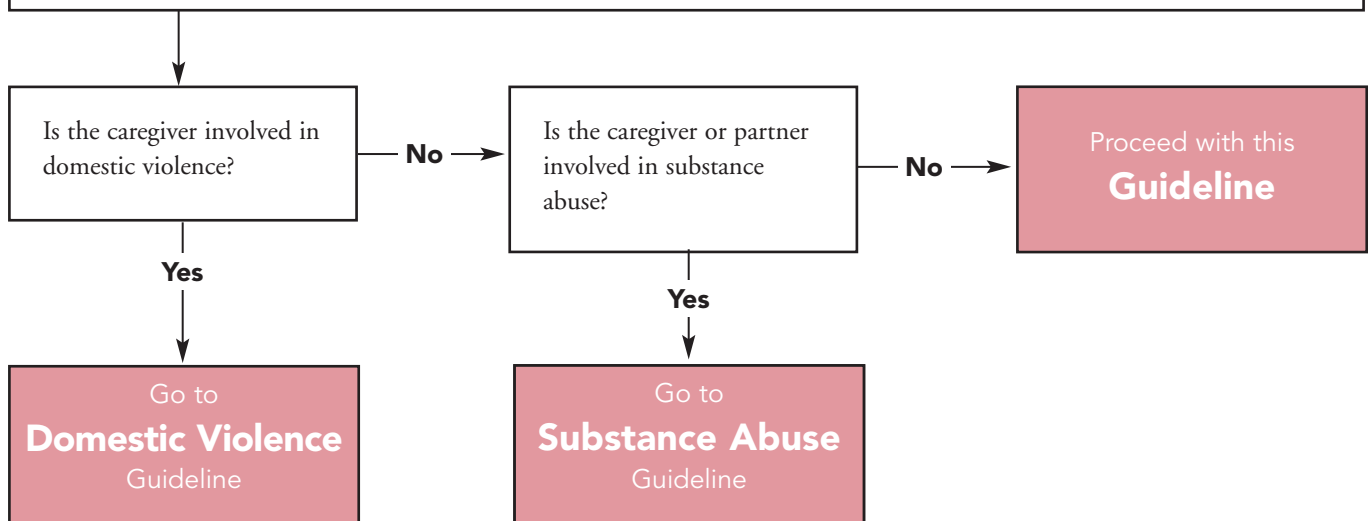
Yes
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Go to **Physical Abuse – Major Injury** guideline

Step 1. Assessment: Assess Seriousness of Abuse

Examples of Minor Injury:

- No medical treatment needed.
- May need medical treatment, but immediate release afterwards.
- Injuries to areas not considered sensitive:
 - head, torso, except buttocks = sensitive.
 - limbs, buttocks = less sensitive.
- Minor injuries to children old enough to protect themselves.
- A single bruise or mark to a limb, or single small, superficial burn.



Step 1. Assessment: Identify Case Type

There are four case types identified for physical abuse - minor injury. Some of the case types actually disguise more serious abuse case types, hence suggestions for ruling out more serious abuse are provided.

