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## THE UNTREATABLE FAMILY

DAVID P. H. JONES, MB.CHB., M.R.C. PSYCH., D.C.H. D(OBST)  
R.C.O.G.

Consultant in Child and Family Psychiatry, The Park Hospital for Children, Old Road, Headington,  
Oxford OX3 7LQ, U.K.

**Abstract**—The untreatable family is defined as one in which it is unsafe to permit an abused child to live. Despite the fact that many families turn out to be resistive to treatment, they have received very little attention. In the field of physical abuse, 16-60% of parents reabuse their children following the initial incident. Sexual reabuse is estimated to occur in 16% of cases. Treatment of abusive families also aims to alter family functioning. From studies in physical abuse we find 20-87% of families are unchanged or worse at the end of treatment. In sexual abuse the equivalent figures are 16-38%. Parental factors associated with a poor outcome include parental history of severe childhood abuse, persistent denial of abusive behavior, refusal to accept help, severe personality disorder, mental handicap complicated by personality disorder, parental psychosis with delusions involving the child, and alcohol/drug abuse. Parents lack empathy for their child and fail to see the child's needs as separate from their own. Severe forms of abuse (fractures, burns, scalds, premeditated infliction of pain, vaginal intercourse or sexual sadism) are more likely to prove untreatable. Munchausen by proxy, nonaccidental poisoning, and severe forms of nonorganic failure to thrive are similarly resistant. An early recognition of untreatability may help to reduce burnout by diverting precious resources from the untreatable to the families for whom there is relatively more hope.

**Résumé**—L'auteur définit la famille intraitable comme une famille dans laquelle il est imprudent de laisser un enfant qui a été maltraité et de lui permettre de continuer à y vivre. Bien des familles sont résistantes aux traitements et malgré cela on s'est peu occupé d'elles. Il est reconnu que dans le domaine des sévices physiques le 16 à 60% des parents récidivent et infligent de nouveaux sévices à leurs enfants à la suite de l'incident initial. On estime qu'en ce qui concerne les sévices sexuels la récurrence survient dans le 16% des cas; le traitement des familles violentes a pour but d'altérer le fonctionnement familial. Quand on regarde les choses de près dans les cas de violences physiques le 20 à 87% des familles n'ont pas changé ou sont même pires à la fin de la thérapie. Le chiffre pour les sévices sexuels est de 16 à 38%. Les caractéristiques des parents ayant un mauvais pronostic comprennent: une anamnèse de sévices sexuels subis dans l'enfance, le manque persistant d'aveux, le refus de toute aide et des troubles graves de la personnalité, l'arriération mentale compliquée par un trouble de la personnalité, la psychose avec hallucinations au sujet de l'enfant ainsi que la toxicomanie à l'alcool et aux stupéfiants. Ces parents n'ont aucune sympathie pour leur enfant, ils sont incapables de considérer les besoins de leurs enfants comme étant différents des leurs. Les formes graves de sévices sont plus souvent intraitables que les formes mineures (fractures, brûlures par des liquides, sévices douloureux infligés avec préméditation, rapports sexuels vaginaux et sadisme sexuel). En outre le "syndrome de Munchausen par procuration," l'empoisonnement non accidentel et les formes graves d'hypotrophie d'origine non organique sont également résistantes au traitement. Il serait utile que l'on reconnaisse très tôt les familles intraitables afin de réduire le phénomène de lassitude ressenti par les gens des professions qui s'occupent de ces problèmes et afin de réserver les quelques ressources disponibles pour le service des familles qui ont un meilleur pronostic.

### INTRODUCTION

STUDIES OF ABUSIVE FAMILIES reveal a proportion who fail to respond to treatment [1-8]. However, there have been remarkably few in-depth studies of such families [9]. The idea that some families do not respond appears to be anathema to some practitioners and researchers alike. Yet the reality for those who work in the field of child abuse is that some families cannot be treated or rehabilitated sufficiently to offer a safe enough environment in which children can live. In England there have been outpourings of public indignation, combined with critical official inquiry, whenever a child dies from further parental abuse while a rehabilitative plan is underway [10-12]. Still in some quarters to determine that a family is untreatable is unacceptable. This paper contends that there is

much to learn from such study. Furthermore, helping parents understand that it is not safe for their child to live with them would seem equally therapeutic as helping families lay aside abusive tendencies. If we are to avoid tragedies such as the Jasmine Beckford case in England [10], we must possess sufficient objectivity to be able to identify a family as untreatable or unresponsive to treatment. Further management policy can then be based upon this conclusion.

