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Ready or Not: Uses of the Stages of Change Model in Child Welfare

Julia H. Littell and Heather Girvin

This article reviews the popular stages of change model, its potential applications in child welfare, and relevant research. Empirical evidence indicates that behavioral change does not occur in a series of stages. The article considers the validity of the stage model, its underlying assumptions, and other conceptualizations of readiness for change. Although the stage model may have some heuristic value, the empirical evidence suggests that its practical applications are severely limited.

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In cases of child maltreatment, parental motivation and readiness for change are of considerable interest to child welfare workers. Some believe that caregivers who are ready to change abusive or neglectful practices pose less risk of future harm to children and may be more amenable to treatment than are those who are not ready to change. Hence, readiness for change is considered an important component of risk assessment, case planning, decisionmaking, and allocation of treatment and out-of-home placement resources in child welfare (Gelles, 1995, 1996, 2000).

Readiness for change is a central component of the stages of change (SOC) model developed by Prochaska and DiClemente (1984, 1986, 1992). The SOC model is part of their larger transtheoretical model, which considers how people change problematic behaviors. The SOC model has gained widespread popularity in the fields of health psychology, mental health, and addictions, in which it is also the subject of considerable debate. Recently introduced to child welfare professionals, the SOC model is beginning to take hold in this field as well.

This article provides a review of the SOC model, its potential applications in child welfare, and empirical research on the model. It raises questions about the validity of the stage model and concerns about practical applications of the model in child welfare. The article also considers the heuristic value of the SOC model and other conceptualizations of readiness for change.

SOC Model

According to the transtheoretical model, behavioral change occurs in a series of discrete stages, whether within or outside of formal treatment, and in relation to virtually any problem behavior (Prochaska & DiClemente, 1984, 1986, 1992). Researchers identified stages in the mid-1980s and have revised the SOC model several times since (Isenhardt, 1994; Littell & Girvin, 2002). The current model consists of five stages (Prochaska, Velicer et al., 1994). In the precontemplation stage, people are unaware of a

problem or are not thinking seriously about change. People in the contemplation stage are aware a problem exists; they may struggle to understand the problem and begin thinking seriously about change. Those in the preparation stage are not just thinking about change but are getting ready to take some action to resolve the problem. In the action stage, people are making changes in their overt behavior and perhaps in their environment. In the maintenance stage, people may struggle to preserve gains they have made. If maintenance strategies fail, individuals may relapse, returning to a previous stage.

Progress through these stages is thought to be nonlinear and cyclical; people move backward as well as forward through the stage sequence and may cycle through the stages several times before attaining lasting changes in their behavior. Although stage status changes over time, at any given moment a person is assumed to be in a single stage; hence, the stages are thought to be mutually exclusive (Martin, Velicer, & Fava, 1996, p. 69). Individuals "pass through each stage" in an orderly fashion, and stage-skipping is not expected (Prochaska, DiClemente, Velicer, & Rossi, 1992, p. 825).

In the transtheoretical model, stages are linked to other constructs, such as a cognitive "decision balance" (weighing the pros and cons of a behavior), self-efficacy, and basic processes used to modify problem behaviors; however, the SOC model is the central organizing construct (Martin et al., 1996) and the portion of the transtheoretical model that has been of greatest interest to helping professionals (Davidson, 1992, 1998).

Initially developed in research on cigarette smoking cessation (DiClemente & Prochaska, 1982; Prochaska & DiClemente, 1983) and psychotherapy (McConaughy, DiClemente, Prochaska, & Velicer, 1989; McConaughy, Prochaska, & Velicer, 1983), the SOC model was quickly extended to alcohol dependence (DiClemente & Hughes, 1990) and other addictions, and then to a wide range of behaviors, such as overeating, safe sexual practices, and exercise acquisition (Prochaska, Velicer et al., 1994).

