C. Conducting the Family Assessment

Conceptual Framework

Randy, age two, went to his mother, lifted his leg, and in a whiny voice said, "Randy hurt." Randy's mother examined his leg and found nothing obviously wrong. However, as she watched Randy, she noticed that he was limping. She assumed he'd bumped himself, and it would probably go away. When Randy continued to limp and whine for another three days, his mother became concerned. She made an appointment with the pediatrician, who also examined Randy's leg, foot, and hip. He found nothing. He suggested they observe Randy for several more days and, if the problem didn't go away, he would make a referral to an orthopedic specialist.

While Randy's limp seemed to be better at times, it always worsened again. One day, when Randy was particularly uncomfortable, his mother called the pediatrician and requested the referral to the specialist. The specialist performed a series of X-rays and blood studies, costing many hundreds of dollars, and reported that she could find nothing significant in any of them. She suggested they recheck him in three months, if it didn't get better. Still, Randy's limp continued, and he continued to complain periodically.

> Shortly thereafter, Randy's grandmother was babysitting and noticed his limp. She asked Randy what was wrong. Randy whined, "hurt," and again lifted his leg. Randy's grandmother took off Randy's shoes, and examined his leg and foot, and found nothing obviously wrong. She then examined Randy's shoe, thinking that it might be too small for him. As she put her fingers into the shoe, she felt something hard and sharp, and she pulled out one of Randy's small, metal toy trucks that had become wedged tightly in the toe of the shoe. She removed the toy truck. Randy's limp disappeared.

This humorous, but true story illustrates a simple, but fundamental truth of problem solving: a problem cannot be solved until it has been properly assessed and identified.

Randy's limp and pain were the visible, "presenting" symptoms of an underlying problem. Any number of problems could have created pain and a limp: a sprained ankle, a bone deformity, tight pinching shoes, or other injury. Different interventions would be called for, depending upon the nature of the underlying condition.

There are lessons to be learned from Randy's experience. First, more careful questioning of "what exactly hurts" might have identified that his foot hurt more than his leg. Careful observation would have revealed that Randy limped only when he was wearing his shoes, never when he was barefoot. Randy's mother and pediatrician quickly began looking for a medical problem. Randy's

grandmother considered more obvious environmental factors in her assessment; she knew that children limped when their shoes were too tight. In our technologically sophisticated world, we often tend to overlook such fundamental factors.

Child abuse and neglect, the "presenting problems" of child welfare, are normally symptoms of personal, family, environmental, or social problems. Every family presents a unique picture of interacting problems and strengths. Unless we fully understand the interaction of factors contributing to maltreatment in a family, we cannot develop relevant safety and intervention plans. A comprehensive and accurate assessment is, therefore, the cornerstone of the casework process.

We must involve families in the assessment of their own problems and needs, since they have information we do not. We must observe carefully, and we must ask questions to assure that we are properly interpreting what we have observed. At times, we may see or understand things that families may not be aware of, or may not be able to tell us. And, we must always seek the obvious potential contributors to the problem, as well as the more obscure. In a casework model, therefore, the family assessment is always conducted jointly by the caseworker and family members. This team approach to assessment enables family members to better understand their own situation, and helps the worker understand the family's values, perceptions, needs, strengths, problems, and personal goals, from the family's perspective.

A frequent error in case planning is to brainstorm and select solutions without first fully assessing the problem. The inadequacy of this "laundry list" approach

to case planning is that it generates solutions to treat only the symptoms. It is easy to see why many such solutions are likely to be irrelevant and ineffective. As an example, it can be dangerous to prescribe treatment for a chronic cough, which is a symptom, unless we know why someone is coughing. If the answer is "bacterial pneumonia," the best treatment is antibiotics. If the answer is "smoker's cough," antibiotics won't help; giving up smoking will. Similarly, if a parent neglects or abuses her child because she has paranoid schizophrenia, sending her to parent training classes will not resolve the problem. Treating the underlying psychotic disorder, or finding a more competent caregiver for the children, would be more effective interventions.

When a comprehensive family assessment is conducted to identify the underlying causes of maltreatment, the best solutions to eliminate maltreatment will follow logically and rationally from assessment data. The solutions will also be individualized to address the family's unique needs or problems, and will build upon family members' strengths, thus greatly increasing the likelihood of success.

In summary, in a properly implemented case planning process, case goals, objectives, and action steps will evolve logically from the information contained in the family assessment. Conversely, without a complete and accurate assessment, we can presume that our goals, objectives, and solutions will probably not solve the immediate problem, much less generate positive and lasting family change.

Content and Process in Casework

Understanding the underlying dynamics in maltreating families is a prerequisite to an accurate family assessment. However, it is not always easy to discern these dynamics. The skilled caseworker is able to recognize, elicit, and help families properly interpret these dynamics. The first step is understanding the meaning of family members' communications and behaviors.

The terms "content" and "process" refer to aspects of communication. The "content" of communication includes the words, syntax, and sentence structure in verbal communication. It is sometimes referred to as the "surface" information. "Process" refers to the underlying dynamics, such as feelings, symbolic meaning, and unrevealed intent that define the context, and thus contribute to the full meaning of a communication. In communicating with a computer, you need only deal with the content of communication. In communicating with people, both the content and the process of communication must be considered.

In casework, content usually refers to the strict, logical implication of the verbal communication between the caseworker and the family, or between family members. Content is what family members say to the caseworker, or to each other, and what the caseworker says to them. Content includes facts and descriptive information about family members, their situation, their problems, strengths, and needs. While content can give us much valuable information, the logical implication of the words themselves is only part of the picture.

Process in casework includes the observable dynamics of behaviors, interactions, and feelings (affect). It includes nonverbal behaviors, such as tone of voice, body posture, and facial expressions; emotive or affective responses; interactions between family members, or between the caseworker and family members; and family members' expressed feelings and perceptions about their situation. Process also includes the implicit meaning family members assign to their own behavior and actions.

In any communication, the content message (the logical implications of the verbal message) may not be consistent with the process message (the nonverbal, affective, or behavioral one). When a verbal and a nonverbal message are inconsistent or contradict each other, the nonverbal one is generally more accurate.

Some case examples can help clarify the distinction between content and process.

Sara

Sara told her caseworker that she had looked forward to having her son, and while she was worried that he had been born two months prematurely, it didn't really matter to her. She said she was still proud of him, even though he was so strange looking. The doctor said he'd outgrow it. She said she sometimes felt stressed that he needed so much care, and she was very tired, but she knew he would catch up eventually. She did, indeed, look tired; she had dark circles under her eyes, and she moved slowly, as if weary. As the worker observed Sara with the baby,

she treated her son with gentle, if awkward, care. She responded immediately when her son cried, and she cradled and rocked him in her arms, smiling and talking quietly until he settled. And despite the difficulties she experienced in feeding him, Sara responded with patience and encouragement.

The content of Sara's communication was, "I am glad to have my son, his prematurity is a problem, but it doesn't make me feel any different about him." The process between Sara and her son was congruent with the verbal message. The worker concluded that Sara had lovingly bonded with her baby, in spite of his problems and her lack of experience.

Lucy

Lucy saw her two-months premature son for a moment in the delivery room, and then refused to look at him or hold him. She claimed she was much too tired and sore after a long and difficult labor. When encouraged to hold him the next day, she appeared afraid, claiming he was so little, and "awfully strange looking." She seemed eager to give him back to the nurses, and requested that the nurses feed him. The doctor had reassured Lucy that her baby was perfectly healthy, and would catch up within a couple years.

When her caseworker visited, Lucy talked about how cute her son was, even though he was little, and how happy she was to have him. During two follow-up home visits, the baby was in his crib in the bedroom. Lucy

ignored his cries for long periods. When she did hold him, she did so awkwardly, and then quickly returned him to the crib. When the worker asked Lucy why she never held him, Lucy shrugged and said, "I hold him as much as he wants." She told the worker he ate and slept really well, and had adjusted to being home, and that she was really happy.

The worker concluded from the process-level communication that Lucy was still uncomfortable holding and handling her child, and she did not appear to have developed a strong attachment to him. Lucy's verbalized acceptance of the baby was not congruent with her apparent behavioral rejection of him. The worker believed the process message, and continued to monitor the case closely. She was correct in her assessment; she returned the small, sickly baby to the hospital two weeks after he had come home, and he was diagnosed failure to thrive.

Conducting the Assessment

To conduct an accurate family assessment, the caseworker must elicit, observe, and interpret process-level issues and concerns. This requires expert listening, questioning, observation, and interviewing skills. (See related discussion in Section IV-F, "The Casework Interview: Implementing the Helping Process.")

Assessing a family requires tenacity. The skilled worker must continue to ask herself "Why?" until she is fully satisfied that she has an answer that is consistent with what she has observed or already learned. If she becomes aware of a discrepancy, she will continue to question and search until she can resolve it.

She will work until she is comfortable that she has fully explored the issue and understands all its dimensions, and hopefully, identified its roots.

