Nature and Consequences of Personality Problems in Maltreating Caregivers

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Abstract

From the authors' perspective and value-based assumptions, neglect and abuse occur not out of malice or intent to harm but rather out of an inability to cope with the demands of children whose developmental needs overwhelm the coping resources of parental caregivers. In this article the authors develop a theoretical model that views caregivers who repeatedly maltreat their children as limited in providing appropriate parenting responses to their offspring because of psychosocial problems that pervade most sectors of their functioning. The proposed theoretical model targets 3 interacting dimensions of personality functioning (interpersonal relationship capacity, emotion regulation, and self-esteem maintenance). Implications for the development of assessment and intervention strategies and for empirical testing of the model are outlined.

WE HYPOTHEZIZE THAT CAREGIVERS who repeatedly maltreat their children are limited in providing appropriate parenting responses to their offspring because of their own psychosocial problems that pervade most sectors of their functioning. Although there are numerous definitions of the various forms of child maltreatment, there are few, if any, well-developed theoretical models for understanding the psychosocial profiles of caregivers who repeatedly neglect and/or abuse their children. In general, child welfare intervention programs have been based on educational and stress-coping paradigms for understanding and addressing the needs of the maltreating caregiver. Typically, interventions target for a change in general parenting skills, stress management, anger control, and management of problematic child behaviors. Studies of outcomes of intervention programs for maltreating caregivers are difficult to interpret because of problems in design and methods, such as small, heterogeneous samples; lack of control over reliability of intervention; failure to randomize; and no long-term follow up regarding the duration of effects (Edgeworth & Carr, 2000; Wolfe & Wakerle, 1993). Despite these methodological flaws, study reports have indicated that some caregivers do benefit from treatment, as manifested in reduced abuse and neglect. Of concern is the subgroup of caregivers who do not benefit and who continue to neglect and/or abuse their children. An alternate theoretical paradigm for understanding the needs of this subgroup of maltreating caregivers is warranted.

We propose a theoretical model for describing caregivers who repeatedly neglect and/or abuse their children. It targets three key areas of functioning: (a) factors that explain repeated failures in establishing and maintaining mutually supportive relationships, (b) deficits in regulating emotions that interfere with implementation of effective problem-solving strategies, and (c) characteristics of chronic problems in goal achievement and self-esteem maintenance.
Motivation for Maltreatment

Underemphasized in the family developmental literature is the fact that parenting under the best of circumstances is a demanding and stressful task, and it is successfully achieved only when the parents are able to sufficiently contain their own psychological issues and not impose them on their offspring. Each phase of child development makes different demands of the parent that require flexible, supportive caretaking responses to accommodate the child’s shifting needs. Accordingly, it is not surprising that the most dangerous periods for child abuse and neglect occur between 3 months and 3 years of age, and that the next high-risk period for abuse occurs in adolescence (Azar & Wolfe, 1998). It is during these developmental phases that children make higher demands on their parents.

Caring for infants is physically and emotionally exhausting, especially in the absence of support from a partner or other family member. Single mothers are the primary caregivers in 87% of all neglect cases and in 93% of physical neglect cases (Azar & Wolfe, 1998). The presence of an infant with a constitutionally difficult temperament adds even more stress that would tax the patience of any mother, but it is especially demanding of a single mother with limited internal and external resources. Thus, from our value-based perspective, neglect and abuse occur not out of malice or intent to harm but rather out of an inability to cope with the demands of a helpless, dependent, and possibly difficult child. What is viewed by outsiders as demands that are typical of the developmental needs of any infant may be perceived by the maltreating caregiver as demands that overwhelm limited resources and exacerbate anxiety and depression emanating from other life stresses. Thus, a neglecting response may be a form of denial of both the child’s needs and the caregiver’s frustration at having to meet those needs.

Similarly, during a child’s adolescence, parents must alter their parenting behaviors; on the one hand, they are wary of releasing too much control while on the other, they are relaxing controls. Maltreating caregivers who often have had little control over their own lives are ill-equipped to respond flexibly to their adolescents’ developmental need for control. Physical abuse, which is the more common form of maltreatment during adolescence, may be a response to the parent’s perception of the loss of control and the concomitant rage at feeling vulnerable and powerless. These postulates as to why caregivers neglect or abuse their children at various stages of development are intended to foreground (a) the magnitude of the task of child rearing by any parent and (b) the entrenched, maladaptive mental processes that can thwart caregivers’ attempts to effectively parent their children. These hypothesized paradigms for explaining motivation for maltreatment suggest that the component parts of the maladaptive mental processes need to be understood in the broader context of the caregiver’s characteristic patterns of behavior that define her or his personality.