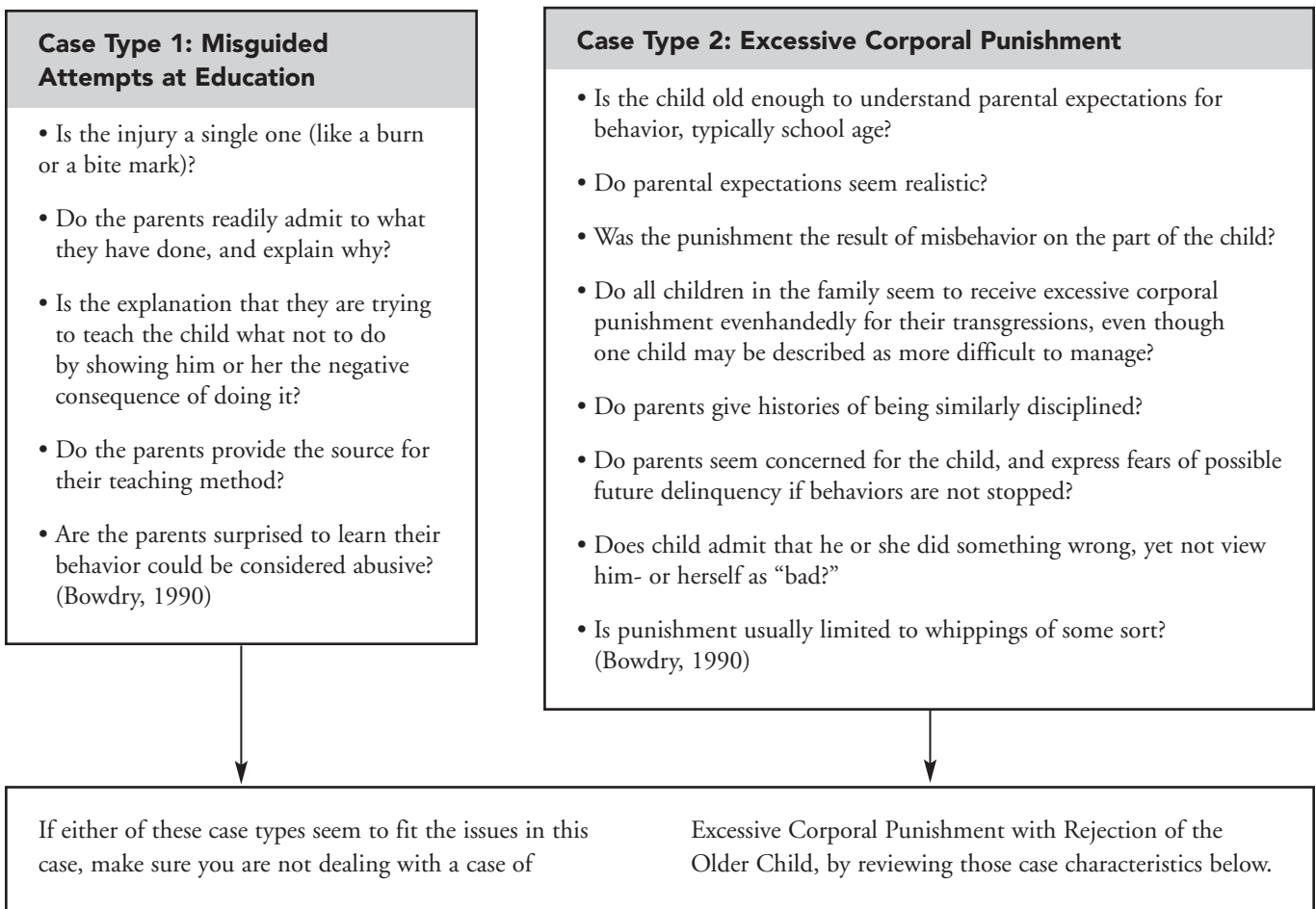
- **Case Type 1: Misguided attempts at education and**
- **Case Type 2: Excessive corporal punishment**

may be disguising a more serious case type, excessive corporal punishment with rejection of the older child, which can be a physical abuse with major injury case type. These issues should be carefully reviewed to rule out the more serious abuse case type.

- **Case Type 3: Battered Child and**
- **Case Type 4: Serial Batterer**

May appear as minor injury case types, but may be moving toward major injuries. Again, steps are suggested to rule out major injuries. Case Types 1 and 2 are appropriate case types for this guideline. If a child falls into Case Types 3 or 4, but only minor injuries are confirmed, the child should be monitored very closely and frequently to assure abuse does not escalate.

Review each of the case types carefully to determine which one most closely fits the issues in this case.



Step 1. Assessment: Identify Case Type

Excessive Corporal Punishment with Rejection of the Older Child

These cases are typically characterized by children in the early elementary age range or in early teenage years, predominantly males. Children are referred for physical abuse, with injuries such as bruises, cuts, or welts. Initially, they may appear to be victims of misguided attempts at education. A careful assessment of the issues should include:

For children in the younger age range:

- Does the caregiver reveal a history for this child that includes significant trauma and/or hospitalization, which is suspect of child battering?
- Is the child perceived negatively by the parents or caregivers, and often by the siblings, and may be the family scapegoat?
- Does the child perceive him- or herself negatively, or describe him- or herself as “bad”?
- Does the parent request out-of-home placement of the child in order to “straighten the kid out”?

For children in the older age range, add the following:

- Does the child have severe behavior problems and/or antisocial conduct?
- Does the parent describe the child as cruel or harsh to younger children in the family or neighborhood, possibly with sex offenses?
- Does the parent reveal a history of placing this child outside the home for much of his (or her) life?
(Bowdry, 1990)

No →

Go to next **Case Type**

Yes ↓

Go to **Physical Abuse – Major Injury** Guideline

Step 1. Assessment: Identify Case Type

Case Type 3: The Battered Child

- Is the child young, often under 4 years old?
- Are the parents immature emotionally?
- Do the parents have unrealistic expectations of the child and of parenting?
- Do the parents have histories of maltreatment in their own childhoods?
- Are the parents socially and emotionally isolated?
- Does the child have injuries that are unexplained or inconsistent with the explanation offered? (Bowdry, 1990)

Case Type 4: The Serial Batterer

- Does this case have the same characteristics of Case Type 3, the battered child, except that the abuser or other source reveals that the abuser has injured another child in the past? (Bowdry, 1990)

If this appears to be a serial batterer case, the child is at high risk of further injury and should be removed from the home, or the abuser should be removed from the home, with adequate protection against re-entry into the household.