Clinical experience suggests that there are several different categories of families that do not respond to treatment. None of the published studies have examined the extent to which the following categories contribute to the overall conclusion, "untreatable." They are noted here, however, in order to underscore different reasons for a family's failure to respond to treatment:

1. There are some families who simply will not change. They do not intend or want to change.
2. Some parents persistently deny abusive behavior in the face of clear evidence to the contrary.
3. Some families cannot change in spite of a will to do so. There may be a subgroup here of families who are willing to change but resources to help them are not available.
4. Some parents can change, but not "in time" for their child's developmental needs. For example, a 6-month-old baby's abusive parent, who after two years becomes less impulsive and dangerous, but in the meantime whose baby has developed a strong attachment to a surrogate parent.
5. Similarly, other parents may change in time for their next child but not for the index one.
6. Finally there is the category of untreatable parents who fail to respond to one treatment approach but who may be amenable to another agency or approach.

An issue which is linked to the fourth and fifth situations is that of the adult who responds well to a treatment approach aimed at his/her individual problems but who fails when extending the progress made in the individual sphere to the interpersonal one. Thus an abusive parent may be a treatment success as an individual yet still be unable to be an adequate parent or spouse. For example, one mother's psychiatrist recommended that her 2-year-old child be returned to her after one year in foster care because the mother had made such good progress in the treatment of her anxiety neurosis. No assessment had been made by a children's professional, in spite of the fact that the mother had deliberately poisoned her child with Amitriptyline (nonaccidental poisoning is a diagnostic category which has proved hard to treat). Three years after return to her parents, she reappeared in the system, sexually and emotionally abused within her family with direct collusion by her mother.

This paper reviews studies of untreatable families, considers the potential benefit of further work, and briefly considers other fields of study which have a bearing on such families. It concludes with an overview of our present understanding of untreatable families.

### FREQUENCY OF UNTREATABILITY

How many families do not respond to rehabilitative attempts? There are various ways of approaching this question. One is to ask what proportion of abused children are re-abused during or immediately following attempts to rehabilitate. Table 1 shows reabuse rates.

Table 1. Rates of Reabuse

Study	Proportion of Sample Re-injured
Cohn, 1979	30%
Green et al., 1979	16%
Herrenkohl et al., 1979	53% (37%*)
Lynch & Roberts, 1982	20% (13%†)
Morse et al., 1970	35%
Rivara, 1985	30%
Skinner & Castle, 1969	60%
Taw, 1979	56%

\* Proportion re-injured in the extra-treatment group.

† Proportion with demonstrable injuries.

### Recidivism

Methods used to measure reabuse vary. For example, Taw scrutinized the social service case records and revealed documentation of reabuse which was not reflected in official figures and records [8]. Lynch and Roberts searched hospital admission records and did individual case follow-up to arrive at their 20% figure [3]. Other studies were less exhaustive in their search for evidence of reabuse. The rates of reabuse do correlate with the intensity of the rehabilitative program. The higher figures in Table 1 derive from those programs which utilized a case management response [7, 8, 13-15]. The lower rates come from programs which contain various forms of psychotherapy [3, 7, 9]. Within Cohn's study of 11 separate treatment programs, those with active outreach components did better than those without [2]. Thus there is support for the idea that intensive casework with a psychotherapeutic element is associated with less reabuse than purely child protective programs. What is not clear, however, is whether selection plays a part in these differences. Do the more successful programs enjoy the luxury of deciding whom they will treat? Do local authority social workers get left with hopeless cases, and instead of managing to convince the courts of this fact, carry out a rehabilitative plan which fails, resulting in higher rates of reabuse? More work is needed to clarify the reason or reasons for variation in reabuse rates between different programs; however, it is clear that it is high. In the above studies the type of abuse was usually physical abuse and/or child neglect. Only a few cases of sexual abuse were represented.