For example, if a worker observed that three young children were unusually small for age and sickly, she would likely ask, "Why aren't they growing?" She might learn that they're malnourished. She would again ask "Why?" and might determine it is because their mother does not feed them. She must question, "Why not?" There are multiple possible answers: the mother doesn't know how; she has no money; she is involved with her boyfriend and forgets; she's mentally retarded and doesn't understand she should; she's psychotic and out of touch with reality; she's a member of a cult that preaches starvation as penance; she is always spaced out on crack; she is impulsive and spends her money on recreation. Once the worker has determined the answer to this last "why," she will have identified the primary origin of the children's poor development.

The effectiveness of the solution, however, is entirely dependent upon whether it correctly addresses the problem. Teaching the cult member how to properly prepare meals, and devising a feeding schedule won't result in change, unless the mother's values can also be changed. Telling a psychotic parent she must feed her children will not eliminate the irresponsible behavior associated with her psychosis. Teaching good nutrition to a mother who has no money will not enable her to buy sufficient food for her children, regardless of good intentions.

In child welfare casework, the presenting problems of abuse or neglect are usually a manifestation of underlying conflicts, concerns, and stressors, which can only be identified by assessing the dynamics of the family's situation, i.e. the

"process." (See related discussion in Section II-B, "Dynamics of Child Maltreatment.")

While most families can tell us a great deal about their situations, many are unaware of how interpersonal, social, and environmental conditions, as well as their own perceptions, needs, and feelings, contribute to the "presenting" problems of abuse or neglect. A goal of casework intervention is often to help families develop a better understanding of their own situations, and identify the factors that affect them. Helping families correctly identify the underlying problems can generate successful solutions.

Similarly, many families remain unaware of their own strengths and potentials, since these are often overshadowed by stresses and problems. Becoming aware of these valuable personal and interpersonal resources enables families to utilize them as coping and management strategies. If the family assessment is jointly conducted, it can provide families with necessary information to identify solutions to their problems, and empowers them to utilize their skills and strengths to implement them.

Application

This section reviews and discusses the relevant factors that should be routinely considered in a child welfare family assessment. The factors to be assessed are fully described, including listings of behavioral indicators. The ways in which these behaviors constitute either risk factors or strengths are also identified. Finally, relevant issues for case planning and intervention are also discussed.

Determining the Composition of the Family

The caseworker's first task in family assessment is to determine who is included in the family. We can make serious errors if we make assumptions without asking the family members themselves.

The term "family" generally refers to persons who are related through a common genetic heritage. However, the actual composition and structure of families may differ considerably among cultures and over time, and even within a particular family, as new members are born, added, die, separate, or emancipate. Families often include grandparents, aunts, uncles, and cousins, as well as close family friends, godparents, or honorary aunts and uncles who are incorporated into the family system.

There are also significant differences in the structure of families. The stereotypical definition of an American family is a husband and wife, and their children. In reality, this isolated nuclear family is the exception, rather than the rule. Most healthy families, regardless of culture, have strong ties to grandparents, adult siblings, and in many cases, large extended family networks of cousins, aunts, uncles, and others. The relative importance of these people may vary among families and within families under different circumstances. For example, in some families, extended family members have regular, perhaps daily contact with each other, participate in each others' decisions, and serve as an important source of support. Other families manage their day-to-day living within the context of their immediate family, and communicate with extended

family members less frequently. However, during times of celebration, such as a graduation, a wedding, or reunion, or during a crisis, such as the death of a family member, entire extended family networks may celebrate or grieve together. Cultural, interpersonal, and geographic factors all contribute to the degree and nature of any family's involvement with extended family members.

We must also differentiate the biological family from the psychological family. Both are important. While the biological family is determined by heredity, the psychological family is determined by attachment, and includes persons who perceive themselves to belong together as an intimate social group. This may include people unrelated by heredity, and in some cases, may exclude persons who are biologically related.

Child welfare workers must understand how each family sees itself. Who is included, and who is not? How are they important to each other? Who provides support and help to whom, and under what circumstances? Who leads or directs family activities? Whose influence is respected, and whose advice is likely to be followed? And, who can potentially interfere with a change effort, particularly if they are not engaged and involved?

The best way to determine the composition of any family and the relationships between its members is to ask its members open-ended questions, such as, "Tell me who is included in your family. Who are you closest to? Who makes the rules in your family? Whose opinion do you value? Whom do you ask for help, or advice?"

The caseworker might also ask family members to each draw their family, however they like. Using large sheets of paper and crayons or markers promotes creativity, and gives family members considerable freedom to express their views in a nonthreatening manner. They can then review each others' drawings, and discuss similarities and differences. Genograms are another means of identifying family patterns and relationships.

Finally, workers must solicit information about family members who are not currently involved with a child. This includes absent or "unnamed" fathers or mothers, and their extended families. These persons may be very important resources for children in our care. Yet, workers often fail to identify and locate these family members, or to engage them as supportive resources for children.

Several factors related to family composition, structure, and relationships should be assessed to identify problems and strengths. These are:

Strengths

- Families that include a consistent group of people who have relationships of long duration, and who have regular access to each other, in person, by telephone or letter, or through periodic visits.

- Families in which members maintain a strong identification with one another and view themselves as a family group.

Conditions That Increase Risk

- Nuclear families that are emotionally disengaged and isolated, or geographically separated from other family members.

- Families in which the pattern of membership is constantly changing, with little stability or continuity in relationships. Husbands or wives, boyfriends and girlfriends, and extended family members are continually changing.

- Family members do not agree on who constitutes their family. There is no consistent identification of members with the family unit.

- Parents who are isolated, without consistent family involvement, lack a significant source of support during times of stress. The absence of family support also increases stress, which concurrently increases risk.

Family's Strengths, Skills, Protective Capacities, and Motivation

A thorough assessment of the family's strengths and abilities is a critical component of the family assessment process. It helps to identify areas of strength and protective capacities that can be directed toward resolution of current risk and problems. A secondary benefit is the increase in self-esteem and motivation that can result when family members recognize their own positive traits and attributes, and receive validation of these strengths from the caseworker and other family members.

The caseworker considers family strengths throughout the assessment process. To fully identify a family's strengths, data collected during the assessment should be summarized, and the following factors should be assessed:

- What do the family members do well? What are they proud of? What gives them a sense of self-worth and satisfaction?

- What types of stresses and problems has the family dealt with successfully in the past? How did they do it? What resources and coping strategies did they use?

- In what ways might the family's strengths be supported and directed most effectively toward helping to resolve the current problems?

- What further education, support, or other interventions can build upon and further develop the family's existing strengths and resources?

- What are family members motivated for? What do parents want for themselves and for their children? How can they direct their energies toward the achievement of their own, self-selected goals.

- How are the family's own goals or desires consistent with the agency's expectations, and what may interfere with the family's ability to pursue these goals? What barriers can the caseworker or agency help to eliminate to enable the family to work toward achieving their own goals?

- A family's strengths must be viewed beyond the individual or nuclear family. Strengths may include a strong network of extended family and friends, identification with a larger social or cultural group, and commitment to group values and standards.

Points of Discussion

A family's strengths and protective capacities may not be immediately evident to the caseworker, or to the family members themselves. It is easy to lose sight of strengths and abilities when we are confronted with multiple, complicated, and challenging problems. However, a family's ability to manage under adverse circumstances should be recognized as a valuable strength. Examples are: the ability to meet basic needs on a very limited income; surviving a 24-hour day with four children under the age of five; and personal characteristics such as stubbornness, willfulness, and determination, which can be positively directed toward problem resolution.

Strengths may also be nascent. That is, precursor abilities or traits may be present, but the strength may not be fully developed. Casework intervention with a developmental focus will help the parents to identify traits, qualities, and attributes in themselves that can be considered elements of strength, and can help them learn to use and develop these abilities in productive ways. Casework strategies to promote such growth include modeling new behaviors, rehearsing, providing positive reinforcement and feedback, and rewarding the effective use of new strategies.

Families are often labeled "unmotivated" by their workers when they fail to do what the agency or caseworker believes should be done. Some of these families are actually highly motivated – to retain the status quo, to avoid change, and to avoid engaging with the caseworker. The question is not, "Are they motivated?" but rather, "What are they motivated for?" To achieve an accurate assessment of a family's motivation, the caseworker must assess the family's ability to persevere toward a goal that they have selected for themselves.

Family-centered practice supports the identification of goals and objectives that family members and the worker can agree upon. Service activities can then be formulated which the family sees as valuable. A mutual approach to case plan development, therefore, can increase the family's motivation to implement plan activities. Casework activities should also be directed toward helping the family recognize the value of agency intervention, and enlisting their involvement in the change process.

Environmental Stressors and Resources

A family's economic stability is one of the most important factors in determining family needs and strengths. The physical environment can create stresses and challenges that make it impossible for family members to attend to anything other than daily survival. The physical environment can also offer significant resources and supports to help a family meet its needs.

Abraham Maslow's hierarchy of needs provides a framework within which to understand the profound effects of a stressful, unsupportive economic and physical environment on family functioning. Maslow's model represents human needs as a triangle, with the most basic of needs – physical survival –at the base of the hierarchy. Maslow contends that all energy will be directed toward meeting fundamental survival needs first.

Many families in the child welfare system live in economic situations that qualify as poverty. At times, the poverty is of long duration, and is not likely to change in the near future. Maslow's paradigm suggests that it is ludicrous to talk with family members about "self-actualizing" behaviors, such as attending classes or developing a hobby, when the family doesn't know how it will feed itself next week.