More recently, it has been considered in relation to child maltreatment (Gelles, 1995, 1996, 2000) and parental substance abuse in child welfare cases (Hohman, 1998; Rullo-Cooney, 1995). It might seem unlikely that common stages could be discerned across such a wide range of behaviors, but "the transtheoretical model was intended to be a general model of behavior change rather than being specific to a single behavior problem like smoking" (Prochaska & DiClemente, 1992, p. 201).

Potential Applications

Heuristic Uses

In the past, researchers have viewed readiness for change as "a dichotomous phenomenon, a presence or absence of motivation" (DiClemente & Hughes, 1990, p. 218). Clients were either ready or they were not. Similarly, behavior change has been described as "a one-step process—one simply changes from one form of behavior to another" (Gelles, 1995, p. 4). The SOC model is thought to have considerable heuristic value for practitioners (Sutton, 1996) because it portrays readiness for change and behavior change as phenomena that develop over time.

By suggesting that many behavioral problems are not quickly or easily remedied, the stage model may encourage greater patience and persistence in change efforts. The SOC model may promote less pejorative views of clients who are not ready for change and of those who relapse (Davidson, 1992). In the SOC model, problem denial (precontemplation) can be seen as a common state and a potential starting point in the change process. Some professional and continuing education programs for practitioners in child welfare and other human services have incorporated the model.

Practical Applications

Proponents claim that the change stages are practical predictors of treatment participation and outcomes across a variety of prob-

lems and populations (Prochaska & Velicer, 1997). "Interventions can only work if they are matched to a client's stage of change" (Gelles, 1996, p. 88). Researchers in several other fields are developing stage-matched interventions and providing stage-matched advice via computerized expert systems (Velicer et al., 1993) and self-help manuals (Prochaska, DiClemente, & Norcross, 1994). Some believe motivational techniques and experiential processes are most useful in the early stages, whereas behavior modification strategies and support for change efforts are appropriate in the action and maintenance stages (DiClemente, 1991).

Some child welfare scholars believe the SOC model is useful in assessing the risk of future harm to children, identifying appropriate interventions for families of abused and neglected children, and making out-of-home placement and reunification decisions (Gelles, 1995, 1996, 2000; Hohman, 1998; Rullo-Cooney, 1995). Gelles (1995, 1996, 2000) proposed a two-dimensional risk assessment model that considers assessments of risk of harm to children and the caregiver's SOC:

Addition of a new and critical dimension to risk assessment—readiness to change on the part of the abuser—would greatly improve both the process of risk assessment and the appropriate targeting of interventions in cases of child abuse and neglect. (Gelles, 1995, p. 1)

Using this two-dimensional risk assessment framework, Gelles (1996) showed how SOC might be linked to the provision of parent education, family preservation and reunification services, out-of-home placement, and termination of parental rights. He argued that "one of the reasons...child welfare interventions in general, and intensive family preservation programs in particular, have such modest success rates is that most interventions are 'action' programs often provided to precontemplators or contemplators" (1995, p. 12). Gelles hoped the development of an SOC measure for child maltreatment cases would result in better targeting of action-oriented interventions and more swift, deci-

sive actions to protect high-risk children. Child welfare workers "will have the ability to identify families where 'reasonable efforts' [to preserve families] are unlikely to work—e.g., high risk precontemplators" (Gelles, 1995, p. 13).

Hohman (1998) and Rullo-Cooney (1995) echoed the notion that different intervention strategies are needed at different change stages. Both suggested that motivational interviewing (cf. Miller & Rollnick, 1991) may be a useful strategy for moving substance-abusing caregivers through the early stages. Although Gelles (1995) believed that intensive family preservation services ought to be reserved for families with caregivers in the action and maintenance stages, Rullo-Cooney argued that motivational interviewing could be conducted during intensive family preservation services to make these services more effective with caregivers at earlier stages.

The utility of stage-matched interventions depends on the ability to identify stages accurately and efficiently (Weinstein, Rothman, & Sutton, 1998), which, as we will see, is quite limited.