Maladaptive Mental Processes and Personality Traits

There is great confusion in the psychiatric literature as to definitions of maladaptive personality functioning. Part of the debate is concerned with distinguishing a “normal” from an “abnormal” personality, with the former defined in terms of basic personality dimensions (e.g., five-factor model: neuroticism, extraversion, openness to experience, agreeableness, conscientiousness; Costa & Widiger, 1994, 2002) and the latter defined in terms of deviant, maladaptive traits and symptoms (Larstone, Jang, Livesley, Vernon, & Wolf, 2002). Of importance is the view that normal and abnormal personalities lie along a continuum and share the same traits or styles but differ in terms of rigidity and maladaptive expression of trait-based behaviors (Millon, 1996; Millon, McGeheer, & Grossman, 2001). According to the International Statistical Classification of Diseases and Related Health Problems (ICD–10) definition, abnormal or disordered individuals have “deeply engrained, enduring behavior patterns manifesting themselves as inflexible responses to a broad range of personal and social situations—they are developmental conditions which appear in childhood or adolescence and continue in adulthood” (World Health Organization, 1992, p. 200). Studies of early life precursors of adult personality problems have supported this definition (Harter & Vanecek, 2000; Reti et al., 2002a, 2002b). Furthermore, recent research has linked the genetics of personality with behavioral models of psychopathology (Jang, Vernon, & Livesley, 2000). The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM–IV; 1994) has provided a categorical system for identifying persons with personality problems (Axis II Personality Disorders). The problems with this system are many, including vaguely worded criteria, overlap of criteria across the diagnostic categories, and a lack of rationale for distinguishing a personality disorder from a normal personality (Livesley, 1998, 2001a; Millon, 2000). Thus to label maltreating caregivers as having any one of the DSM–IV categories of personality disorder is not useful, nor is maltreatment a symptom of a disordered personality. Rather, what is needed is a systematic way for isolating dimensions of personality functioning that are problematic in terms of managing the demands of daily living.

Preferable are approaches that define problematic personalities in terms of (a) behavioral genetic factors associated with behavioral and emotional disturbance (O’Connor & Plomin, 2000); (b) coping capacities that are ineffective for managing difficulties in relation to others, for regulating affect, for achieving goals, and for dealing with stress (Vollrath, Ainaes, & Torgersen, 1996a); (c) manifestations of severe and
chronic interpersonal dysfunction (Benjamin, 1993; Benjamin & Pugh, 2001); and (d) failure in three interrelated realms of intra- and interpersonal functioning: self-system, familial or kinship relationships, and societal or group relationships (Livesley, 1998; Livesley & Jang, 2000). Livesley further defined the nature of relational failures in these three domains: (a) self-system failure refers to the incapacity to establish stable integrated representations of self and others; (b) interpersonal relationship problems that include failure to develop the capacity for intimacy, failure to function adaptively as an attachment figure, and failure to establish affiliative relationships; and (c) societal relationship problems that include a limited capacity for prosocial behavior.

In each of these attempts to define the primary features of problematic personality functioning, relational capacity is the central theme. The term relational is defined as the capacity to engage in relationships with others, and it includes an awareness of a self-identity as being separate from that of others. From infancy to old age, relationships with significant others shape each individual’s beliefs about herself or himself within the demands of culturally defined situations and events. When relationships contribute positively to self-esteem maintenance, personal growth is promoted. This growth includes the ability to reciprocate in providing relational support for others. When relationships across the life span are experienced as negative, demanding, and unrewarding, self-esteem suffers, and the capacity to nurture and care for others is impaired. In addition to relational problems, two other key features of maladaptive personality functioning are difficulties in regulating affect and lack of success in goal achievement. Although relational capacity, emotion regulation, and goal achievement are interrelated processes, each dependent on the other for optimal functioning, the three constructs are discussed separately as they apply to understanding motivation for maltreatment in primary caregivers.