When families are subjected to stress from environmental and economic deprivation, they may be less able to provide for the basic needs of their children. This can result in marginal care or neglect, and can also be a precipitating stressor for abuse. One objective of child welfare services is to identify and eliminate economic stressors that contribute to risk of maltreatment in families.

The family assessment should evaluate the family's immediate economic and environmental situation, including: level and stability of income; ability to budget and manage money; availability of food, proper clothing, and home furnishings; safety and appropriateness of housing; availability of utilities and services; and the accessibility of transportation.

The availability of support systems and resources, and the family's ability to access such services, should also be assessed. This should include:

- The family's values regarding the use of formal agencies and other community support services.

- The family's knowledge of the services available to them.

- The family's current use of community support agencies, resources, and services to meet basic survival needs. Are they utilizing all supports and resources that are available to them?

- The family's current use of community and neighborhood resources for interpersonal support, including churches, neighborhood networks, parent groups, and community service agencies.

- The family's ability to access services, and potential barriers to access, including lack of transportation, lack of confidence, lack of understanding of the system, and previously unpleasant experiences with service providers.

Strengths

- The family can meet their basic needs for food, shelter, clothing, safety, and health care.

- The family is able to manage on a limited income, and can maximize the use of their resources.

Conditions That Increase Risk

- The family cannot meet immediate, daily survival needs. The family is without regular food, shelter, and other essentials for basic survival. The family is homeless.

- The family is without a dependable source of income, and cannot assure even short-term security. The ability to meet basic needs is cyclical.

- The family cannot manage on a limited income; money is not budgeted nor expended in the most efficient manner.

Services

When there are no psychodynamic factors contributing to maltreatment, the provision of support services to meet basic needs can greatly improve the quality of care given to the children. In families where there are multiple contributors, meeting their basic needs can eliminate a source of stress, and allow the family to direct energy toward resolving other problems.

The caseworker should serve as a case manager to identify and access economic and supportive services for the family. Such environmental problems should be addressed immediately.

Points of Discussion

A family that lacks the resources to meet their children's basic needs is not necessarily a neglectful family. Neglect implies a failure to provide for the children by a parent who has the capability to do so. In neglectful families, choices are made that are not in the children's best interests, even though other more appropriate choices could have been made. Poverty seriously limits choices, and day-to-day survival is a continual challenge. A family living in poverty, but doing the best they can with what they have, may need supportive services, but they should not automatically be labeled neglectful unless there is evidence to justify this.

The child welfare field has a responsibility to prevent child maltreatment whenever possible by helping families meet their children's basic needs. However, income-related social services cannot be the primary responsibility of the child welfare system. Many services needed by families living in poverty should be provided by other community service agencies, including county departments of human service or public welfare, community centers, housing agencies, and food pantries. Community-based, interagency service agreements are the most effective safety net for families experiencing economic stress. By accessing such community services, we can secure resources to eliminate significant family stress. However, the child welfare agency should allocate its own limited resources to assuring services for families in which children are at high risk of abuse or neglect.

Parental Conditions That Affect Parenting Ability

There are several conditions that can affect an individual's ability to parent, including mental illness, mental retardation, and other psychological conditions.

Mental Illness and Other Mental Health Problems

Mental illness and other mental health problems include psychotic conditions such as schizophrenia and paranoia; bipolar (manic-depressive) disorder; personality disorders; depression; suicidal thoughts or behavior; anxiety disorders; and severe behavioral or emotional disturbance.

Psychotic parents display pervasive thought disorders, emotional withdrawal, may have hallucinations or delusions, and may display erratic and unusual behaviors. Untreated psychosis can render a parent incapable of providing proper care to the children. The psychotic parent's inability to assess reality, and his or her often illogical thought patterns, can create very dangerous situations for children. Only a small percentage of parents who abuse, neglect, or sexually abuse their children are psychotic. Of those that do, many have been previously diagnosed and treated, but have failed to maintain their treatment or medication. Parents with mental illness may be able to parent, if they are properly diagnosed, treated, and maintained on an appropriate therapeutic regimen.

Indicators of Psychosis

The principal diagnostic indicators of psychosis listed below have been adapted from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). Clients who display these behaviors should be referred for psychiatric evaluation:

- *Delusions*. Delusions are erroneous and irrational beliefs that cannot be altered by rational argument or fact. Psychotic persons may have delusions of being persecuted or controlled by others; believe themselves to be very powerful; or believe themselves to be someone else. They may also believe that gestures, song lyrics, or other environmental cues are specifically directed at them. Some delusions are quite bizarre; for example, a psychotic person may believe that a stranger has removed his internal organs and replaced them with someone else's, without leaving any scars. One psychotic mother of a neglected child insisted that the pastor of the local church had been to her house during the night, and had searched her cupboards to locate and remove all the cooking oil.

- *Hallucinations*. Hallucinations are sensory experiences not consistent with real world stimuli. They may occur in any sensory modality (auditory, visual, smell, taste, or touch), but auditory hallucinations are the most common, such as hearing voices, often threatening, that are perceived as separate from the person's own thoughts. These must be differentiated from dreams and illusions. Hallucinations may also be drug-induced, and at times are an accepted part of religious experience in certain cultures.

- *Severely Disorganized Thought and Speech*. Thoughts may emerge with little serial connection and with loose, if any, association. Answers to inquiries may be only obliquely related or unrelated to the question. Speech may be so disorganized as to be incoherent. This is sometimes called a "word salad." The words may be clear and understandable, and the sentences may be well-constructed, but the meaning cannot be understood. For example: "My mother thinks John should go to school and visit the people in town, but when he does, he gets really upset, and in spite of this, in spite of this very fact, we just can't upset her. It's not right."

- *Grossly Disorganized Behavior*. May range from childlike silliness to unpredictable agitation. Activities of daily living may not be performed, resulting in unusual dressing patterns, inappropriate dressing for weather, and a markedly disheveled appearance. Grossly inappropriate social or sexual behavior may also be seen.

- *Catatonia*. Refers to a marked decrease in reactivity to the environment, sometimes reaching a degree of apparent complete unawareness. May include physical maintenance of rigid posture with resistance to attempts to be moved; maintaining bizarre postures; or displaying purposeless and excessive motor activity.

- *Flat Affect and Related Behaviors*. Includes poor eye contact; a face that appears immobile and unresponsive (as opposed to expressive and animated); the range of emotional expressiveness in tone of voice and

affect is clearly diminished most of the time. Person may sit for long periods of time and show little interest in the surrounding environment.

- *Paranoia*. Refers to the presence of prominent delusions or auditory hallucinations which are typically persecutory, grandiose, or both. The individual may have a superior and patronizing manner, and either a stilted, formal quality, or extreme intensity in interpersonal interactions. Associated features include anxiety, anger, aloofness, and argumentativeness.

Mood Disorders

Mood disorders include depression and bipolar disorders, which combine manic and depressive behaviors.

A depressed parent may not have the emotional energy to attend to the children's needs. Depressed feelings and behaviors may be situational, of relatively recent origin, and may be in response to a traumatic loss. Clinical depression is more chronic, normally long standing, less related to situational causes, and often has a physiological basis. Depression can also result from taking certain medications, including those for treatment of high blood pressure.

Diagnostic indicators of a major depression include the following symptoms, reported most of the day, nearly every day, for at least a two-week period:

- Depressed mood, including feeling sad, empty, tearful, either by self-report or observation by others; markedly diminished interest or pleasure in all, or almost all, activities; significant weight loss when not dieting; weight gain; or, change in appetite; regular insomnia (inability to sleep) or hypersomnia (sleeps all the time); agitation and restlessness, or slow, lethargic motor activity; fatigue or loss of energy; feelings of worthlessness, or excessive or inappropriate guilt; diminished ability to think or concentrate; indecisiveness; or recurrent thoughts of death, recurrent suicidal thoughts without a specific plan, a suicide attempt, or a plan to commit suicide.

Bipolar disorders combine manic and depressive behaviors. Indicators of manic episode include:

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood. This may include: inflated self-esteem; grandiosity; decreased need for sleep; more talkative than usual; the subjective experience that the individual's thoughts are racing; distractibility; significant increase in goal-directed activity; and excessive involvement in pleasurable activities that have a high potential for painful consequences.

Personality Disorders

Parents who have personality disorders may display dysfunctional patterns of behavior in all aspects of their lives. There are several types of personality

disorders with different symptoms. The personality disorders that most often contribute to child maltreatment are borderline, antisocial, paranoid, and dependent. The following reviews some of the more prominent symptoms of personality disorders that might contribute to abusive or neglectful parenting:

- Disturbances in interpersonal relationships, such as: the absence of healthy emotional attachments; frequently changing and "shallow" interpersonal relationships; a pattern of unstable and intense relationships characterized by alternating extremes of idealization and devaluation (borderline); acute discomfort with and reduced capacity for close relationships (schizoid); preoccupation with unjustified doubts about the loyalty or trustworthiness of others (paranoid); avoidance of interpersonal contact because of fears of criticism, disapproval, or rejection (avoidant);

- An absence of empathy and concern for others;

- Chronic impulsivity in ways that are potentially self-damaging (borderline); frequent disruption and changes in life circumstances; abandonment of children; erratic parenting;

- Antisocial or criminal activity, and failure to conform to social norms with respect to lawful behaviors; deceitful, repeated lying, use of aliases, or conning others for personal profit or pleasure; reckless disregard for safety of self or others; consistent irresponsibility (antisocial);

- Identity disturbance; markedly and persistently unstable self-image or sense of self (borderline);

- Excessive dependency; cannot make even small decisions without advice and reassurance from others; lacks autonomy and initiative; needs others to assume responsibility for most major areas of life (dependent); and

- Exaggerated self-esteem and self-importance; grandiose, unrealistic self-estimation of his or her capability and talents; unreasonable expectations of favorable treatment; takes advantage of others to achieve his or her own ends; arrogant, haughty, feels entitled (narcissism).