Empirical Evidence

Proponents claim that there is strong empirical support for the SOC model across a wide range of populations and problems (e.g., Prochaska et al., 1992; Prochaska & Velicer, 1997; Prochaska, Velicer et al., 1994; Velicer, Hughes, Fava, Prochaska, & DiClemente, 1995; Velicer, Rossi, Prochaska, & DiClemente, 1996). In contrast, several reviews conclude that empirical support for the SOC model is weak (Carey, Purnine, Maisto, & Carey, 1999; Davidson, 1998; Sutton, 1996; Weinstein et al., 1998, p. 298). The following discussion is based on an extensive review of 87 empirical studies of SOC in the fields of health psychology, mental health, and addictions (see Littell & Girvin, 2002). There are no published studies of the SOC model in child welfare samples, although several investigations are under way.

Assessment of Stages

Studies have assessed the SOC model in several ways. The most common involves applying an algorithm (a set of decision rules) to participants' answers to a few questions about their current behavior, future intentions, and past attempts to change. The algorithm is used to place each participant in a single stage. Questions and stage criteria are not consistent across studies that use this approach. For example, studies use various time frames in questions about future intentions, and some studies do not include questions about past attempts to change (Littell & Girvin, 2002; Weinstein et al., 1998). Any shift in algorithm criteria alters the distribution of people across stages (Weinstein et al., 1998, p. 293).

Other stage measures are based on the University of Rhode Island Change Assessment (URICA) scale (McConaughy et al., 1989; McConaughy et al., 1983) or one of its variants. URICA includes eight items for each of four hypothesized stages. The preparation stage is not included because that stage was added to the SOC model after the URICA scale was developed. Shorter forms are also available (Carbonari, DiClemente, Addy, & Pollak, 1996). Respondents rate their agreement or disagreement with each item on a five-point scale. These ratings are averaged to obtain independent scores for each of the four stages. Sample items are: "I may be part of the problem, but I don't really think I am" (precontemplation), "I have a problem and I really think I should work on it" (contemplation), "I have started working on my problems but I would like help" (action), and "I may need a boost right now to help me maintain the changes I've already made" (maintenance).

Several authors have noted that the URICA scale was developed in middle-class, white samples and may not perform well in other populations (Hutchison, 1996; Jefferson, 1991). Although some studies support the internal consistency of the URICA subscales, others do not (Carey et al., 1999; Littell & Girvin, 2002). Most attempts to use the URICA scale to classify participants into

stages have relied on the highest subscale score; however, tied (equal) scores on two or more subscales are often encountered. Methods for handling tied scores are not consistent across studies (e.g., some investigators place subjects with tied scores in the most advanced stage, whereas others treat these cases as distinct groups), and different methods produce quite different results (Hutchison, 1996; Tsoh, 1995).

It is assumed that either approach is appropriate for measuring the stages (Martin et al., 1996; Prochaska et al., 1992), but the stage algorithms and scales tap very different constructs. URICA does not use any of the algorithm criteria (current behavior, future intentions, past attempts to change), and it focuses on problem denial or admission, thoughts about change, efforts to work on problems, and concerns about relapse. Few published studies have compared results of stage algorithms and scales, but available evidence suggests that there is little agreement between them (Belding, Iguchi, & Lamb, 1996; Elder et al., 1990; Lerner, 1990; Stern, Prochaska, Velicer, & Elder, 1987).

Validity

If the stage model is valid, the stages should emerge as a set of mutually exclusive and qualitatively different states in cross-sectional analyses, and longitudinal studies should detect movement between adjacent stages. Some people might be in transition between two adjacent stages, but no one should be in two nonadjacent stages (e.g., precontemplation and action) at the same time. Although participants can be placed in mutually exclusive stage categories via an algorithm, this approach reifies but does not test the stage model. Scales that provide independent assessments of each stage are more useful in this regard.