**Caregiver Problems in Interpersonal Relating**

According to Livesley (1998) and Livesley and Jang (2000), persons with problematic personalities have an impaired ability to engage in rewarding, reciprocal relationships because of negative early life experiences with attachment figures. This hypothesis is well-supported in the attachment literature, including cross-sectional and longitudinal studies of the sequelae of attachment failure (Liem & Boudewyn, 1999; Neal & Frick-Horbury, 2001; Wekerle & Wolfe, 1998). The results of these studies suggest that maltreating caregivers with severe personality problems have experienced in their own childhood years insecure, troubled relationships with parents or their substitutes (Bugental & Shennan, 2002; Gopfert, Webster, & Sceman, 1996; Johnson, 1999). In consequence, they have failed to develop images of themselves as possessing positive attributes, power, and control over their lives. Not surprisingly, their perceptions of others are corrupted by expectations of criticism, rejection, and possible abandonment. When these self-other perceptions are reinforced over time, these individuals acquire a rigid mental image of what to expect in relationships, both from themselves and from others. This image is accompanied by a sense of hopelessness that anything will change. The self is vulnerable, unloved, and powerless, whereas others are strong, worthy, and powerful. This mental image or schema imposes on the individual a rigid set of expectations of self and others that overrides the actualities of any given interpersonal situation or transaction. Family members, friends, employers, and social service providers are viewed from a subjective perspective such that thoughts, feelings, and attitudes imbedded in the mental schema are indiscriminately attributed to them (Horowitz, 1998, 2002). For example, in an interpersonal transaction, if the caregiver with the rigid self-schema is feeling angry, she or he is more than likely to see the other person as angry with her or him. This skewed perception results in negative, defensive communication from the caregiver that inevitably invokes anger in the other person, even though it was not present initially. The result is great distress and suffering because the very relationships that are needed for adaptive functioning (couple, parent-child, extended family, friends, employers, social service providers) are in constant jeopardy. In contrast, individuals who have had early positive and secure attachment experiences have stored in memory a broader repertoire of self-other schema, allowing for a range of possible outcomes.
in interpersonal relationships. Perceptions of self are not as vulnerable to the expectation that other’s responses will be critical and rejecting. Consequently, an individual’s thoughts, feelings, and attitudes can be understood and modified accordingly in the context of specific interpersonal situations. Under these circumstances, it is possible to appreciate differences between self and others, as well as to extend empathic understanding of others.

For caregivers who maltreat their children, problems in relating interfere with effective parenting. The child may not be viewed as a separate entity with discrete motives, behaviors, and emotional expressions. Rather, the child is viewed frequently from a subjective perspective, such that the caregiver’s own observations, feelings, and motivations are projected indiscriminately onto the child. For example, when under conditions of stress the caregiver’s frustration is projected onto the child (the child is viewed as being angry), the child feels neither understood nor appreciated, responds negatively, and thereby confirms the parent’s expectation. When this skewed interpersonal process is repeated over time, the breach between child and parent becomes increasingly difficult to mend. Neglect and abuse are manifestations of their mutual frustration with one another. Thus the caregiver is stuck in a repetitive cycle in which general problems in interpersonal relating interfere with the ability to deal with the changing requirements of children, whether from moment to moment or from one developmental phase to the next (Norton & Dolan, 1996).

There is some research that supports the view that caregivers with severe problems in interpersonal relating are at greater risk for neglecting or abusing their children. For example, Bugental and Happaney (2002) described characteristics of neglecting or abusing caregivers that have close parallels with maladaptive self-other schema of interpersonal relating. They suggested that neglecting and abusing parents’ internal representations of self and other (child) are “power schematic”; that is, there is an imbalance in the perception of power in interactions between parent and child. In a series of studies Bugental and Happaney (2000) and Bugental, Johnston, New, and Silvestre (1998) have been able to show that it is the child who is perceived as having power and the parent who is threatened. The threatened parent responds defensively by becoming initially submissive and then verbally and physically aggressive. Bugental and Happaney (2000) and Bugental et al. (1998) linked this imbalance in power to the caregiver’s attachment history. For example, parents who are assessed as having an insecure attachment style see the parent–child relationship as power imbalanced (Grusce & Mammon, 1995). Furthermore, in a randomized control trial Bugental et al. (2002) have been able to show that a home visitation program that focused on changing negative power attributions with high-risk caregivers of newborn infants was more effective than standard child welfare services in reducing neglect and abuse.

In summary, we hypothesize that caregivers who chronically maltreat have fundamental problems in initiating and maintaining reciprocally rewarding relationships, whether with their children, partners, extended family, friends, or employers. Their inflexible responses to a broad range of personal and social situations reflect rigid self–other mental schema arising from a variety of negative early life experiences with caregivers (neglect, sexual and physical abuse, loss, erratic and inconsistent parenting, parental marital problems, and parental problems with substance abuse; Johnson, 1999). These early life experiences parallel the experiences of children who are neglected and/or abused. Furthermore, understanding the parallels between the interpersonal experiences of maltreating parents and those of their offspring is central to understanding motivation for neglect and abuse.