Strengths

- Parents who have sought medical or psychiatric help to control and manage potentially problematic physical or mental conditions.

- Parents who exhibit a willingness to accept help, both from professionals and other family members.

- Parents who recognize their limitations, and allow other family members to assume a more active parenting role with their children.

- Parents who have a history of good problem-solving and management skills, and who have survived stressful and problematic situations in the past.

Conditions That Increase Risk

- When a parent's mental condition or emotional problems result in grossly inappropriate or harmful parenting behaviors.

- When parents have a diagnosed mental illness or emotional disorder, but refuse to maintain themselves in a treatment program, including refusing to take antidepressant or antipsychotic medications.

- When parental behaviors are irrational, and parents cannot be trusted to make sound decisions or judgments about their children's needs or welfare.

Services

Some mental illness, particularly psychotic, depressive, and anxiety conditions, can be treated with proper medication, individual and family therapy, and supportive services. The prognosis for parents with personality disorders is variable, and will depend upon the type and severity of the disorder. A thorough mental health assessment is necessary to determine the severity of the disorder, and the prognosis for adequate parental functioning.

Limitations in Cognitive and Adaptive Social Skills

The intelligence and adaptive skills of parents with limited cognitive ability, or mental retardation, must be fully assessed to determine whether these parents have the capacity to retain primary responsibility for the care of their children.

Competent parenting often requires significant cognitive and adaptive capabilities, including the ability to process information and make judgments; the ability to use language for accurate communication; the ability to logically assess and solve problems; the ability to retain information; and the ability to make decisions after having considered probable consequences and outcomes.

There are two measures of a person's cognitive ability: formal measured I.Q., and their level of adaptive or functional behavior. Both should be considered to most accurately determine parenting ability.

Standardized I.Q. assessments cannot by themselves always accurately predict cognitive ability or functional capability. Illiteracy and learning disabilities may reduce cognitive performance, particularly in an academic or test setting, and these may be misinterpreted as more general cognitive limitations.
Assessing adaptive behavior provides additional data with which to determine an individual's functional abilities. Adaptive behavior is broadly defined as the degree with which a person can meet the expectations of personal independence and social responsibility expected of his or her age and cultural group. Adaptive behavior is usually comprised of:

- Skills to meet basic physical needs. These include eating, dressing, toileting, and personal hygiene and care.

- Skills for functioning in a living environment or community. These include: domestic skills such as cooking, cleaning, laundry, and home maintenance; travel skills; budgeting and shopping skills, and the ability to appropriately use money; and the ability to care for belongings.

- Social living skills include: interpersonal relationship skills, the ability to cooperate and get along with other people; language and communication skills; the ability to initiate and carry out purposeful activities; behaving appropriately in social roles and in social situations; the ability to assume responsibility; and parenting ability.

In some situations, persons may score higher on adaptive behavior measures than might be expected from their measured I.Q. score. For example, a person with a learning disability, such as a reading or verbal processing problem, may have difficulty on some aspects of an I.Q. test, but may not be significantly hampered in daily living activities. Learning disabilities are usually specific to a particular area of cognitive functioning, most often information processing and/or reading. While persons with learning disabilities may not perform well in school, their general knowledge and intelligence in other areas is often normal, or even exceptional.

The same is true for illiteracy. Many adults cannot read or write, often because of lack of opportunity to learn, or because of learning disabilities. They may be

embarrassed to acknowledge this, and as a result, may be misinterpreted as resistant when they fail to follow through with written agreements, such as the case plan.

Most parents with limited cognitive skills who are served by the child welfare system are in the borderline range of intelligence, or the mild range of mental retardation. A parent's level of intelligence and adaptive skill will determine whether the parent has the capability to retain primary responsibility for care of children. Many parents who function in the low-normal or borderline range, and in the upper range of mild mental retardation, can live independently in the community. They may be able to parent their children, when adequate supportive services are available. These supports may be provided by family members, friends, volunteers, or community agencies. (Additional information about serving persons with mental retardation can be found in Chapter VII, Child Welfare Services for Children with Developmental Disabilities.)

Strengths

- Parents who display cognitive strengths in their ability to process information, think through and solve problems, and communicate with others.

- Persons who are of low-normal intelligence or mildly mentally retarded, but who have well-developed adaptive behaviors, and can appropriately utilize supports and resources to assist them in their parenting.

Conditions That Increase Risk

- Parents who lack the cognitive ability to gather and process information needed to solve basic problems of day-to-day life and meet basic survival needs.

- Parents whose cognitive limitations result in harmful parenting practices and poor judgment in matters related to their children.

- Parents accurately diagnosed as mentally retarded, with significant limitations in both cognition and adaptive behavior, who have no family or community support, and who have sole caregiving responsibility for their children.

Services

Each parent who is thought to be cognitively limited or mentally retarded should be assessed by a psychologist who is proficient in assessing adaptive behavior, as well as intelligence, and who has had considerable experience working with persons who are cognitively deficient, or mentally retarded. Linkage to specialized services is essential.

Supportive services for persons with mild mental retardation may be difficult to find in many communities. Most funding in the field of mental retardation is prioritized for individuals who have more severe disabilities. Volunteer

programs, parent-aides, neighborhood networks, church groups, community centers, and other community-based services are possible resources.

When children remain with parents who are mentally retarded, out-of-home supportive and educational services can enhance the care they receive from their parents. The use of protective day care, preschool/Head Start programs, after school recreational programs, and involvement in community center activities provide children with stimulation, and with opportunities for social and emotional growth that may not be available to them within the home setting.

Points of Discussion

In situations where a parent with mental retardation cannot independently care for the child, and the child must be removed from the home to assure his safety, shared parenting between the primary parent and the child's foster or adoptive parent or caregiver can be an effective plan. The worker should consider the potential use of shared parenting as a permanent solution for children whose parents are mentally retarded and unable to independently care for their children, but who share close emotional attachments with their children.

Additional Psychological and Developmental Issues

As has been discussed above, some maltreating parents exhibit serious mental health, cognitive, and emotional problems, with subsequent problems in adaptive behavior. There are also less serious or pervasive psychological and developmental factors that, while not representing a particular clinical disorder,

can negatively influence parenting capacity. The caseworker should be able to recognize symptoms of these psychological or developmental issues, and should know how to refer the family to a psychologist or other mental health professional for further assessment.

Personal and interpersonal maturity are developmental variables that describe the degree to which a person has developed adult ways of relating to other people, and of dealing with life tasks and events. These factors are often referred in the psychological literature, specifically ego psychology, as "ego strengths."

Several factors are included in the category of ego strengths. Well-developed ego strengths contribute to resilience, resourcefulness, the ability to cope with stress, and the ability to constructively manage the challenges of daily living. By contrast, failure to develop these abilities and emotional resources reduces adaptive coping ability, increases vulnerability to stress, and increases the potential for dysfunctional behavior and ineffective parenting. We can examine each of these factors individually, and delineate typical behaviors for various points on the continuum.

Emotional Self-Control

Strengths

- The parent has good emotional control, displays emotional stability and constancy, and can manage stressful situations without extreme and unwarranted expressions of emotional distress. The parent is reasonably

even-tempered and goal-directed when faced with stressful and problematic situations. The parent reacts to minor stresses with patience, fortitude, and self-control. The parent holds his or her temper, and can express anger in an appropriate and non-harmful manner.

Conditions That Increase Risk

- The parent is emotionally labile and volatile, given to rapid mood swings, explosiveness, and strong emotional outbursts, with little apparent provocation. The parent flies into a tantrum when the child drips milk on the floor. The parent's moods vary widely from anger, to tears to euphoria on a moment-to-moment basis, depending on the immediate situation. The parent is easily provoked by very small, and seemingly insignificant, incidents.

Ability to Delay Gratification

Strengths

- The parent is able to plan ahead and can follow his own plan. The parent engages in behaviors that meet the children's needs before engaging in activities to meet his own needs. The parent can work toward a desired goal in small steps over a period of time. The parent budgets and saves money to purchase a costly item. The parent stays home when she cannot get a babysitter for her children, even when it means she cannot do what she wants. The parent spends money wisely to be sure she can feed the

family and pay the rent, even though she sees a dress she would really like to own.

Conditions That Increase Risk

- The parent acts in ways that provide immediate gratification, regardless of whether the timing is appropriate or socially acceptable. The parent is unable to wait a long period for gratification. The parent's "plans" are transitory, and can be frequently changed depending upon the immediate context, situation, and his emotional needs. The parent does "what he pleases, when he pleases" with little attention to the effects on others, including the children. The compulsion to "do what feels good now" is overwhelming, and is often acted upon. The parent misses a school conference because a friend called and asked her to go out. The parent goes out in the evening and leaves her children alone, even though she knows she should get a babysitter and she may get in trouble if she doesn't. The parent spends her paycheck on a television, even though she knows it may mean a week without food at the end of the month.