Researchers have used several methods to test the validity of the stage model, using the URICA and similar scales. Some investigators have encountered tied subscale scores, which indicate that people can be equally involved in two or more stages at a time. Studies that used principal components or factor analysis do not consistently support the proposed stage structure.

Precontemplation usually emerges as a distinct component or factor, and the other stages are distinct in some studies (DiClemente & Hughes, 1990; McConnaughy et al., 1989; McConnaughy et al., 1983; O'Hare, 1996; Rollnick, Heather, Gold, & Hall, 1992) but not in others (Belding, 1993; Belding et al., 1996; Elder et al., 1990; Hutchison, 1996; Isenhardt, 1994; Lamb, Belding, & Festinger, 1995; Rosenbloom, 1991). Similarly, studies that used cluster analysis tend to identify a small but distinct precontemplation cluster (i.e., a group with high precontemplation scores and below-average scores on all other SOC scales) and anywhere from 1 to 17 other clusters with above-average scores on two or more scales or equivalent scores on all four scales (Beitman et al., 1994; DiClemente & Hughes, 1990; Hilburger, 1995; McConnaughy et al., 1989; McConnaughy et al., 1983; O'Hare, 1996; Willoughby & Edens, 1996).

For example, in O'Hare's (1996) analysis, only 10% of subjects had high scores on a single SOC scale (precontemplation), three other clusters had nearly equal means on two or more scales, and fully 42% of the subjects were in a cluster termed *uninvolved*, with approximately equal means on all four SOC scales. Several studies have found illogical patterns, such as high precontemplation and high action scores (e.g., Heather, Rollnick, & Bell, 1993). These results do not support the existence of discrete stages, claims to the contrary notwithstanding.

An observation made in 1983 still holds true today: "Rather than simply being in one stage or another, clients show patterns of differential involvement in each of the stages" (McConnaughy et al., 1983, p. 374). If a person can be in more than one stage at a time, "the concept of stages loses its meaning" (Sutton, 1996, p. 195).

Most of the recent research in this area has ignored the evidence that the stages are not mutually exclusive and uses algorithms to place people in a single stage. This creates an artificial stage structure. Based on the artifacts of algorithms, researchers have used advanced statistical techniques to develop models of stability and movement between stages over time (Hedeker & Mermelstein, 1998; Martin et al., 1996) and factors associated with

stage status or progression (Hedeker, Mermelstein, & Weeks, 1999). Although data from participants in different stages have been arrayed to illustrate progression through the entire stage sequence (Prochaska, Velicer, Guadagnoli, & Rossi, 1991), no known studies have actually documented this full progression.

Practical Applications

Stage-matched interventions are said to be more effective than interventions that are not matched to the stages (Prochaska, 1995), but there is limited empirical support for this assertion (Littell & Girvin, 2002). In the Project MATCH study, participants with high initial motivation did equally well in each of three different treatments for alcoholism. At four months, cognitive behavioral treatment seemed superior to motivational enhancement therapy for outpatients with low motivation, but this pattern reversed over time, with motivational enhancement becoming superior to cognitive behavioral treatment in this subgroup. This finding was only significant at one point in time (15 months), only for one of two outcomes examined, and only among outpatients (Project MATCH Research Group, 1997). It is unclear how stage-matched interventions can work, if the stages are not distinct.

In sum, the weight of the empirical evidence does not confirm the existence of discrete stages, orderly progression through a sequence of stages, or the benefits of staged-matched interventions. Critics suggest that, like all stage theories, the SOC model imposes artificial categories on continuous processes (Bandura, 1997, 1998; Davidson, 1992, 1998; Sutton, 1996). "Debate has emerged as to whether the descriptive aspects of the model oversimplify or even misrepresent the more complex reality of human change" (Miller & Heather, 1998, p. 1).