**Caregiver Problems in Emotion Regulation**

Studies of the developmental pathways through which the capacity for affect regulation is acquired define emotions as the primary motivational forces in all human interaction. They provide the organizing principles for interpersonal relating and determine the quality of attachments and the conditions for separations (Oatley & Jenkins, 1996). The concept of emotion regulation is embedded in three developmental domains: biologically based temperament, cognitive capacity, and family socialization practices (Goldsmith, Lemery, Aksan, & Buss, 2000). For children, stages of learning about emotions parallel developmental phases, initially involving physical expressions of basic emotions (joy, fear, anger) followed by understanding situation-based emotions, distinguishing feelings arising from internal states from those associated with external events, and finally, in late adolescence, acquiring the capacity for effective processing of mixed emotions (Calkins, Dedmon, Gill, Lomax, & Johnson, 2002; Emde & Hewitt, 2001; Izard, Schultz, Fine, Youngstrom, & Ackerman, 1999–2000; Oatley & Jenkins, 1996; Stifter, 2002).

Studies of the processing of emotion are closely linked to studies of child temperament. Emotions expressed through temperamental dispositions provide the core of continuity in the development of the self throughout the life span (Emde & Hewitt, 2001; Izard, Lawler, Haynes, Simons, & Porges, 1999–2000; Izard, Schultz, et al., 1999–2000). Temperament can be defined as the characteristic manner in which emotions are expressed and processed by each individual (Sceif, 1998). Results of studies of temperamental disposition and emotion recognition and expression have shown that (a) children raised in the same environment manifest individual differences in emotional and behavioral development; (b) children are active agents in shaping their own environments; and (c) neurobehavioral and genetic factors, combined with environmental variables, contribute to child behavioral and emotional attributes (Davidson,
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reports indicate that dimensions such as emotional dysregulation, social avoidance and withdrawal, and antisocial behavior underlie the personality disorders, and of these, the most prevalent dimension is emotional dysregulation (Livesley, 2002). Emotional dysregulation refers to an inability to adjust emotions according to the context in which they are experienced. That is, emotional responses can be overly suppressed or significantly exaggerated, resulting in confusing and oftentimes negative transactions with others. It follows that the parenting behaviors of maltreating caregivers with severe personality problems are significantly compromised by maladaptive traits such as emotional dysregulation. Their relationships in general are negatively affected by errors in decoding others’ emotions because their judgments are very much colored by their own cognitive–emotional traits. In relation to their children, maltreating caregivers show less understanding of children’s emotional displays and fewer affective strategies for helping their children cope with emotionally arousing situations (Shipman & Zeman, 2001). The effects of the caregiver’s maladaptive strategies for regulating emotions impact on their children’s emotion regulation abilities and socioemotional adjustment (Maughn & Cicchetti, 2002; Pollak, Cicchetti, & Klarman, 1998). For example, when an infant cries and appears inconsolable, the caregiver needs to judge the meanings of the crying: Is the infant uncomfortable, in pain, hungry? Concomitantly, the caregiver needs to be aware of her or his own feelings as well as appraise her or his own ability to respond in a manner that will soothe the infant and stop the crying. Finally, the caregiver needs to decide which action(s) to take in response to the trigger event (infant’s crying). It is postulated that for maltreating caregivers, each element of emotion processing is difficult to manage. The significance of the infant’s crying is either exaggerated or underappreciated; subjective feeling responses are often high anxiety and/or extreme frustration and anger, followed by actions that are overreactive (shaking or striking the infant) or underreactive (ignoring the infant). From an interpersonal context, the maltreating caregiver has difficulty in interpreting her or his own thoughts and feelings as separate from others, and this results in skewed emotional responses. As illustrated by
Bugental et al.’s (2002) studies reviewed earlier, if the caregiver attributes power to the infant, her or his feeling responses are determined by this attribution (anxiety and anger). The subsequent abusive actions conclude the sequence of responses in this misguided process. In summary, maltreating caregivers are ill-equipped to deal with strong emotions evoked in interpersonal contexts. They have difficulty appraising the significance of life events because their observations are so clouded by the power of their own emotional reactions that they have difficulty distinguishing from the feelings and needs of others. When the source of the agitated emotional state is located in the other person (e.g., a child), a defensive response in the form of neglect or abuse follows.