Sexual abuse programs have existed for a shorter period of time and thus studies of reabuse rates are more difficult to find. Table 2 sets out the reabuse rates for those programs which specialized in the treatment of sexual abuse.

The rates vary widely [6, 7, 16]. Bentovim et al.'s figure is similar to that obtained in intensive physical abuse treatment programs and corresponds with clinical impression [6]. We emphasize, however, that children who have been reabused sexually within the family would be unlikely to report their experience a second time [17]. Low rates of reabuse in incest offenders were reported by Gibbens [18]. However, in studies such as this the offender is removed from the family to prison, making it difficult to compare the findings to family-oriented treatment programs. Many clinicians consider that the figure initially achieved in Giarretto's program may well be optimistic as anecdotal reports of reabuse increase [16]. The secrecy issues in child sexual abuse compel us to look further than simple recidivism in order to assess efficacy of treatment.

Table 2. Re-abuse Rates, Sexual Abuse

Study	Proportion of Sample Re-abused
Bentovim et al.	16% + 15% 'concern'
Herrenkohl et al., 1979	50%
Kroth, 1979	0.6%

### Treatment Response Rates

Another way of looking at the issue of how many families do not respond to rehabilitation is to examine treatment response ratings. Table 3 shows those studies where this has been done.

Here again results of treatment programs are sobering. The majority of the programs report a limited response to treatment. A variety of different methods of assessing the outcome have been used, but, in general, the results mirror those for recidivism. The way in which improvement is defined varies between the studies. The most relevant measures are those of parenting ability, feeling for the child, or family functioning. None have included child variables in their outcome measures or a combination of child and parental ones.

Lynch and Roberts emphasize that their study reports the outcome for children and families and should not be taken as an evaluation of treatment efficacy [3]. Thus to extrapolate any results of treatment from their work is hard; however, 9 out of 39 children did well (23%). Blythe [19] and Smith et al. [20] have provided useful critiques of outcome evaluation methods in child abuse treatment programs. Both studies emphasize that problems in the definition of abuse as well as the measurement of successful outcome have bedeviled work in this field. Smith et al. emphasize that outcome must include measurement of the quality of life for the abused child [20].

Despite these methodological problems, more intensive treatment programs appear to produce better results [1, 5, 6, 9, 16]. Support for the value of psychotherapy also comes from the study by Herrenkohl et al. The subgroup who received individual or group therapy did better than the larger group who received casework only [7]. Furthermore, the highest rates for failure of intervention stem from those programs with few psychotherapy or outreach components. This would suggest that the formation of a therapeutic relationship with the abusive family is an important ingredient over and above casework. It also suggests that outreach and active follow-up are necessary [2].

In Table 3 three studies concentrate on child sex abuse outcomes. Here results are variable but improvement in approximately two-thirds of cases seems realistic with the remainder either showing no change or worsening. Again comparison between studies is difficult as treatment refusers are not always included in sample descriptions, and selection criteria are not specified. Kroth's study of Giarretto's program concentrates on data from therapist or parent, as opposed to direct observation of family functioning, parenting, or the child's report [16]. Therefore, care must be taken with the interpretation of these results.

Table 3. Abusive Families' Response to Treatment

Study	Type of Abuse	Proportion of Sample Unchanged/Worse
Cohn, 1977	PA + neg	58%
Gabinet, 1983	PA	68%
Green et al., 1981	PA, neg. + CSA	32%
Kempe & Kempe, 1978	PA	20%
Rivara, 1985	PA (in under 2s)	87%*
<b>Sexual Abuse</b>		
Bander et al., 1982	CSA	38%
Bentovim et al., in press	CSA	35%
Kroth, 1979	CSA	16%*