If Case Types 3 or 4 appear to fit the issues in this case, and abuse or injuries appear to be minor:

- Ask caregiver for complete medical records and evidence of preventive check ups, or names and addresses of medical facilities and a signed release of information, so you can verify medical history without evidence of abuse, or

- Arrange for full body x-ray and complete developmental screen to rule out major physical abuse history or a pattern of abuse or neglect.

If review of records indicates major physical injury in the past, use the guideline for Physical Abuse - Major Injury.

Otherwise proceed with this guideline.

Step 1. Assessment: Review Risk Factors

Review the risk factors below to determine the level of risk to the child, and to help determine the level of intervention needed.

1. Pattern of Abuse: Reoccurrence of maltreatment is more likely:

- The greater the severity, frequency, or recency of the maltreatment.
- Once a person has been a perpetrator of maltreatment.

- The degree to which the functioning of the perpetrator is impaired by substance abuse or mental dysfunction.
- The degree to which a partner is an active participant, or does nothing to stop the maltreatment. (Sigurdson & Reid, 1990)



2. Caregiver Response: Reoccurrence of maltreatment is more likely:

- If caregiver admits no guilt about the child's injury.
- If the caregiver does not view discipline as a developmental technique, but as a punishment for wrong deeds.
- If the caregiver believes that physical force or threats of violence are the only way to correct behavior.
- If the caregiver seems more concerned about what might happen to him or her, rather than the child, as a result of the abuse.
- If the caregiver show little or no concern about the injury itself, the treatment, prognosis, or aftercare.
- If the caregiver or partner seems unable to protect the child.
- If the caregiver has little reaction to the injury.
- If the caregiver failed to adequately treat the injury. (Sigurdson & Reid, 1990)

Factors associated with the most abusive behaviors are:

- Young age of abuser (18-30).
- Low income or poverty.
- Stressful life events.
- Social isolation and lack of social support.
- Experiencing or witnessing violence as a child.
- Alcohol and/or substance abuse. (Gelles, 1999)

Step 1. Assessment: Review Risk Factors

3. Household Lifestyle: Reoccurrence of maltreatment is more likely:

- The greater the level of dysfunction within the family.
- The higher the level of stress experienced by the caregiver.
- The greater the disconnection of a caregiver from the family and the community.

- If the caregiver is violent in any context.
- The greater the acceptance of maltreatment within the family and/or community. (Sigurdson & Reid, 1990)



4. Child Risks: Reoccurrence of maltreatment is more likely:

- If the child is too young to be able to tell others of the abuse.
- If the child is too frightened or too intimidated to tell others of the abuse.

- If the child is isolated from contact with others due to his or her age, lack of extended family or community involvement, or location of the home.
- If the child has special needs (e.g., ADHD, developmental delay, special health problem, etc.).
- If the child is treated differently from others in the household, or singled out for abuse. (Sigurdson & Reid, 1990)



Remember:

- The more serious the injury, the more you should be concerned with who, what, when, and how the incident occurred.
- **The more minor the incident**, the more you should be concerned with the pattern of abuse and its impact on child safety.

- The more chronic the pattern of maltreatment, the more likely it is that other forms of maltreatment have occurred as well; assess for neglect and sexual abuse. (Wilson, 2000)

Step 2. Family/Cultural Issues: Assess Community, Family, and Cultural Issues

Assess community and cultural factors and your familiarity with them.

- Is it possible that community, cultural, or ethnic beliefs or practices that you are not familiar with are a factor in the parent's behavior? **Even if they are, remember that child safety is your first concern.**

No →

Go to **Next Page**

Yes
↓

- Find someone in your agency knowledgeable about the family's culture before proceeding. Develop your understanding of how the family's beliefs, values, interests, and concerns may differ from your own and affect their behavior before you assess needs or begin planning services. When you understand how your cultural views and the family's culture and beliefs affect your assessment of the family's issues and needs, it may also affect how you plan to remediate them.
- If no one is available within your agency to help you understand the family's culture and belief system, identify community or neighborhood representatives (e.g., community leaders, community-based organizations, religious leaders, etc.) who could assist you in assessing needs and planning for families within this culture and in understanding the values and beliefs of this cultural group.