Stage Classifications in Child Welfare Cases

As in other fields, stage classification is not straightforward in child maltreatment cases. As the developers of the SOC model

observed, rarely is there "a single, well-defined problem...reality is not so accommodating, and human behavior is not so simple. Although we can isolate certain symptoms and syndromes, these occur in the context of complex, interrelated levels of human functioning" (Prochaska & Norcross, 1994, p. 470). A parent can be "precontemplating" (not thinking about) one issue, contemplating change in another, and making change in a third area related to child maltreatment. The following examples illustrate child maltreatment cases involving multiple stages:

Sheila is a 20-year-old single mother of two children, ages 3 and 5. She often leaves her children home alone for one or two hours in the evening, when she goes to a neighborhood bar. On several occasions, she hit her children harder than she meant to. One night she came home drunk and, irritated by the oldest child's whining, hit him so hard that she broke his jaw. Later that night, Sheila took the child to the hospital and claimed that he had fallen. Her explanation was not convincing, and the case was reported to child protective services. Sheila's memory of the incident was blurry, but she did recall hitting the child and told the investigator that she deeply regretted this and would never hit her children again. Sheila has kept this promise for a month and is beginning to think that she should cut down on her drinking. She does not think it is wrong to leave her children home alone for a couple of hours, because no harm has come to them in her absence.

Sheila could be classified as being in the action stage regarding physical child abuse, in the contemplation stage regarding her drinking, and in the precontemplation stage with regard to inadequate supervision of her children (child neglect).

Valerie punishes her children by hitting them with a belt, leaving bruises and welts. Like her parents, she believes this is an effective way to "teach children right from

wrong." After watching another parent give a child a time out, she is wondering whether this would work for her children and has begun to try it.

Valerie does not view her behavior as a problem but is making changes. She appears to be in the precontemplation, contemplation, and action stages at the same time in relation to a single behavior (hitting children with a belt). This is consistent with the observations cited previously that people can be simultaneously involved in multiple stages in relation to a single behavior (McConaughy et al., 1989) and that single-stage classifications are not accurate (Sutton, 1996).

Even if we could classify individuals according to change stages, the stage categories have multiple meanings and, hence, would include dissimilar cases. For example, the precontemplation category includes clients who deny they have a particular behavior problem, along with those who acknowledge the problem but are not ready to work on it; these are different issues that call for different intervention strategies. Contemplation covers a wide range of thoughts and intentions, from wishful thinking that things were different to serious consideration of alternatives. Among clients in the action category are those who are making real behavioral changes and those who only say that they are working on their problems.

Underlying Assumptions

The Nature of the Problem

The SOC model assumes that the client has a specific behavioral problem that can be resolved by the client, perhaps with professional help. Herein lie certain assumptions about the nature and locus of the presenting problem, assumptions that may or may not be valid in child welfare cases.

Locus of the Problem. In the SOC model, the locus of the problem is in the individual. This is evident in the URICA items and

SOC algorithms, which focus exclusively on intrapersonal problems and problem behaviors. Although child abuse and neglect can certainly be viewed as caregiving behavior problems, the locus of these problems is not solely intrapersonal. Factors that contribute to child maltreatment include inadequate housing, child care, and economic resources. In many cases of child neglect, the primary problem is poverty (Lindsey, 1994; Pelton, 1989).

Social Construction of the Problem. The SOC model was originally developed in relation to well-defined health decisions (e.g., cigarette smoking and cessation). In contrast, caregiving behavior problems are often ill defined (e.g., "inadequate supervision"). Definitions of child abuse and neglect are socially constructed (Nelson, 1984), and important cultural and individual differences exist in distinctions between less-than-ideal parenting and child maltreatment (Giovannoni, 1989; Rose & Meezan, 1996), particularly in relation to the use of corporal punishment and adequate supervision of children. Reasonable people disagree about what constitutes maltreatment and whether a problem has to do with parenting. Furthermore, legal definitions of abuse and neglect are not consistent across states, and members of different helping professions use different definitions (Giovannoni, 1989).