\* Extrapolated from author's data

## DESCRIPTIONS OF UNTREATABLE CASES

Another way of understanding the problem of untreatable families is to look at the characteristics of those who fail. Some authors have described their treatment failures in detail [1, 4, 9]. Various dimensions have been examined but not with a methodology which allows the different weight attached to variables to emerge clearly. These authors have largely concentrated on personality attributes or psychiatric description of the parents [1, 4, 9]. There has been less emphasis on relating treatment failure to severity or type of initial abuse, parent-child interaction, family functioning, quality and type of treatment, or child variables. Additionally, the issue of whether court-ordered clients do better than voluntary patients is not clarified. Although two studies suggest that court pressure does not help the rehabilitative process, a closer look simply shows that those who fail treatment have also been court ordered [4, 9]. This result is expected as both the parents who fail and the court ordered are likely to have several features in common: namely, parents causing more serious injury, parents with less motivation in treatment, and parents with more antisocial characteristics who display more hostility toward the system. Wolfe et al.'s randomized prospective design, with some clients being court ordered and others voluntary, provides much more compelling evidence that the civil court-ordered treatment group did better [21].

The Kempes pointed to seven groups of parents who commonly proved untreatable: aggressive sociopaths, parents with delusions that involve the child, cruel sadistic parents who with premeditation painfully abuse their children, extreme fanatics, drug and substance abusers, mentally handicapped parents, and those families with a history of prior serious injury or child abuse death [1]. Gabinet found that parents who were sociopaths, addicts, severely inadequate personalities, mentally handicapped combined with a personality disorder, and focal abusers were over-represented in her untreatable families [4]. (Focal abusers were those whose major problem area was child abuse, similar to some of the Kempes' fanatics who were often outwardly respectable yet parented their children abusively.) In Gabinet's study, severely mentally handicapped or psychotic parents were not accepted for treatment. The other major group who proved untreatable were those who refused treatment.

Green et al. found that parents who repeatedly abused their child prior to discovery, who were involuntarily in treatment, who ended treatment prematurely against advice, who denied that they had abused their child, who were themselves seriously abused in childhood, who now had premature expectations of their child, and who showed impaired ability to relate to other adults were more likely to be treatment failures [9]. This study contained some assessment of program variables and found that home visiting was associated with greater success.

The treatment refusers, early dropouts, and those who steadfastly deny wrongdoing are an important group both numerically and methodologically when considering untreatable families. Such parents were featured in all three studies [1, 4, 9] and were also important in Smith and Rachman's evaluation of a behavioral management program for child abuse [22].

Schetky et al. report their experience in assessing families prior to termination of parental rights [23]. They found that parental deficiency in capacity for empathy, viewing the child as a possession, a parent's history of abuse in childhood, parent's low self-esteem, poor judgment and impulsivity, maternal psychosis, and paternal personality disorder (usually sociopathy) were common in the parents whose rights were terminated. They additionally noted that many of these parents refused help or treatment.

## TYPES OF ABUSIVE ACT AND UNTREATABILITY

We can also consider whether the type of abusive act affects prognosis. For example, is physical abuse more or less responsive to treatment than sexual abuse? Is one type of assault associated with a worse prognosis than another? Comparative data between broad types of abuse is not available as yet, and so we cannot say whether physical abuse is more or less responsive to treatment than sexual abuse. Whether such a broad comparison would be clinically useful, even if it were available, is doubtful. We do have preliminary information about discrete types of abuse which appear to be associated with a worse prognosis than others. For instance, nonaccidental poisoning and Munchausen's syndrome by proxy are both types of abuse associated with a poor prognosis [24-27]. Such cases involve a significant mortality rate for the child as well as a high proportion of families that prove resistant to treatment efforts. The more severe forms of nonorganic failure to thrive (with the most disturbed parent-infant interactions as well as children with psychosocial short stature) have a worse prognosis than milder varieties [28]. Abuse which reflects a sadistic component, such as abuse which involves the infliction of slow, premeditated pain, cigarette burns and torture have been found to be more resistive to treatment [1, 3, 9]. More severe injuries such as burns and scalds do seem to be associated with a worse prognosis [9]. However, studies that compare injury type, while carefully controlling for parental personality and other variables, are not currently available. Nevertheless the consistent trend is that the more severe, as well as those specific types of abuse mentioned above, are associated with poorer outcome.

In the field of child sexual abuse there have not been clinical descriptions of untreatable families. Clinical experience to date suggests that similar groups of parental attitudes and problems as well as the more severe forms of child sexual abuse are associated with a worse prognosis for family rehabilitation [6, 17]. For example, parents who deny the responsibility or who refuse treatment are unlikely to do well. Similarly those situations where the nonabusive spouse chooses the perpetrator over and above her child have a poor prognosis.