Ability to Accept Responsibility for Own Behavior,

Strengths

- The parent understands the relationship between his own behaviors and outcomes; and, he is able to recognize when his behavior has contributed to, or created a problem, or an undesired outcome. He can learn from his

mistakes. He can assume responsibility, and will try to make adjustments to his behavior to prevent the problem from reoccurring. The parent feels shame or guilt about her behavior and its negative effects on her children. The parent understands how her anger at her own mother was inappropriately transferred when she slapped her child, and she knows she must find other ways to deal with her anger without taking it out on her children. The parent realizes that her continuing involvement in drugs is the result of her spending time with drug-using "friends."

Conditions That Increase Risk

- The parent does not assume responsibility for his own actions, and often believes himself not responsible for events and their outcomes. He inappropriately places blame on outside forces or other people for his troubles. (The key word is "inappropriately." The worker must discern whether the negative event is, indeed, the result of someone else's actions.) The parent blames the referral source for calling the agency, even when he has severely beaten his son. The parent blames his boss for firing him, even though his own behavior on the job was inadequate. The parent believes it is "fate" that resulted in his using drugs. The abusive husband claims his wife was at fault for the abuse, because she "provoked me and asked for it."

Capacity to Realistically Assess Own Strengths and Limitations

Strengths

- The parent is able to participate in an introspective self-assessment, and recognizes both his strengths and weaknesses. The parent can be proud of his strengths, and can accept his faults without undue self-recrimination and chastisement. The parent recognizes his shortcomings and wants to address them. The parent can talk about what she does well and what she needs to learn to do better. The parent with limited reading ability asks for help in filling out a job application to be sure it is done well. The parent attends a parent education class because she realizes her child management techniques could be improved.

Conditions That Increase Risk

- The parent believes himself to be "faultless," and has an unrealistic perception of his own status and ability. He justifies his behaviors, regardless of their outcomes. He finds fault with people who criticize him, and believes himself undeserving of such criticism. The parent denies that he has any shortcomings. He defends his behaviors as being perfectly okay the way they are. He contends that his violence against his family is a perfectly appropriate way of keeping the family in line.

Level of Self-Esteem and Confidence

Strengths

- The parent feels confident and competent in important areas of her life. She can evaluate her own successes in positive terms. She feels good when she accomplishes something new, and she takes pleasure in her positive traits and attributes. Self-esteem and confidence support her efforts to try new things. She views new endeavors as a challenge. The parent expresses pride in her children and their accomplishments. The parent feels she did a good job in managing her tight budget to be able to buy her daughter a birthday present. The parent believes herself to be an excellent housekeeper, and wants to show the caseworker the new kitchen curtains she sewed. She shops at thrift shops to save money.

Conditions That Increase Risk

- The parent believes herself to be incompetent and incapable. She is highly self-critical, minimizes her achievements, and overestimates her faults. Her lack of self-confidence makes her afraid to try anything new, and she avoids unfamiliar and challenging situations. The parent does not follow through with case plan activities because she believes herself not capable, and is therefore defeated before she begins. The parent verbally chastises herself for all her failings, and takes more than her share of responsibility for problems. She may be depressed and immobilized. Or, she may insist defensively that she knows best what her children need, and may exaggerate the importance or effectiveness of her activities.

Capacity to Be Self-Directed and Autonomous

Strengths

- The parent can follow a planful course of action to define a problem, and to develop and carry out a proposed solution. The parent has confidence in her own ability to make decisions about day-to-day life events, can weigh the pros and cons of various courses of action, and can make the best decision based on this assessment. She can contribute information or an opinion about an issue, and is comfortable supporting her opinions or her decisions. The parent recognizes that her child is ill, and makes arrangements to take the child to the doctor. The parent learns that she is eligible for an additional subsidy and calls the agency to request application materials. The parent is able to communicate what she believes to be the best way to discipline her children, based upon their nature, and the seriousness of their behavior.

Conditions That Increase Risk

- The parent is not able to make autonomous decisions. She is dependent upon other people to tell her what to do, and how and when to do it. She defers to others to express an opinion. She vacillates, and never commits to a course of action. She is paralyzed by indecision. When asked what she thinks, she typically says, "I don't really know. What do you think?" When given options to choose from, she is unable to make a choice. She is unable to follow through with directions, unless someone else is with her

to guide her. There may be many people in her life on whom she relies to make even simple, day-to-day decisions. She rarely begins and completes a course of action on her own.

Services

In general, parents with a higher level of developmental maturity have significant strengths that can be used to improve parenting. These strengths should be identified during the family assessment process, and parents should be provided with support and guidance to develop and utilize their strengths to achieve positive change.

Parents who are developmentally immature can be helped to acquire and develop more adaptive skills through consistent, supportive counseling with a trusted, caring caseworker or therapist, or involvement in a supportive peer education group. Treatment should be directed toward helping the parent meet her own emotional needs, increasing her self-esteem, and learning that planful, autonomous, and responsible behavior can be emotionally rewarding.

Points of Discussion

Some parents who display behaviors which reflect very deficient ego strengths may have borderline, dependent, or other personality disorders. An accurate diagnosis is essential in order to develop the proper service intervention. A good psychological assessment can help the caseworker differentiate between clients with personality disorders, and clients who are developmentally immature.

Nature and Quality of the Parents' Interpersonal Relationships

Adults who are psychologically healthy are able to participate in mutually satisfying relationships with other people. Abusive or neglectful parents often have a history of painful, unsatisfying, or traumatic relationships. A parent's generalized distrust and avoidance of relationships may result in social withdrawal, sometimes referred to as "self-imposed isolation," and in chronic interpersonal conflict, both of which can be contributing factors to child abuse and neglect.

Strengths

- The parents can trust selected others, and believe that others can care about them and can be depended upon. They look to others for support, and expect to receive it. (The strength is in the intact *ability* to trust others, as exhibited by trust in close relationships. This does not necessarily mean that the parents will, or should, trust or accept help from anyone.)

- The parents display positive attachments to their children and to other family members. They reach out or respond to others; express affection and caring verbally and in culturally appropriate physical gestures; they appear to enjoy having their children around them, and they talk in positive or warm terms about other family members and their attributes.

- The parents can tolerate conflict in their relationships with others without feeling seriously threatened or uncomfortable. They are able to "work it out." (How this is done may vary among cultures; however, a mutually satisfactory or compromise solution is achieved.)

- The parents seek out help from others, and look to their relationships with friends and family members for support, nurturance, and guidance.

- The parents are selective with whom they choose to be intimate (emotionally, as well as physically); they show a normal degree of ambivalence or resistance in new or threatening relationships; they know when to be open and trusting, and when to be more reserved; and they are able to build intimacy with selected others over time.

Conditions That Increase Risk

- The parents are generally suspicious and untrusting of other people. They verbalize their belief that other people will harm them, or will let them down. (This may or may not be an accurate assessment of the quality of their relationships; however, the important variable is whether they have the ability to be trusting, provided the person they are with is trustworthy. Some people will not trust anyone.)

- The parents' relationships with their children appear to be distant, detached, or insecure. Parents may be withdrawn or indifferent to their children. They seem remote and unconcerned with their children's needs.

They do not respond emotionally to their children's cries or discomfort. They may be negatively involved, constantly hostile, combative, or punitive toward their children.

- The parents cannot tolerate interpersonal conflict. They withdraw, take offense, become remote, and sullen. Or, they deny the presence of conflict and try to avoid confrontation.

- The parents do not seek help, support, nurturance, and guidance from anyone. They do not have a reliable support system, either within or outside their families, and this appears to be by choice, not from lack of opportunity. The parents appear to promote a "self-imposed isolation," in which their issues, concerns, and needs are not shared with anyone. This limits their access to help and support during times of stress.

- The parents are indiscriminate in relationships, and will be equally intimate or distant in all relationships. They never allow themselves to get close to anyone; or, they are immediately open, sharing, and effusively communicative with strangers. They may express being "very close" to people they have only just met.

- The parents have continually shifting loyalties and involvements; persons who were best friends yesterday are enemies today, and vice versa. Other people may be overidealized or devalued on the basis of insignificant behaviors or unimportant personal qualities.

Services

Casework counseling and family therapy can help parents improve their interpersonal relationship skills, and can increase their satisfaction in relationships with spouses, extended family members, and with their children. Success in the counseling relationship can also increase a parent's willingness to turn to other people for help and support. Other service interventions may include support groups and treatment programs such as Parents' Anonymous, or Alcoholics Anonymous, in which group participation and support are central features. While a parent who is ambivalent about relationships may initially resist participation in such groups, with outreach and support from group members, they may eventually become integrated into the group and benefit from it.

Points of Discussion

Information about the quality of parents' interpersonal relationships may help the caseworker assess whether they can be engaged into a casework relationship. Parents with seriously damaged relationship ability will often not be able to form a trusting relationship with the caseworker. Parents who have the ability to relate to others in a trusting manner may still not engage with the caseworker, if the caseworker is perceived as a threat. However, these family members can often be engaged through persistent attempts by the caseworker to gently address and defuse their anger, hostility, resistance, and suspiciousness. (See

Section IV-B, "The Casework Relationship: The Foundation of Family-Centered Child Welfare.")