- Are there community and cultural beliefs that can be reinforced to encourage positive parenting practices?
- Are there specific formal community or cultural programs, supports, or services that can be accessed to address the issues in this case?
- Does the family have informal community or cultural ties or resources, such as an extended kinship network or membership in a community of faith, which can be accessed to support positive family functioning?

Step 2. Family/Cultural Issues: Assess Community, Family, and Cultural Issues

Review family’s assessment of reasons behind physical abuse.

- Are there factors or issues identified by the family that were not identified by you?
- Is it possible that issues raised in the family’s assessment of the situation could be partially responsible for the physical abuse?
- Do they have any specific ideas about how to resolve the issues?
- Do any of their ideas seem reasonable?

- Can family members (including extended family) help implement any of the ideas?
- Can you help implement any of their ideas, either through development of the case plan goals, provision of services, or flexible funding?
- To the extent that you can reasonably include any of the family’s (including extended family) ideas in developing the case plan goals, services and interventions, you should do so as a high priority. **Remember they know each other better than you do.**



Identify and review family (including extended family) strengths:

- Identify the strengths that will help this family become independent from the child welfare system. (Include relationships, employment, education, personalities, skills, support systems, etc.).
- If the family’s issues and needs overwhelm their strengths, identify extended family members who could help support this family.

- Identify extended family strengths that could help this family become independent from the child welfare system.
- Consider all of the strengths identified; both of the family involved in physical abuse and of the extended family, in developing the case plan goals, services, and interventions. Plan specific steps to use to bolster family strengths. Rely on family strengths whenever possible to address issues. **Remember the strengths that you successfully reinforce will remain with this family after the case is closed.**

Step 3. Permanency Planning: For Native American Children, Keep ICWA Requirements in Mind as You Begin Planning

Determine the child’s Native American heritage — Is this child a member of a federally recognized Indian tribe, a child of a tribe member, or eligible for tribal membership?

No →

Go to **Next Page**

Yes ↓

Notify the tribal court that the child is the subject of an open child welfare case. Keep in mind that the Adoption and Safe Families Act (ASFA) requirements for timely

permanency **do not** supersede the requirements of the Indian Child Welfare Act (ICWA).

Regarding reasonable efforts:

ICWA requires that active efforts must be made to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family. Such efforts should “involve and use the available resources of the extended family, the tribe, Indian social services agencies, and individual Indian caregivers.” This requirement is for

Native Americans living both on and off of reservations. ASFA provides for efforts to prevent family breakup on a case-by-case basis. Your agency should consider ICWA legal standards for placement with extended family, other members of the child’s tribe, and other Indian families, before suspending active efforts to aid the family and before considering termination of parental rights (TPR).

Regarding termination of parental rights for American Indian children:

Parental rights may be terminated only where there is evidence beyond a reasonable doubt, including testimony of expert witnesses, that the continued custody of the child by the parent (or Indian custodian) is likely to result in serious emotional or physical damage to the child. Active

efforts to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family must have been made before a termination of parental rights may be sought. Remember that failure to adequately utilize appropriate tribal, extended family, and community resources could trigger the “failure to provide services” exception in the TPR filing requirement.

Make sure your agency attorney reviews ICWA before filing any actions with the court regarding permanency for this child. Remember that any permanency plan developed for a Native American child which provides for an out-of-

home placement, including an adoptive placement, would be subject to the placement preferences in ICWA (which include placement with extended family, other members of the child’s tribe, and other Indian families).

Step 3. Permanency Planning: Keep in Mind ASFA Safety and Permanency Goals and Required Timelines as You Begin Planning

For healthy development, children need consistent care and a feeling of belonging in a safe, permanent home. To help ensure permanency for children, the federal Adoption and Safe Families Act (ASFA), requires an initial focus on child safety, then development of a permanency plan for each child within 12 months.

- Can immediate child safety be assured only by placing the child outside the home?

No →

Go to next step for identifying case goals and services. Ensure that plan includes supports for child safety at home. Include monitoring for child safety in plan.

Yes ↓

Begin permanency planning efforts immediately.

Develop a permanency goal and permanency plan for the child, in collaboration with the child’s parent(s).