Thus a picture emerges which emphasizes the poor prognosis for parents who have major personality disorders, psychoses that involve the child, addiction problems, or mental retardation. Untreatable parents are commonly those who were seriously damaged as children and who appear to have little or no capacity to love, relate to others, or empathize with a child. Additionally they are hostile, refuse help or treatment, and persistently deny the need for such. There is evidence that specific types of abuse, as well as abuse resulting in severe injuries, may be associated with a poorer prognosis. Many abusive families have elements of the above features. However, the studies suggest that extreme degrees of the above situations, as well as their occurrence in combination, are common in untreatable families.

## POTENTIAL BENEFIT OF FURTHER RESEARCH

What could be gained by further examination of the problem of untreatable families? What more do we need to know? In the first place, more precise studies are needed to allow us to tease out the relative contributions of different factors to the overall conclusion that a family is untreatable. Problems of definition are commonplace in child abuse research [29], but working definitions are available as a base line for studies of outcome. A variety of measures of outcome is needed to do justice to a multifaceted problem such as child abuse, for example, including the prevention of further abuse, improving the

quality of the child's life—emotionally and behaviorally—physical growth, and enhancing the quality of parenting and family communication.

In this way we should be able to understand why and in what respect a family has proved untreatable. Most studies have concentrated on descriptions of personality variables and psychiatric diagnoses of the parents of untreatable families. These are vital data, but we also need data on other areas to obtain a complete picture. Quality of parenting is one area that has not received enough attention, yet a combination of self-report, professional report, and direct observation does allow valid observations to be made about this aspect of family life. Dowdney et al. [30] provide a good example. Family variables, too, have been relatively neglected. Family structure, emotional tone, hostility, capacity for empathy, and communication ability can all be observed in family sessions. Research has not yet established whether the prognosis is poorer if both parents are abusive, although very likely this would hold true. Type and severity of abuse may well be important prognostic indicators. While some observations indicate this is true, more data is needed [9]. Severity of sexual abuse has been related to outcome [31, 32], but we need to determine the essential components of severity (i.e., genital versus nongenital, use of force or violence, or other variables). Our own preliminary findings suggest that vaginal penetration is the noxious ingredient as opposed to physical harm, force employed, or the duration of abusive activity [33]. Child factors have also been ignored in the studies to date. Does the child's understanding of the meaning and cause of the abusive experience relate to outcome? Some children seem well aware that they were abused by a parent and that they, as children, were not responsible for this misdeed. Others feel guilty and responsible, sensing that they were maltreated because of some badness within. Such perspectives can be understood as the cognitive impacts of abuse: some adaptive, others maladaptive. Do these cognitions relate to case outcome?

Finally, in our experience some of the children who were reabused by their parents knew that treatment was incomplete. "It was too early. I'd changed a lot but I knew my dad hadn't." Do we ignore the child's viewpoint? After all, the child may know his/her family better than professionals, provided his/her perspectives can be dissected from all the other pressures the abused child faces.

Factors such as these can be correlated with both untreatable as well as successfully treated families. Concentration on the untreatable family means that important differences between factors associated with good and bad outcomes fail to emerge. Outcome studies which highlight these two ends of the spectrum are likely to be more fruitful than restriction to either extreme.

Few published studies have included the therapeutic and professional system variables in their analyses. What are the effects of court-ordered treatment for example? Does the type and quality of social work response correlate with outcome? There is preliminary work to suggest that it does [34], but the quality of social work response has not as yet been linked with parent, child, and family variables in the assessment of outcome. Clinical experience suggests that the quality of a therapeutic relationship is important. After all, some workers get on better with deprived, hostile, abusive parents than others. Including this dimension would seem necessary in outcome studies.

The impact of foster care placement and whether such placements encourage visits and contact with the natural parents is another area requiring further research. Studies to date suggest that the type and quality of foster care placement may well be important to the eventual case outcome [34]. However, further research is needed to clarify the relative contributions of parental, family variables, and foster care to the final case outcome.