Attribution bias contributes to different constructions of the problem. Brehm and Smith (1986) noted that "across a variety of settings, individuals are likely to assign causality for their own behavior to external, situational factors, but assign causality for the behavior of others to internal, dispositional factors" (p. 76). "Thus, parents 'blame' their children, and county social workers 'blame' parents for problems in a family" (Robin, 1989, p. 124). Child maltreatment is usually identified as the primary problem and is the focus of concern for child welfare workers, but children's caregivers may have very different perspectives on the issue. For caregivers, other problems—such as poverty, unemployment, parental stress, loneliness, domestic violence, and children's health or behavior problems—may be paramount. Some parents, like Valerie, do not view their treatment of chil-

dren as abuse or neglect. Some clients view the problem as the intrusion of the child welfare system into their lives.

The social construction and locus of a problem are critical, but the SOC model does not take them into account. It begins by assuming the client has a particular problem and, in the case of precontemplators, someone else has defined the problem. Clients who do not agree with someone else's assessment of their situation, those who say, "I'm not the problem one" or "The problem doesn't have to do with me" (McConaughy et al., 1989) are too easily labeled precontemplators. Other plausible explanations for problem denial include the absence of a problem (as in cases in which false allegations of maltreatment have been substantiated) or disparate views of the situation.

The client's perception of the nature of the problem and its causes, course, and potential solutions (what Leventhal, Lambert, Diefenbach, and Leventhal [1997] termed the "problem domain") are paramount in several models of client participation in treatment (Littell, Alexander, & Reynolds, 2001) and may be important in understanding readiness for change.

The Nature of Readiness for Change

In the SOC model, readiness for change is discussed in relation to a set of discrete, internal states that have cognitive and behavioral components. Others have viewed readiness for change as a continuous process that may have affective components and may be heavily influenced by social and environmental factors.

Discrete States Versus Continuous Processes. There is little evidence that certain thoughts and behaviors form discrete states or stages. "Motivation or intention to change may be more realistically thought of as a continuum with no necessary assumption that people move along this continuum in one direction or through a sequence of discrete stages" (Sutton, 1996, p. 203). Bandura (1997) suggested that

people do not recycle through stages. They fluctuate in their struggle to exercise control over their health behavior...In these behavioral fluctuations, which can occur quickly in some health domains, people are varying in their self-regulatory command, not undergoing repeated transformational changes. (pp. 413-414)

Indeed, "many of the data taken as supportive of the stage model are arguably more consistent with a continuous model" (Davidson, 1998, p. 36).

Affective Components. In addition to cognitive and behavioral components, readiness for change may have affective aspects as well. Ripple, Alexander, and Polemis (1964) viewed client motivation as a balance between discomfort with the status quo and hope for the future. They thought this "discomfort-hope balance" could be affected by relationships between clients and caseworkers and by treatment settings.

Social and Environmental Influences. Readiness and resistance to change are complex phenomena (Berry, 1998) that do not reside solely in the client (Gitterman, 1983; Miller, 1985; Moore-Kirkland, 1981). Social and environmental pressures influence clients' views of their problems and alternatives. Readiness for change is often confused with readiness for a particular intervention (Carey et al., 1999). A client may be ready to change but not amenable to working with a certain caseworker, not interested in the type of intervention offered, or not comfortable in the treatment setting. When readiness for change is assessed in a context that is uncomfortable for the client or not conducive to change in the client's view, he or she may appear unwilling to change. Hence, resistance or lack of motivation are sometimes attributed to the client when their sources are interactional or environmental (Gitterman, 1983; Miller, 1985).

Most clients enter the child welfare system on an involuntary basis, and some feel powerless in this system (Diorio, 1992). Readiness

ness for change may be particularly difficult to assess under such circumstances. Resistance and hostility may be rational responses to an intervention that is viewed as unnecessary, intrusive, or coercive (Pelton, 1989). Furthermore, some child welfare clients seem to focus on the potential consequences of their responses to questions about their readiness for change. Veterans of the child welfare system may learn that it is to their advantage to say that they are working on their problems. The SOC model does not distinguish between responses aimed at appeasing others and genuine interest in behavioral change. Assessment of client readiness for change is further hampered by the limited information available to child welfare workers and pressures on them to respond quickly and protect children.