- Involve the child’s parents, the child (generally if the child is 14 or older, and/or able to understand the situation), other relatives, or persons important to the child in the planning process.
- Do “concurrent” planning, that is, plan at the same time for the possibility of reunification of child and parent or finding an alternate permanent home for the child with relatives, through guardianship, or by adoption.
- Focus on child safety as the paramount goal, but make reasonable efforts to return the child home, unless the

parent has assaulted, seriously injured, or killed a child or another child of the parent or there are “aggravated circumstances” such that the child’s safety would be endangered by reunification. “Aggravated circumstances” not requiring reunification efforts include any listed in your state’s law and the following as defined by federal ASFA law: abandonment, torture, chronic abuse, or sexual abuse.

- Ensure that the child’s permanency plan includes: protection of the child’s health and safety, type and appropriateness of the child’s placement (see the Placement Level of Care guideline), any services to be provided to the child and the reason, any services to be provided to the child’s biological and foster parents, and identified permanency family.

Under the ASFA, federal law requires compliance with the following timelines to ensure permanency for children in the custody of state child welfare agencies. State law timelines may be more restrictive.

- If reasonable efforts to return a child home are not being made due to aggravated circumstances, a court permanency hearing must be held within 30 days of placement.
- For every child in an out-of-home placement (including placement with relatives), a court permanency hearing must be held within 12 months of the date of the child’s first placement out of the home to determine the child’s permanency plan.

- If a child has been in placement for 15 out of the last 22 months, a court petition to terminate parental rights must be filed, unless:
 1. A relative is caring for the child.
 2. There is a documented compelling reason that termination of parental rights is not in the child’s best interests.
 3. The state failed to provide the family with services, unless reasonable efforts to reunify the family were not required for the reasons listed above.

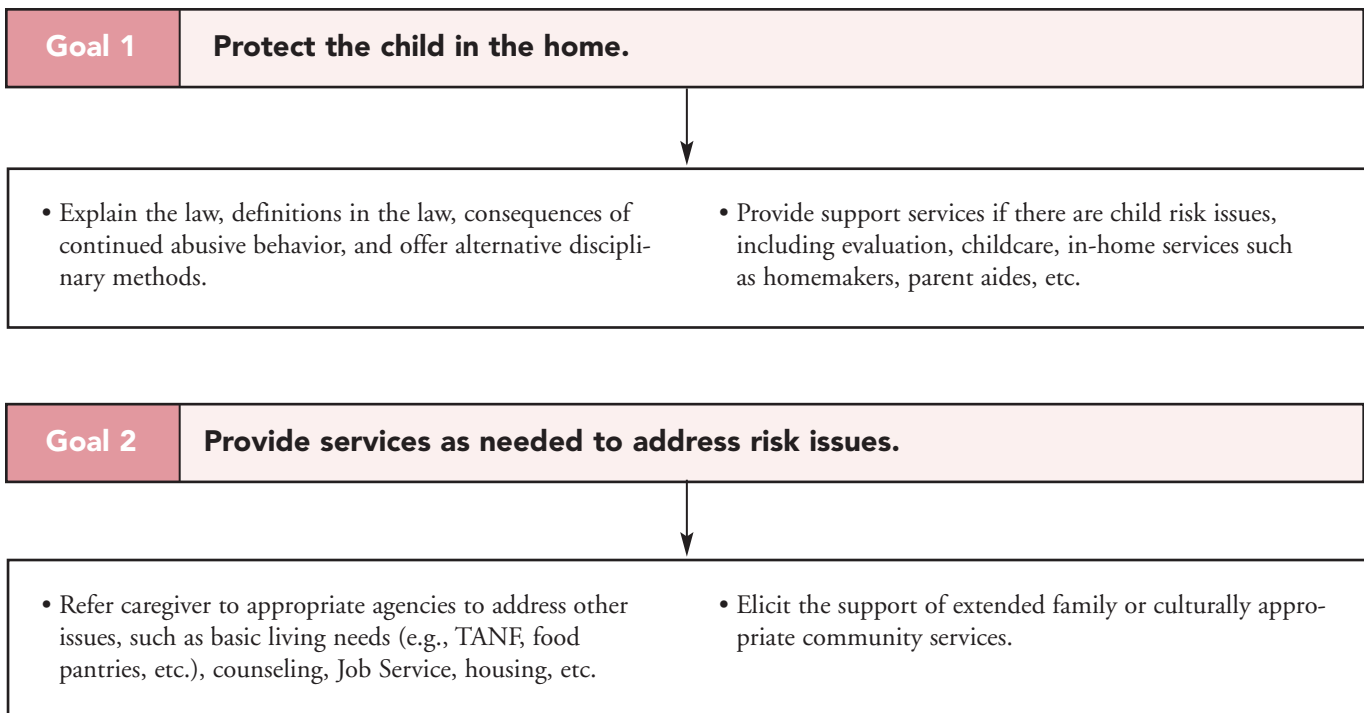
Step 4. Goals and Services: Identify Goals and Services

Service interventions should address the following issues:

1. Protect the child in the home.
2. Provide appropriate services to the caregiver and child to address stressors that led to abuse and to redress immediate abuse issues.
3. Stabilize the family.