There has been little emphasis upon the process of treatment. An adequate conceptual framework within which to place treatment efforts must originate from a concept of the

impact of abuse upon the victim [35, 36]. Such a framework allows us to set realistic aims of treatment, over and above the aim to stop further abuse. Outcome studies are also needed which specify the type of therapy employed, whether casework, family group work or individual therapy, therapy with an accent on play groups, day centers, parent groups, or a combination of these [19].

### ASSESSMENT OF DANGEROUSNESS

We have looked at aspects of the families we treat and considered how more precise studies may enable us to tease out the factors involved in producing a successful or unsuccessful outcome. Professionals in other fields, such as forensic psychiatrists and psychologists, have grappled with the pressure upon them to accurately predict the response of individuals to treatment or intervention [34, 38]. While some have stated that such mental health forecasting has little to offer, some helpful indicators in the assessment of dangerousness have emerged. These include the number of prior violent episodes; the precipitants of prior violence (can they be understood by professional or patient, and, perhaps even more important, can the patient make use of such an understanding?); the degree of sadism or sexual deviancy involved in the aggressive assault, as well as present day sexual feelings, urges and functioning; drug or substance abuse at the time of the offense and the present level of dependence; interpersonal skills, including relationships with significant others; and a capacity for empathy and feeling for past victims, present friends, and children. While attempts are being made to quantify these and other factors [39], essentially decisions about dangerousness involve weighing the various factors, preferably by well-trained experienced professionals who can incorporate the observations of those who know the offender well, e.g., experienced nursing staff [40].

Quinsey has reviewed the literature on the assessment of dangerousness in sexual offenders [41, 42]. He restricted the concept of dangerousness to the study of those who will commit a future violent offense. What sparse evidence there is suggests that the most dangerous sexual offenders are those with sadistic sexual preferences, those with active, violent sexual fantasies, those who use more violence than needed to obtain their victim's cooperation, and those unresponsive to the victim's pain. These data are relevant to child abuse work especially as we become increasingly aware of the fact that incest offenders are not a separate or distinct breed of offenders but show more in common with other sexual offenders than we have hitherto realized [43].

Quinsey's most recent work centers on a comparison of professional and lay assessments of treatability of offenders [44]. He discovered that professionals and lay assessors alike used the common sense criterion of severity of original offense as the most likely predictor of future offending behavior (the secondary issue of whether they were correct is not addressed in this work).

### A SUMMARY POSITION

We can now draw some consensus conclusions about untreatable families from existing studies and clinical experience while awaiting the results of further studies. An untreatable family may be defined as one in which it is unsafe to permit an abused child to live. This is not to say that such a family should not receive treatment and help, but the help should be aimed at aiding relinquishment rather than reuniting the child and parent(s). Some children may be so damaged by the experience of having been abused that they do not respond to treatment [36]. In this paper the concern has been with whether the child

can be reunited or continue to live in safety with his/her parents, rather than a consideration of the child's individual progress. Some families are untreatable at the point when abuse occurs but later on become safe units because of a change in family composition, the child's developmental behavior, or other changes. Thus an abusive father may leave the home, making the family safer than before. In cases of sexual abuse this is a fairly common resolution [6, 17].

Identifying untreatable families is a common problem. Among such families are many who simply refuse involvement with helping agencies. Little is known about the characteristics of this group, but those parents who refuse help or drop out of treatment prematurely or steadfastly deny abuse do not seem to change their parenting habits spontaneously [4]. The characteristics of untreatable families may be summarized by grouping the variables into parental factors, parenting qualities, type of abuse factors, indicators of dangerousness, and treatment factors. All the following have the support of more than one study and represent a present consensus. We suggest that presence of the following characteristics be taken as a warning to professionals, not as an indication of certain failure. Lynch and Roberts aptly remind us that the diagnosis of severe personality disorder does not equate with untreatable [3]. However, such a diagnosis should compel us to exercise caution in rehabilitation, particularly in the difficult period after reuniting a child and his/her parents, as exemplified by the Jasmine Beckford case [10]. The characteristics which follow apply to all forms of abuse, and any that are peculiar to child sexual abuse are mentioned at the end of each paragraph.