The casework relationship may be used as a therapeutic tool. Through a consistent, trusting, and satisfying relationship with a caseworker, at times family members can learn to trust others and can develop interpersonal skills, which can then be transferred to other relationships. The caseworker should not underestimate the potential benefits of casework for a family.

Coping Strategies and Responses to Stress

Crisis has been described as a predictable emotional state which results when people are subjected to overwhelming and unmanageable stress. Crisis theory suggests that much human behavior is directed toward maintaining physical and emotional equilibrium (homeostasis). When problems or events (stressors) occur which lead to an upset in this steady emotional state, people engage in a series of behaviors (coping), to resolve the problem, and to reestablish equilibrium. Crisis may result when normal coping activities are not adequate to resolve the stress, and equilibrium cannot be restored.

Crisis theory also suggests that problematic events are not equally stressful for all people. The meaning of the event to the individual (perception) influences the degree to which the event is experienced as stressful.

Stress

Stress usually involves some type of change in life circumstances. Changes in the environment, in interpersonal relationships, or in a person's individual development can be stressful. Some events are universally highly stressful, such as the death of close family or friends, marital separation, serious illness and personal injury, and environmental disasters. Normally, the magnitude of a change affects the degree to which the event is stressful. (A tornado that uproots trees in the yard is considerably less stressful than one which destroys the house.)

Coping

Most effective human coping responses can be described as constructive problem-solving responses. These include assessing the problem, using appropriate resources and support systems, and developing plans and strategies to directly address and overcome the problem. When such strategies are effective in managing a stressful situation, equilibrium is generally reestablished and crisis is avoided.

When an individual's repertoire of coping responses is inadequate to master and overcome the stressful situation, crisis often results.

Perception of the Event

The same or similar events may be experienced quite differently by different individuals. The individual's perception of the event affects the degree to which the event is experienced as stressful.

Crisis intervention theory has described three ways events may be interpreted, and has identified predictable emotional responses to each of these.

l) If the event is perceived as a loss or a potential loss, the predictable emotional response is depression. The greater the loss, the greater the degree of depression and the more severe the stress.

2) If the event is perceived or interpreted by the individual as a threat or a potential threat, the predictable emotional response is anxiety. The more significant the threat to the individual, the greater the degree of anxiety experienced, and the more severe the stress. Many events may be perceived as both a loss and a threat, thus causing both depression and anxiety.

3) If the event is perceived or interpreted by the individual as a challenge, and the individual believes himself or herself capable of avoiding a situation of significant loss or threat, the predictable emotional response is a mobilization of energy and activity directed toward resolving the situation.

Whether a crisis results from a stressful situation depends upon the interrelationship of stress, coping, and perception. Generally, low stress, effective coping ability, and a realistic and accurate perception of the event tend to prevent the development of crisis. Conversely, high stress, poor or limited coping ability, and a distorted or inaccurate perception of the event increase the likelihood of crisis.

Persons in a state of clinical crisis may display excessively high levels of anxiety and depression, and are generally unable to engage in purposeful, goal-directed behavior. Clinical crisis in a family is identified by assessing their recent history. If a recent event has created a threat or loss for family members, resulting in excessively high stress for them, and their psychological symptoms were precipitated or exacerbated by this event, then family members may be in crisis. The referral complaint of maltreatment, and the subsequent involvement of the child welfare agency are, at times, sufficiently traumatic to create a situation of crisis for a family, particularly if the children are removed.

The ways in which parents typically respond to problems can provide insight into their coping abilities. At times, the absence of effective coping abilities in otherwise healthy and well-intentioned parents can contribute to child maltreatment. Families who have limited coping ability and resources are at higher risk of crisis in the face of normal life stresses.

Strengths

The presence of effective coping strategies is a significant strength in families. It is evident that many coping strategies require the ego strengths that were discussed earlier in this section. These include:

- The ability to plan ahead; the ability to use structured, problem-solving activities to eliminate a stress or resolve a problem; the ability to take constructive action; the ability to identify and properly use community services, supports, and resources; and the use of interpersonal relationships for emotional support.

Conditions That Increase Risk

Ineffective coping strategies that tend to exacerbate, rather than resolve stress include:

- "Flight" responses, such as denying that problems exist, avoiding problem situations, or physically leaving the environment; and "fight" responses, which include blaming others for the problem, or becoming angry, belligerent, and demanding.

Services

Families in clinical crisis can be helped significantly by providing immediate, intensive, and supportive services. The family members' inability to act in

productive, goal-directed ways is a normal symptom of the emotional disequilibrium of the crisis state. Crisis theory suggests that most clinical crisis resolves within about six weeks. The outcome for the family can be either positive or negative. If the caseworker can establish a supportive relationship with the family during the crisis period, and, if the caseworker can provide services that reduce or eliminate the source of stress, the family can survive the crisis period with few long-term negative effects. In many instances, the positive actions of the caseworker during the crisis period can help the family function at an improved level after the crisis has been resolved. Families in crisis feel the need for help, and are, therefore, often more willing to accept guidance or intervention. A skilled caseworker can use the crisis period to help a normally resistive family engage in productive change.

This dynamic may help to explain the positive results obtained by intensive family preservation programs, when families are referred during a time of crisis. The crisis may be precipitated by the possibility of placement of the children if the situation does not improve. Not only are families more amenable to help and change when faced with crisis, but the structured interventions of the home-based service program provide immediate, concrete, and intensive assistance, with opportunities for families to learn new coping skills at a time when they are open to learning them.

Families who receive no supportive services when in crisis may become even more susceptible to stress, prone to further crisis, and may function at a less effective level than they did prior to the crisis. Caseworkers should be ready to identify situations in which the precipitant for crisis is the involvement of the

child welfare agency, and should assure that the family receives adequate supportive services as quickly as possible.

Many parents can learn to use more effective planning and problem-solving strategies through education and counseling. Family counseling sessions may be used to demonstrate planning and problem-solving skills, and to give family members the opportunity to practice these skills by addressing their own problems. In addition, by providing links to "naturally occurring" supports within the family's environment, the caseworker can reduce the family's vulnerability to stress, and can increase their capacity to solve problems.

The worker should note that parents who have mental health problems, are mentally retarded, or developmentally immature will often perceive stressors as more threatening, or have less coping capability, or both.

Points of Discussion

The strengthening of a family's coping abilities is a central strategy of crisis intervention counseling. A family in crisis is likely to be very receptive to trying new strategies, particularly if they hold promise of resolving the crisis situation. Caseworkers should be able to teach, demonstrate, and support the development of productive coping strategies by families they serve, and should routinely include these activities in their case plans.

Workers should also assess their agency's capability to provide immediate crisis intervention and intensive in-home services to families. This necessitates rapid

case transfer from intake to ongoing or in-home services, and the initiation of in-home services by a skilled caseworker within a matter of hours after receiving the case. Workers should understand that rapid provision of services to families in crisis can, at times, create a period of positive change which might not otherwise be possible. This may significantly shorten the period of time the case needs to remain open.

Parenting Skills

A thorough assessment should be made of the parent's usual parenting strategies and methods. The assessment of parenting skills must be made within the context of the family's social and cultural environment. The worker must understand the accepted parenting practices of the family's cultural and social group, including the meaning and intent of parenting interventions. It is possible to misinterpret the parent's behavior as inappropriate, if it is assessed from an inappropriate cultural perspective.

The parenting practices and capability of parents should be thoroughly assessed. Most parents have some parenting skills and strengths. They may have less knowledge or skill in some areas, or emotional factors may interfere with their parenting ability. These barriers may include debilitating poverty, mental illness, or lack of opportunity to learn. By helping families to meet their basic economic needs, by alleviating depression, and by providing parents with constructive and supportive feedback, we can often strengthen parenting capability.

Parenting abilities should be assessed independently in each of the following areas:

Basic child care skills: feeding and nutrition, bathing, dressing, maintaining a schedule; meeting health care needs; and health-related hygiene.

Strengths

- Parent provides child with regular feedings that meet child's nutritional needs. Parent provides a hygienic environment for the child. Parent dresses the child in clothes that are appropriate for the weather and that protect the child from illness. Child receives basic preventive health care (immunizations, dental care), and receives medical care when ill. Parent provides basic health-related hygiene (bathing, brushing teeth).

Conditions That Increase Risk

- Parent fails to meet child's nutritional, health, and safety needs. Feedings are intermittent, irregular, and do not meet basic nutritional needs. Children are not dressed to protect them from adverse weather conditions. Children's hygiene is not sufficient to maintain good health (serious diaper rash from leaving infants in soiled diapers; changing diapers without cleaning the diaper area; serious tooth decay from lack of hygiene). Children are not provided with necessary medical care.

Nurturing strategies to promote attachment: holding, cuddling, talking or playing with the child, responsiveness to the child's cues and approaches.

Strengths

- Parent regularly engages child in interaction through talking, playing, or cuddling. Parent responds in a timely manner when child is distressed or needs care. Parent properly interprets children's verbal and behavioral communications, and recognizes when child is hungry, tired, frightened, or in need of attention. Parent responds in an encouraging and positive manner when child approaches. Parent routinely demonstrates affection for child in a manner that is appropriate within the family's culture.