It is unlikely that the child will have to be removed from the home in physical abuse — minor injury cases unless the case appears to be Case Type 4: Serial Batterer. (If the identified abuser has already seriously injured another young child, the likelihood of his or her doing so again is very high, in spite of the fact that the current injury may have been minor.)

**Case type 1: Misguided attempts at education and
Case type 2: Excessive corporal punishment**



Step 4. Goals and Services: Identify Goals and Services

Goal 3 Stabilize the family.

- Monitor the home for 3-6 months (6 months if child risk factors exist).
- Subsequent incidents within that time period, which are more severe, but continue to be minor abuse, may warrant parenting classes to learn more appropriate discipline methods.
- Goal is to reduce frequency of corporal punishment and to add alternative disciplinary methods to replace abusive disciplinary or teaching methods.

Go to **Step 5** Page 22

Case type 3: Battered child

Goal 1 Protect the child in the home.

Based on the four sets of risk factors identified at the end of Step 1, is this child at higher or lower risk for subsequent abuse?

Higher Risk →

Lower Risk

Assure regular contact with children through in-home services or case monitoring. Scale your response to the level of risk. Lower risk households should receive bi-monthly monitoring for three months without recurrence.

Assure regular contact with children through purchased in-home services (e.g., homemaker, parent aide, family visitor), childcare, or case monitoring. Scale your response to the level of risk. Higher risk households should have at least twice weekly contacts from outside agencies, caseworker, or combination of both. If no recurrence within 3 months, gradually scale back on contacts.

Step 4. Goals and Services: Identify Goals and Services

Goal 2 Address causes of crisis or stress.

- Refer caregiver to appropriate agencies to address basic living needs if that is an issue (e.g., TANF, food pantries, etc.), counseling, Job Service, housing, etc.
- Elicit the support of extended family or culturally appropriate community services.

Goal 3 If child is high risk, assure child’s needs are adequately addressed.

- Refer special needs child for community services (e.g., evaluation, early intervention, special education, etc.).
- If child is below school age, provide a developmental screen and consider childcare.
- If child is singled out for abuse, child should receive a psychological evaluation.

Goal 4 Address abusive behavior.

The motivation of the abuser should be carefully assessed in determining the therapeutic interventions that should be provided, and the long-term risk to the child. The four abuser types below are typical motivations of child abusers, with types 2 and 3 being most prevalent. In cases of minor abuse, these motivations may not be as clear, but review each of the case types to look for signals as to what is motivating the abuse. This will help you determine how much intervention is needed and the long-term risk to the child in this household.

1. Negative Affect Toward the Child:

- The caregiver has strong negative feelings about the child; child may be a scapegoat.
 - Negative feelings toward a spouse, partner, self, or other may be displaced onto the child.
 - The child may be blamed for being dependent and immature and not nurturing the parent.
 - If the parent is incapable of ambivalent feelings, he or she may exaggerate the negative feelings toward the child.
- Treatment success is possible if abuser can be made to see who he or she is really angry at, or if abuser can become more confident in managing the child. Parenting classes may help only if abuser has a real problem managing the child. **Therapy for the parent is recommended.** (Salter, Richardson & Martin, 1985)

Step 4. Goals and Services: Identify Goals and Services

2. World View that Rationalizes the Abuse:

- The caregiver feels that the child deserves to be abused because of the child’s behavior.
- Minor infractions may be blown out of proportion and described as personal affronts toward the caregiver.
- The abuse is seen as the only way to control the child for as long as possible, because once the child has grown, the child may “turn” on the caregiver.
- The caregiver may not see any reason to control his or her impulses when provoked by a child who cannot fight back.

- The caregiver sees the world as a tough place to live, and others are out to do him or her in, so he or she has the right to abuse this child.
- The caregiver makes no attempt to control his or her impulses because he or she perceives his or her actions to be reasonable.

These caregivers are resistant to change and manipulative. Treatment success is possible only if the abuser can begin to understand and face the fact that he or she really thinks that hurting a child is justifiable. Parenting classes or anger management classes will have little impact on changing this behavior. Abuser needs therapy. (Salter, Richardson & Martin, 1985)



3. Inability to Control Impulses:

- The caregiver becomes overwhelmed by his or her impulses and cannot weigh pros and cons accurately.
- The caregiver may express guilt or confusion about his or her behavior and promise to “do better.”