1. *Parental Factors Associated with Untreatability.* Parental factors associated with untreatability include a parental history of severe childhood abuse, a persistent denial of abusive behavior, severe personality disorder (sociopathy or grossly inadequate personality), and mental handicap when associated with personality disorder. Psychotic parents whose delusions involve their child and those persistently addicted to drugs or alcohol often prove untreatable. Less evidence supports the notion that parents for whom child abuse is their only obvious problem and fanatics frequently prove untreatable. In the field of child sexual abuse, those parents who harbor persistent violent sexual fantasies are hard to treat.
2. *Parenting Quality Associated with Poor Outcome.* The parenting quality which most authors and clinicians find to be associated with poor outcome is a lack of empathic feeling for the child, either when victimized or in the present. Such parents fail to see their child's needs as separate or different from their own. In child sexual abuse this basic fault may have a sexualized component, too, i.e., the child is seen as having sexual needs and desires of identical nature to those of the parent.
3. *Aspects of Abuse Associated with Untreatable Outcome.* Aspects of the abuse itself appear to be associated with an untreatable outcome, e.g., severe types of abuse such as fractures, burns and scalds. Cases where there is a long history of abuse prior to discovery prove harder to treat, as may be abuse which has involved premeditated torture or infliction of severe pain. Munchausen by proxy, nonaccidental poisoning, and severe failure to thrive are especially resistant to change. In the field of child sexual abuse, in addition to the factors above, cases involving vaginal intercourse or sexual sadism appear to be more difficult to treat.
4. *Dangerousness to Child.* With respect to dangerousness, cases where the parent has perpetrated previous violent acts are more likely to prove untreatable. The greater the number of such acts the greater the risk of repetition.
5. *Type of Professional Response.* Lastly, there is a trend which links successful treatment outcome with the establishment of a helping relationship combined with an outreach component. Where this does not occur outcome seems less good.

## CONCLUSIONS

Not all the families whom we treat will change sufficiently to become a family to which a child can safely return. We do have some guidelines to help identify these families, including recognition of certain characteristics of their behavior, personality style or psychiatric diagnosis, as well as by the type of abuse, parental biography of violence, and, less certainly, treatment variables. In these situations, there should be a time limit for effective and active treatment. If the best treatment efforts are not producing any reasonable degree of change within this time, then termination of parental rights should be sought. One proposal is that the limit for this period, at the outside, be 12 months for those families in which the child is under 3 years of age and 18 months for those over 3 [45]. In many situations, it is not reasonable to treat for this period of time without attempting to make alternative plans. If treatment efforts are clearly stalled, permanent alternative plans for the child should be made even sooner than the guidelines indicate. In the Kempes' words, "we should stress that when we say that a family is untreatable, we do not mean that the parents do not deserve treatment. What we mean is that the child should not be used as the instrument of treatment. . . there must be a more civilized way of dealing with incurable failures than providing a martyred child" [1].

Further outcome studies are sorely needed in order to test the hypothesis that characteristics of those families who will not respond to treatment can often be determined at a much earlier stage than at present. This would allow children to be freed for earlier adoption before they have been subjected to long periods of uncertainty, while treatment plans, which are doomed to failure from the beginning, are vainly attempted. We also need careful assessment of the sexual abuse treatment programs in order to rate their efficacy.

One reason why the subject of untreatable families may have received less attention than it deserves relates to the feelings which are generated within the professionals who work with these families. Feelings of discomfort, helplessness and self-recrimination are not uncommon [46, 47]. This is not surprising as helping professionals are recruited and trained to reconstitute and rehabilitate their clients. Few feel their calling in professional life is to be part of the process of separating parents and children. However, the development of a child's perspective on family life [48], or a "child's eye view" [17] can help the professional appreciate that identifying untreatability can be as important as reuniting a child and parents. Unfortunately many professionals experience feelings of failure when involved in a child abuse case where the outcome is parental relinquishment. We can argue that the inordinate proportion of time spent by professionals on those families who are the least likely to respond contributes to the high rate of foster parent, mental health, and social service burnout, and consumes resources that could more effectively be used to assist the large number of treatable families.

*Acknowledgment*—This article's title is identical to the Kempes' chapter heading in their book, *Child Abuse* [1] and is repeated here in order to acknowledge the author's appreciation of their work and understanding.

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