Conditions That Increase Risk

- Parent consistently ignores child, or fails to respond to child's advances. Parent does not differentiate child's cues, and does not respond to child's needs in a timely manner. Parent does not typically initiate play or interaction with child. Parent does not demonstrate affection for child. Parent handles and communicates with child in an abrupt, harsh, punitive manner.

Discipline strategies: including setting and enforcing limits, strategies to manage behavior, consistency in approach, and effectiveness of discipline strategies.

Strengths

- Parent sets limits for child's behavior that are appropriate for the child's age and development. Parent is consistent in enforcing limits, and utilizes interventions that are age-appropriate, culturally appropriate, and nonharmful to the child. The extent of discipline is appropriate for the situation. Discipline is administered in a manner that protects and educates the child simultaneously. Child understands "family rules" and the reasons for them.

Conditions That Increase Risk

- Limits set by parents are extremely rigid, or are unrealistic for the age and developmental capacity of the child. Discipline is rigidly and harshly administered. Discipline is excessive for the situation. Parent sets and enforces few, if any, consistent limits on child's behavior. Parent provides no structure or consistency for child. Child does not understand the "rules" of behavior.

Adequacy of supervision and parent's ability to recognize harmful situations and protect child from them.

Strengths

- Parent is always aware of child's location and activities, and intervenes to prevent child from harm. Parent redirects child when child appears to be in danger. Child is not permitted to engage in activities that exceed the child's developmental capacity. Parent leaves children with competent babysitters/caregivers. Parent also recognizes when she is experiencing excessive stress, which may affect the quality of child care, and can ask others to care for the child temporarily, or to provide help and support.

Conditions That Increase Risk

- Parent leaves young children unattended for long periods. Parent does not monitor child's activities, or allows child to engage in activities that exceed child's developmental capability. Parent does not redirect child from potentially hazardous situations. Child is left alone, or in the care of persons who are not competent caregivers. Parent does not seek help when under excessive stress, and child is placed at subsequent risk.

Parent's ability to encourage child's development: use of play, books, toys, household objects, television, interpersonal games, and other parent interactions with the child to develop cognitive, social, and language skills.

Strengths

- Parent engages child in activities that stimulate child's thinking, language, or motor development. Parent tries to provide child with age-appropriate toys. Parent encourages child to play with appropriate household items, and helps stimulate child's imaginative play (placing a blanket over a table to create a cave; riding a broom handle "horse"; building a city with plastic containers and cups; making up stories about pictures in magazines). Parent engages in conversations with child about child's activities. Parent seeks activities that will catch and hold child's attention. Parent engages in interactive play with child.

Conditions That Increase Risk

- Parent ignores child for long periods of time. Parent does not engage child in play or mutual activities. Parent's verbal responses to child are short, abrupt, and are limited in scope and content. Parent rarely initiates conversation with child. Parent often directs child to "go play," without further interaction or assistance. Parent prohibits imaginative play, or utilization of appropriate household items in play activities.

The degree to which the parent maintains stringent or unrealistic standards and expectations for the child's behavior, considering the child's age and developmental level.

Strengths

- Parent's expectations for child's behavior are consistent with child's age and developmental level. Parent knows typical developmental milestones, and can adjust parenting strategies to be consistent with child's capacity. (Parent does not discipline young infants for "misbehavior"; parent uses simple and clear consequences for misbehavior of toddlers; parent helps a seven year old understand what she did wrong.) Parent does not expect children to behave in adult-like ways. Parent can be flexible and alter expectations for a child in different situations (understanding that children cry more often when they are very tired or sick). Parent can individualize parenting interventions to best address a child's unique personality and needs.

Conditions That Increase Risk

- Parent's expectations for child's behavior are not appropriate for child's age and developmental level. Parent expects child to think, act, and interact in ways that are more typical of an older child or an adult. Parent is rigid in expectations, and cannot be flexible to accommodate different

situations. Parent does not change parenting interventions to meet child's developmental capacity, situation, or personality.

Services

Parent training is an appropriate intervention when neglect or abuse are the result of the parent's limited parenting knowledge and skill. These services can be provided through referral to parenting classes, or training in the home by a caseworker, a parent aide, a homemaker, or a trained foster caregiver.

Points of Discussion

Referral of parents to formal parenting classes is a common casework intervention, but it is not always appropriate. Many parenting classes were developed for parents with adequate parenting skills who seek techniques to improve communication, and promote the development of self-reliance and responsibility in their children. Participation in these parenting classes requires a high level of comfort in social and group situations. Additionally, unless parenting classes are offered from a culturally relevant frame of reference, many parents will refuse to attend, or will not complete the classes.

Formal programs to train parenting skills should be developed specifically to meet the needs of families in the child welfare system. Many parents need training in very basic child care practices. If such training is conducted in a group setting, the group leader must be skilled in developing group process with parents who may have limited social confidence or competence. A group setting

may be very helpful for many families, if they can be made to feel comfortable and supported in the group.

For many families, one-to-one, in-home training and coaching is the preferred means of teaching parenting. Parents are often more comfortable with, and learn more, if coached individually in the familiar environment of their own homes. Regular casework visits, visits in foster or relative homes, and other casework contacts can also be used as opportunities to help parents learn more effective parenting strategies.

Parenting strategies should also be consistent with the family's values and cultural perspective. Training in parenting techniques that are unacceptable within the family's culture will generally be unproductive.

In situations where improper parenting is not the result of lack of knowledge, but rather because of the parent's personal deficiencies or emotional problems, formal parenting classes are not an appropriate intervention. The caseworker must be able to differentiate the contributing factors to poor parenting before trying to determine the best service interventions.

Substance Abuse

The abuse of drugs and alcohol by parents has become an increasingly frequent contributor to child maltreatment. The risks to children can be quite high. Children of alcoholic mothers may be born with fetal alcohol syndrome, which is

characterized by growth deficiency, learning disabilities, behavior problems, and various degrees of mental retardation. Infants whose mothers used crack cocaine during pregnancy are likely to have neurological, behavioral, and other developmental problems. (Refer to Section VII-C, "The Primary Developmental Disabilities: Identification and Early Intervention," for more information on developmental conditions resulting from substance abuse.)

Children with substance-abusing parents are also at higher risk of physical abuse, neglect, and sexual abuse. As an example, it has been estimated that up to 75% of all incest incidents involve use of alcohol on the part of the perpetrator [Thompson, 1990].

Drug abuse can be defined as the use of a drug for other than medicinal purposes, which results in the impaired physical, mental, emotional, or social well-being of the user, or others who are dependent upon the user. Commonly abused drugs are alcohol, prescription drugs, sedatives, stimulants, marijuana, narcotics, inhalants, hallucinogens, phencyclidine, cocaine, and crack. These drugs affect the user's feelings, perceptions, and behavior by altering the body chemistry. Users often experience these physiological changes as mildly to intensely pleasurable – altering mood, reducing anxiety and depression, and creating feelings of euphoria sometimes referred to as a "high."

With some drugs, continued use sufficiently changes the body chemistry to increase tolerance. The user then requires increasing amounts of the drug to produce the same effect. The user may also become physically and/or emotionally dependent on the drug to function. This dependence, also referred

to as addiction, makes it extremely difficult to control or stop use of the drug. Withdrawal can cause a wide range of unpleasant, painful, and potentially dangerous physical and psychological symptoms.

Clearly, not all persons who use drugs or alcohol are drug dependent. The scope, frequency, and circumstances of parents' drug or alcohol use will determine the ultimate risk to their children. Drug use can be limited in scope and frequency, more or less controlled, and it may not significantly affect the user's functioning or parenting ability. However, for many people, recreational use of drugs and alcohol can be a "slippery slope," quickly becoming more chronic and serious, leading to abuse or addiction. This is particularly true of crack cocaine, a highly addictive substance. Zuckerman [1994] states that while becoming addicted to alcohol, heroin, or intranasal cocaine may take years, with crack cocaine this progression from recreational use to addiction can occur within weeks or months of first use.

Once addicted, the user has a "chronic, progressive disease in which there is a loss of control over the use of, and a compulsive preoccupation with, a substance, despite the consequences" [Zuckerman 1994]. The addict's primary goal is to maintain use of the drug. Pervasive disruption in all aspects of the addict's life – physical, psychological, economic, familial, interpersonal, and social – is a common result. The effects of substance abuse on parenting can be pervasive. Since addicts consider their own needs first, their children's needs for basic physical care, nurturance, and supervision are often not met, placing them at high risk of harm. According to Zuckerman [1994] the "primary relationship" of mothers addicted to crack "is with their drug of choice, not with their child."

Howard [1994] reports that mothers who are dependent on crack were found to be significantly less sensitive, responsive, or accessible to their children, and without exception, their children exhibited insecure attachments. Secure attachments were seen only in children whose mothers had been sober for at least six months prior to the testing procedure.