Locus of Change. In cases of severe parental mental illness or failure to protect children from physical or sexual abuse by someone else, it is not always clear whether changes in the caregiver's behavior will solve the problem. Hence, the caregiver's readiness for change is not always relevant.

Summary

Empirical evidence contradicts the SOC model. The concept of readiness for change is not well defined and, despite decades of research on the topic, our understanding of human motivation and readiness for change has major gaps. It is not clear whether readiness for change is a continuous process or set of processes. Issues related to motivation and readiness for change appear to include clients' perceptions of the locus, severity, and potential consequences of their problems; discomfort with the status quo and with change; the perceived relevance, efficacy, and demands of available intervention or change strategies; psychological and sociological barriers to change; and competing demands. The SOC model addresses only some of these issues.

The SOC categories do not shed light on the how the client views the situation (the problem domain), what alternatives he or she has considered, or the extent and nature of the client's efforts to change. The stages are assessed in isolation from the social and environmental contexts in which problems occur. The content and context of problems related to child maltreatment may be far more important than stages or categories of change.

Implications

Heuristic Value

Given the lack of solid empirical support for the model, Sutton (1996) believed that the SOC model

should be thought of not as a descriptive model but as a *prescriptive* model—a model of *ideal* change. It prescribes how, from the viewpoint of a therapist or [caseworker], people *should* change and suggests how they might be encouraged or helped to change. (p. 204)

The SOC model suggests that lasting change should be preceded by a period of reflection (contemplation), in which one makes a commitment to change, and by thoughtful preparation for the change process. The message is "think before acting." This approach appears to work for some people and under certain circumstances, although a period of contemplation is not always necessary for successful change.

The SOC model may promote a less pejorative view of clients who are not ready to change and those who relapse (Davidson, 1992). The model may also encourage greater patience and persistence on the part of clients, caseworkers, and policymakers. This runs counter to interest in identifying—and weeding out—"untreatable" families in child welfare (see Jones, 1987). In the SOC model, no one is untreatable.

With its emphasis on the nonlinear nature of behavioral change and the potential for relapse, the SOC model has implications for the goals and expectations of child welfare interventions. Lasting behavioral change is a primary goal in many child welfare cases, but this may be difficult to achieve in families with multiple and chronic problems, including substance abuse. Instead of seeking quick fixes for complex social problems, policymakers need to develop more realistic expectations, and child welfare workers need better ways to document problems and progress. Short-term interventions are unlikely to produce dramatic, lasting effects on caregiving behavior or family living conditions but may be successful in helping caregivers recognize and begin to deal with the problems they face. When maltreatment results from inappropriate caregiving behavior, increased readiness for change on the part of the caregiver may be an appropriate proximal goal and an indicator of progress.

On the other hand, the SOC model could be used to justify "creaming"; that is, a perversion of the principles of triage, in which scarce service resources are provided to motivated clients and denied to those who are viewed as reluctant to change, regardless of problem severity or other considerations. As Gelles (1995) noted, most child welfare services are "action-oriented," that is, geared for clients who are ready for change. In general, interventions for involuntary clients have been based on traditional models of treatment that were developed with voluntary clients (Rooney, 1992), as if volition does not matter. This raises questions about the suitability of available services for involuntary clients and whether the current array of interventions meets the diverse characteristics and needs of families in the child welfare system. Perhaps reasonable efforts to preserve families should include cognitive-behavioral and motivational interviewing techniques developed for clients who are not ready for change (Miller & Rollnick, 1991; Rullo-Cooney, 1995). In this sense, the SOC model could be used to develop a more complete continuum of care that recognizes clients' diverse views and interests.