Treatment success is linked to the abuser’s belief in external controls, since the abuser cannot rely on internal controls

to control his or her impulses. External controls may not always work, if the abuser sees only minor consequences to his or her impulsive behaviors. Abusers who are highly motivated to eliminate abusive behaviors may be able to develop and rely on internal controls to abusive behaviors. Anger management classes may help, but therapy should be provided as well.

(Salter, Richardson & Martin, 1985)



4. Payoff:

- The abusive act may relieve the caregiver of emotions that are unpleasant (e.g., warding off depression through anger, discharging impulses rather than tolerating them).
- The abusive act may distract a caregiver from interpersonal or other problems.
- The abusive act actually may make the caregiver feel better, by relieving stress or tension.

Treatment success is linked to the abuser finding alternative ways to achieve the same payoff, or to interfere with the ability of the abuse to generate a payoff. **Anger management and therapy are recommended.** Parenting classes are not likely to help.

(Salter, Richardson & Martin, 1985)



Step 4. Goals and Services: Identify Goals and Services

Each of the abuser categories listed on the previous pages requires therapeutic treatment to address the abusive behaviors, and to prevent these behaviors from escalating.

Important to the treatment process is the **recognition by the abuser that abuse has occurred and the motivation of the abuser to eliminate the abusive behavior.**

Abusive parents are difficult to treat, and treatment should be undertaken by clinicians who have experience with abusive parents, and who are able to distinguish between genuine motivation to change one's behavior and an effort to manipulate the clinician. Chronic abusers are often described as having "poor impulse control." For some,

their actual motivation is to **express their impulses through the abusive acts without incurring negative consequences.** They see their children as appropriate objects of their frustrations, and therapeutic contacts as a way to stay out of jail. (Salter, Richardson & Martin, 1985)

Goal 5

Stabilize family.

- If household is isolated, link to culturally relevant community services (e.g., churches, community groups, etc.) for ongoing support.

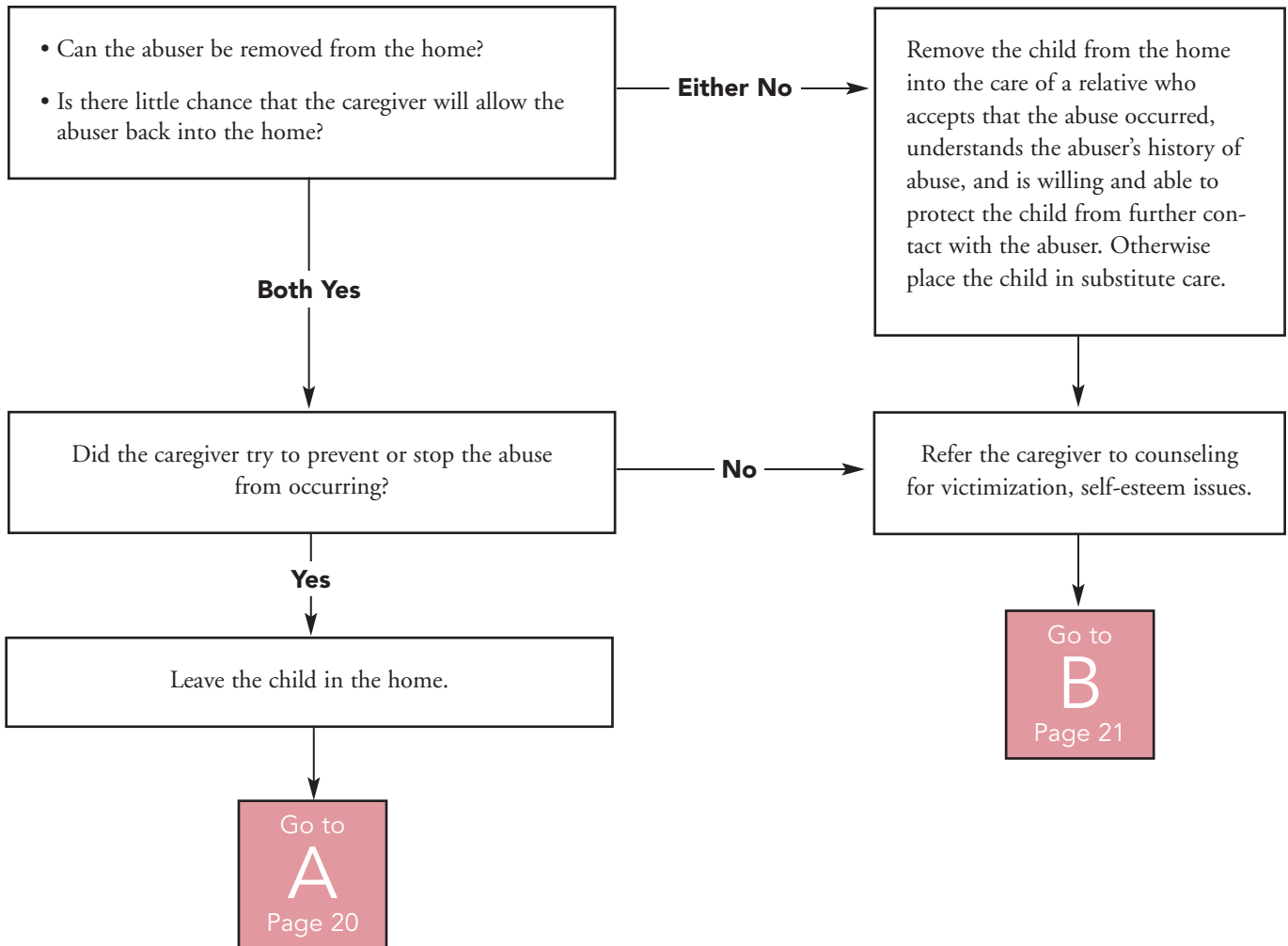
- Try to identify extended family that can help support this family emotionally.
- Abuser should be actively in treatment and progressing through treatment process.