**Caregiver Problems in Goal Attainment and Self-Esteem Maintenance**

The setting and achievement of goals across the life span serves to maintain a balance between positive and negative perceptions of the self in relation to others. In other words, the gage for measuring self-worth is based on the combination of subjective self-appraisal and the appraisal of others. Personal goal selection is matched with perceived internal and external resources. However, life stresses inevitably challenge one’s capacity for goal achievement, and the successful management of stress is largely dependent on perceptions of the self as capable and perceptions of others as supportive.

The cognitive–transactional theory of stress and coping (Lazarus & Folkman, 1991) offers a theoretical and empirical framework for understanding the nature of poor goal achievement and low self-esteem experienced by persons with severe personality problems. Although stress is ubiquitous to the human condition, the intensity and duration of stress varies according to the extent that internal or external demands exceed the resources of the individual. Coping with stress involves emotion-focused coping (emotion regulation) and problem-focused coping (solving the problems that caused the distress; Vollrath, Alnaes, & Torgersen, 1996a). Persons with severe personality problems do not manage stress well because they have little positive regard for their own ability to solve problems and have a paucity of supportive relationships to help buffer the effects of the experienced stress. In addition, their subjective experiences of stress are exacerbated by environmental stresses such as living in violent neighborhoods and having inadequate and crowded housing, low incomes, and inadequate community resources.

Vollrath, Alnaes, and Torgersen (1996b) have shown that maladaptive coping in response to stress involves emotional unsteadiness, reduced tolerance for frustration, reduced seeking of support, disengagement from goals, helplessness, and the use of alcohol or drugs. Caregivers who maltreat their children are handicapped in achieving goals because of a life history of stresses that overtax their resources such that experiences of successful coping are sparse. Also, they have experienced a paucity of consistent, reliable family support and little positive reinforcement for educational and/or employment achievements. Given this developmental context, maltreating caregivers are often lacking the basic tools for determining strategies necessary for active coping. Consequently, efforts at setting and meeting goals are sabotaged by anxiety and confusion, often resulting in goal abandonment and an accompanying sense of hopelessness and depression. It may be that chronic child neglect is the outcome for caregivers whose life experiences have repeatedly resulted in failure and disappointment. Parenting tasks are avoided, not in a consciously planned manner, but rather out of a deep sense of helplessness. Self-esteem is depleted, as evidenced in the lack of physical and psychological energy for tackling the problems typical of daily living with dependent children.

**Conceptual Summary**

Although three salient dimensions of problematic personality functioning in maltreating caregivers have been discussed separately, they operate interactively. Emphasis has been placed on the interpersonal relational dimension as the overarching construct that encompasses problems in emotion regulation and poor outcomes in terms of goal achievement and self-esteem maintenance. Thus, the acquisition of adaptive relational capacity is viewed as fundamental to successful parenting. It is within the context of relationships that information about emotions is processed and communicated. As well, important interpersonal relationships affirm self-appraisal, which is essential for setting and achieving goals and successful problem solving. This conceptual model for understanding maltreating caregivers’ motivation for neglect and abuse suggests guidelines for assessing their needs and for designing effective intervention programs.

**Implications for Assessment, Intervention, and Research**

Tests of the proposed theory would need to address the following questions: What risk assessment criteria are needed to determine the link between the caregiver’s personality problems or needs and the perpetuation of maltreating behaviors? How do the identified personality problems interfere with caregivers’ capacity to access and benefit from intervention programs? Which models of intervention are most effective in addressing personality issues in the domains of interpersonal capacity, emotion regulation, self-esteem maintenance, and goal achievement?

To test the theoretical model in practice, child welfare social workers would need to establish the presence of severe personality problems in the maltreating caregiver. This would require the social worker to apply a set of criteria for determining the presence or absence of severe personality problems.
Reliable measurement strategies such as the Personality Disorder Scale (PDS; Pilkonis, Kim, Proietti, & Barkham, 1996) could be integrated into the risk assessment process. In a recent pilot study, this measure was used with a cohort of 60 maltreating caregivers to determine the incidence of personality disorder (Marziali & Trocmé, 2000). The results showed that 52% of the respondents qualified on the PDS as having serious personality problems. However, researchers would still need to demonstrate validity and reliability of this instrument with a much larger sample of maltreating caregivers. Livesley’s dimensional measure of personality factors (Dimensional Assessment of Personality Pathology—Basic Questionnaire; DAPP-BQ) could be used for comparisons between the PDS, which specifically targets problems in interpersonal relationships, and the DAPP-BQ, which targets factors in three domains (self-system, interpersonal relationships, and societal relationships). In addition, observational data (caregiver–child transactions) would add important information for corroborating the presence or absence and severity of personality problems.