Practical Applications

In child welfare, dilemmas in the use of the SOC model arise when the primary problem is not behavioral or is largely outside the client's control, when the worker and client have fundamentally different views about the nature of the client's problems, and when the model is applied to a complex constellation of problems. At most, the SOC model applies only to a subset of child welfare cases: those with behavior problems that contribute to child maltreatment. Even when specific behavior problems are identified, clients' thoughts and actions are not likely to fit into a single stage. Although it would be useful to have neat, empirically based models to guide child welfare workers' decisions, an invalid stage model is of limited usefulness in this regard. Instead of applying stage categories to specific cases, child welfare workers should focus on the problem domain and try to understand clients' perspectives on their problems and alternatives.

Readiness for change is not solely an intrapersonal state. It is affected by social and environmental pressures and may be particularly difficult to assess accurately in involuntary contexts. Child welfare workers should be cautious in assessing client motivation and consider the potential effects of their actions and the setting on client readiness for change. Furthermore, they should not confuse readiness for change with willingness to cooperate with a worker or readiness to participate in a particular kind of treatment.

DePanfilis (2000) suggested that child welfare practitioners can develop understanding of client motivation and readiness for change by assessing the client's comfort with the status quo, degree of hope that the situation can be improved, values, and goals. These issues are relevant for practice and far more important than attempts to place clients in artificial stage categories.

Conclusions

The SOC model has generated considerable discussion and interest in readiness for change and the processes of change. The

model may have some heuristic value for child welfare workers and may promote more patience, persistence, creativity, and realistic expectations in change efforts. Of course, it can be argued that a stage model is not needed to promote these principles.

Given the lack of empirical support for the SOC model, practical applications of the model are severely limited. People cannot be accurately classified according to stages, in part because the model does not take into account the diverse content and contexts of problems related to child maltreatment. Although the model may be useful for heuristic purposes, the empirical evidence suggests that classification of individual cases according to the SOC model and stage-matched interventions are ineffective. This argues against the use of the SOC model in risk assessment or to justify placement or service decisions. We have a long-standing need for careful, multidimensional assessments of family problems, strengths, and risk, along with empirical and administrative support for casework decisions. ♦

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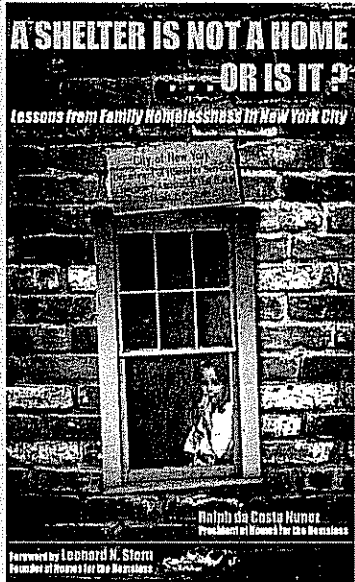
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Comparing the Health Status of Low-Income Children in and out of Foster Care

Robin L. Hansen, Fatema Lakhani Mawjee, Keith Barton, Mary B. Metcalf, and Nancy R. Joye

Children in foster care face poverty, family dysfunction, neglect, and abuse, with high rates of chronic health, emotional, and developmental problems. This study compared the overall health status of a group of children entering foster care with a group of Medicaid-eligible children living with their parents, matched for age and gender. It identified significantly more health and developmental problems in children in foster care than in the comparison group. Possible contributors to the higher percentage of problems among foster care children may be that the foster children have more problems related to the underlying risk factors resulting in placement, or that the foster care physicians conducted a more comprehensive assessment or had lower clinical thresholds. Further research is necessary to identify and treat the problems of this high-risk group.

Robin L. Hansen, MD, is Associate Professor and Vice Chair; Mary B. Metcalf, MD, and Nancy R. Joye, MD, are Clinical Professors, Department of Pediatrics; Fatema Lakhani Mawjee, MS, is Medical Student; and Keith Barton, PhD, is Professor, Department of Human and Community Development, University of California, Davis