Go to **Step 5** Page 22

Step 4. Goals and Services: Identify Goals and Services

Case type 4: Serial batterer

Goal 1 Protect the child.



Step 4. Goals and Services: Identify Goals and Services

A

Goal 2

Stabilize family.

- Refer to needed services in community or therapeutic services for child and/or caregiver.
- Make sure caregiver has reasonable plan and support for dealing with any contact by the abuser.

Go to **Step 5** Page 23

Step 4. Goals and Services: Identify Goals and Services

B

Goal 2

Stabilize family.

- Is caregiver willing to sever ties with abuser?
- Is caregiver actively participating in counseling?

Either No

- Begin concurrent planning.
- Continue working with caregiver to see that choice must be made between children and abuser.
- If caregiver is unwilling to sever ties with the abuser and participate in counseling, suggest relinquishment.
- Without improvement in situation, begin to implement alternative permanency plan.

Both Yes

- Provide in-home support services as needed or refer to community services.

Go to **Step 5** Page 23

Step 5. Achieve Permanency: Assure Permanency and Family Stability

**Case type 1: Misguided attempts at education and
Case type 2: Excessive corporal punishment**

After monitoring home for 3-6 months (depending on the child risk factors),

- without serious injury,
- with a reduction in the use of corporal punishment and an increase in the use of alternative disciplinary techniques,
- with family linked to appropriate community services to reduce household stress levels if needed,
- with household linked to culturally appropriate services and extended family, if available,
- with children in counseling if needed, and
- with caregivers educated about child development and appropriate disciplinary techniques and laws regarding corporal punishment, if needed, case may be closed.

Case Type 3: Battered Child

After monitoring home for at least 6-9 months (depending on the child risk factors),

- without serious injury,
- with caregiver successfully having completed treatment (or having progressed sufficiently based on advice of therapist),
- with family linked to appropriate community services to reduce household stress levels if needed,
- with household linked to culturally appropriate services and extended family, if available,
- with children in counseling if needed, and
- with caregivers educated about child development and parenting,
- with young children (preschool age) linked to services that assure regular contact, case may be closed. If caregiver is not successfully completing treatment, through regular attendance and recognized progress, move toward alternative permanency plan.

Step 5. Achieve Permanency: Assure Permanency and Family Stability

Case type 4: Serial Batterer

If the child is out of the home, and

- the caregiver is committed to protecting the child,
- the caregiver is committed to severing ties with the serial batterer,
- the caregiver has completed needed treatment or counseling,
- the family is linked to culturally appropriate, community services,
- young children (preschool age) are linked to services that can monitor care, and
- there has been no contact with serial abuser for at least 3-6 months, reunification may begin. Otherwise, begin steps toward implementing alternative permanency plan.

Once reunification has occurred, continue monitoring case without contact with serial abuser for 3-6 months.

If the child is in the home, and

- the caregiver has successfully completed needed treatment or counseling,
- the family is linked to culturally appropriate, community services, and
- the caregiver has continued commitment to keep serial abuser away from children for at least 3-6 months, case may be closed. If contact with serial abuser has resulted in additional injuries, alternative permanency plans should be implemented.

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