The relevance of the theoretical model for determining effective intervention strategies for maltreating caregivers with severe personality problems would need to be based initially on an analysis of empirically evaluated treatment strategies for persons with personality disorders (Benjamin & Karpik, 2001; Linchus, 1993; Marziali & Munro-Blum, 1994). However, many of these approaches may not be appropriate for maltreating caregivers in a child welfare context. Livesley (2000a, 2001b, 2002) suggested an approach to intervention that targets emotional dysregulation. He indicated that a useful model would integrate specific interventions that focus on the modulation of maladaptive traits with attention to the treatment relationship and the development of a collaborative working alliance. General intervention strategies would address the core pathology (repetitive patterns of interpersonal conflict), and specific strategies would target maladaptive personality traits unique to the individual. Benjamin and Pugh (2001) focused on interpersonal theory for designing effective treatment interventions for persons with personality disorders. They also emphasized the importance of the treatment relationship in determining outcome (Benjamin & Karpik, 2001) and included therapist respect for and validation of the patient. Overall, there is consensus on the positive outcome potential of models of intervention that attend to the maltreating caregiver’s problems in the interpersonal domain, in regulating emotions, and in processing information effectively for optimizing goal achievement.

Social workers need to keep in mind that maltreating caregivers with severe personality problems have spent a lifetime struggling to control their destinies with little success. The only respectful and caring approach to meeting their needs is for the child welfare system to provide intensive, long-term psychotherapeutic interventions ...

In summary, a theoretical model for understanding motivation for abuse by chronically maltreating caregivers has been proposed. Three interacting dimensions of personality functioning have been targeted for understanding caregivers’ chronic difficulties in managing life stresses. Interpersonal relationship capacity is the overarching construct for assessing the degree of malfunction and its effects on parenting behaviors. Implications for determining the risk assessment process and viable intervention programs have been specified. The ultimate merits of the proposed theoretical model will need to be tested empirically to demonstrate its efficacy for understanding mechanisms that affect change in maltreating behaviors of caregivers who abuse or neglect their children.

Conclusions

The proposed theoretical framework for understanding the subgroup of caregivers who chronically abuse and/or neglect their children underlines the importance of including in risk assessment instruments criteria for determining the presence or absence of severe personality problems in the caregiver. Child welfare service organizations have increasingly focused on assessing the needs of the child by judging the risks for continued maltreatment if the child is to remain in the family home. The mental health problems or needs, especially the possible presence of personality disorder in the maltreating caregiver, are largely ignored, resulting in the provision of inappropriate and/or inadequate intervention...
programs for the family as a whole. However, referring maltreating caregivers with severe personality problems to psychiatric clinics is not the answer. First, they will go only if the court mandates it because they do not perceive themselves as mentally ill, nor do child welfare workers perceive them as such. Second, there are no effective psychiatric treatments for persons with personality disorders. Medications for associated symptoms (e.g., depression or anxiety) can be prescribed, however.

What are the alternatives for managing the needs of this subgroup of maltreating caregivers? Child welfare agencies need to design and implement intervention programs that are responsive to those characteristics within the maltreating caregiver that continually put them at risk for developing and sustaining mutually supportive relationships with the people in their personal networks on whom they depend for survival. Social workers need to keep in mind that maltreating caregivers with severe personality problems have spent a lifetime struggling to control their destinies with little success. The only respectful and caring approach to meeting their needs is for the child welfare system to provide intensive, long-term psychotherapeutic interventions that acknowledge the difficulties that these maltreating caregivers have in establishing rapport and in sustaining a sense of self-worth. Skilled clinicians within the child welfare system must take up the challenge of identifying and addressing the needs of this subgroup of caregivers. Short-term parenting courses, anger management groups, or behavioral approaches to social network enhancement are not going to be effective over the long term for caregivers who chronically abuse or neglect their children. Ultimately, the question that needs to be addressed is as follows: Are child welfare agencies and governments that mandate their practices willing to provide intensive intervention programs for family caregivers who repeatedly maltreat their children?

References


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