It is important to stress that in spite of the potentially serious outcomes of parental drug use for children, most drug addicts do not intend to harm their children, nor are they deliberately indifferent to their needs. They frequently exhibit extreme shame and guilt about the problems their drug use causes their children [Schottenfeld, Viscarello, Grossman, Klerman, Nagler, & Adnopoz 1994]; and they often devise complicated strategies to protect their children from the effects of their drug use [Kearney, Murphy & Rosenbaum 1994].

The deleterious effects of drug use on parenting are pervasive. Heavy use of drugs and alcohol typically interferes with thought processes, judgment, organization, and self-control. Substance abusing parents are often disorganized in their thinking and actions, they lack follow-through in all their activities, and their parenting responses are unpredictable and inconsistent [Howard 1994]. In addition, blackouts, binges, and drug or alcohol-induced stupors, which are common with heavy substance abuse, can create very dangerous situations in which children are left totally unsupervised, placing them at high risk of harm. In fact, Zuckerman [1994] contends that, "If the mother is addicted, the child's safety can be assured only if an adult who does not use drugs is in the household and is willing to take care of the child, or if the mother is actively involved in treatment that regularly monitors the child."

In spite of high correlations between substance abuse and child maltreatment, substance abuse in maltreating families is not always identified. Many caseworkers are not aware of the signs and symptoms of substance abuse or addiction, and they may be uncomfortable asking the pointed questions necessary to determine the scope of drug or alcohol involvement. Denial is also a typical symptom of addiction. Substance abusers often deny that they use drugs or alcohol, or they may contend that their drug use causes no problems for themselves or their children.

In addition, research by Kearney, et al. [1994] suggested that mothers on crack devised many strategies to hide their drug involvement, to shield their children from drugs and the drug life, and to make up for crack's negative effects on mothering. These strategies included keeping children physically apart from cocaine by never using the drug in front of the children; hiring babysitters or leaving children with relatives prior to using the drug; or waiting until the children were asleep or safely situated. Mothers also made certain their appearance did not reveal their drug-using status when they visited schools or other child-related settings, and they lied to agency officials or family members about their drug use. Most women described how they separated family money from drug money to assure that their children's needs were met. As their crack use became more frequent, they reported paying all their bills as soon as their paychecks or welfare checks arrived, because any unspent money was vulnerable. As a result, many of the mothers were able to hide the fact of their drug use from family, friends, and the community.

However, these compensatory strategies eventually broke down for almost 70% of the mothers in the study. Many were unable to reduce or stop drug use, and they eventually exhausted their emotional and financial resources. Many of the mothers then voluntarily entrusted the care of their children to family members, or their children were removed by protective service agencies. The mothers appeared to be more readily accepting of placement of their children if they themselves made the placement arrangements, than if the child protection agency removed their children without their consent. Drug use often escalated after placement of the children, reportedly as they now had no mothering responsibilities, and as an attempt to deal with the pain and sadness of losing their children.

Recognizing Signs and Symptoms of Substance Abuse

Because there are a wide variety of substances used, and an equally wide variety of indicators and symptoms, it is usually not possible for caseworkers to accurately diagnose which drug is being used or to what degree. Users may also concurrently use more than one substance. Anyone suspected of drug abuse or addiction should be evaluated by a professional in the field of substance abuse.

The most common general indicators of substance abuse are: altered mood states (euphoria, anxiety, irritability, excitability, sluggishness, or depression); changes in appetite and sleep patterns; temperamental or erratic behavior; poor memory and judgment; confusion and inability to concentrate; moodiness and restlessness; lack of concern about personal appearance; lack of attention to the environment; and clumsiness and coordination problems.

The following descriptions of the most commonly abused substances are designed to help caseworkers recognize when substance abuse is a contributor to maltreatment.

(Information that follows has been adapted from pamphlets distributed by the Michigan Substance Abuse & Traffic Safety Information Center, and the United States Department of Education.)

Alcohol Abuse

Alcohol is a sedative and a central nervous system depressant. In even small amounts it has a tranquilizing effect on most people, and it depresses the brain centers for self-control and inhibition. Lowered self-control often leads to loud or aggressive behavior, and makes alcohol appear to be a stimulant. Alcohol dulls sensation, impairs memory, decreases muscular coordination, impairs vision and other senses, and impairs judgment. The greater the amount of alcohol consumed in a particular time period, the more pervasive the effect. However, individuals often react very differently to comparable levels of alcohol. When ingested in large quantities, alcohol can cause unconsciousness, coma, respiratory failure, and death. It can also damage many body organs including the liver, heart, and brain. Use of alcohol by pregnant women can cause fetal alcohol syndrome or fetal alcohol effects in their infants. (See Section VII-C, "The Primary

Developmental Disabilities: Identification and Early Intervention," for discussion of fetal alcohol syndrome and fetal alcohol effects.)

Alcohol can be both physically and psychologically addicting. Dependence on alcohol is called alcoholism. The user loses control and continues to drink, despite major and continuing negative consequences. Signs and symptoms of alcohol intoxication include slurred speech, unsteady walk, poor muscle tone, relaxed inhibitions, impaired fine and gross motor coordination, stupor, and slowed reflexes.

Indicators include the odor of alcohol on clothes or breath, and the presence of empty beer, wine, or liquor cans or bottles in the user's environment. Denial may be present. Users sometimes hide alcohol, or may greatly minimize how many drinks they have had. Many alcoholics describe themselves as "social drinkers," and insist they only drink because it's enjoyable and they can stop any time they choose. However, to them it is always enjoyable, and they never want to stop.

Inhalants

Inhalant abuse is the deliberate inhalation of a volatile substance for the purpose of getting "high." Commonly inhaled substances include: glue and other adhesives; paints and lacquers; household cleaners and solvents; fuels and fuel exhaust; hair spray and other

chemicals in cans with propellants; nail polish and remover; typing correction fluid; marking pens; and others similar products. Many of these chemicals are extremely toxic.

The inhaled substances are often quickly absorbed into the blood stream and carried directly to the brain. They can depress the central nervous system, and can cause fatal cardiac arrhythmias (irregular heart beat), asphyxiation, accidents, and suicide. Use during pregnancy can damage the fetus. Because inhalant substances are easy to obtain and are low in cost, they are often abused by youth and other persons who can't afford more costly substances.

Indicators of inhalant abuse vary among individuals and with the substance abused, but often include sores or a rash around the mouth or nose, hand tremors, a chronic cough, red or runny nose, nosebleeds, a chemical smell on the user's breath or clothing, and other signs of acute intoxication (drowsiness, unconsciousness, slurred speech, loss of muscle coordination, slowed reflexes, and a dazed or dizzy look). Users may become abusive or violent toward others. Environmental clues include the prevalence of spray cans or soda cans that smell of chemicals around the house, car, or bedroom. Abuse paraphernalia may include plastic bags, and old rags or socks with peculiar chemical odors.

Street names for inhalants include: laughing gas, whippets, poppers, snappers, rush, bolt, locker room, bullet, and climax.

Cocaine and Crack

Cocaine in its pure form is a white crystalline powder extracted from the leaves of the South American coca plant. Cocaine is normally mixed with other substances before being sold on the street, usually to increase the profit for the seller. The purity may range from 30 to 90%, making it extremely difficult for a user to determine how much is actually being ingested. Accidental overdose is a common cause of death with cocaine abuse. The substances mixed with cocaine are often, themselves, dangerous.

Cocaine in powder form is usually inhaled into the nose, or "snorted." Cocaine may also be converted to be smoked ("freebase") or can be injected. Cocaine is physically risky in all forms; overdose can result in heart failure, convulsions, respiratory failure, and death. In a sensitive individual, even small amounts of cocaine can have life-threatening consequences. Smoking or injecting cocaine greatly increases the risk of overdose, because very large doses reach the brain within seconds.

"Crack" is a crystallized form of cocaine. When smoked, crack transmits cocaine in very high concentrations to the small blood vessels of the lungs, producing an effect comparable to that of an

intravenous injection. Because of its rapid absorption, crack is a very dangerous drug; overdose is frequent, and many deaths have occurred. A high percentage of users quickly become addicted to the drug.

Some effects of cocaine include dilated pupils and increases in blood pressure, heart rate, breathing rate, and body temperature. Initially, the user usually feels exhilaration and a sense of well-being, with more energy, and alertness. Cocaine is a short-acting drug; when snorted, its effects begin within several seconds to a few minutes, peak in 15 to 20 minutes, and disappear within an hour. When injected or smoked, cocaine effects occur almost immediately and diminish sooner. Once the effects of the drug wear off, users are likely to feel more depressed, less alert, and more anxious than before they took the drug ("coke blues"). Use of the drug is then increased to feel "normal." Users often get caught in "binge and crash" cycles, in which other drugs are taken to get rid of the depression that follows the short cocaine high.

Signs of regular use include weight loss, chronic runny nose with damage to the nose and sinus, lowered resistance to infections and disease, and high blood pressure. Needle marks may be visible if cocaine is injected. Behavioral signs include increased irritability, short temper, paranoia, difficulty with concentration or memory, loss of interest in sex, and panic attacks. After weeks or months of binges, depression can become chronic, and hallucinations and

other signs of psychosis may appear. Signs of withdrawal include exhaustion, irritability, sleepiness, loss of energy, depression, and an intense craving for more cocaine. Environmental clues include the presence of white crystalline powder (cocaine); light brown or beige pellets, or crystalline rocks (crack); glass vials; glass pipes; razor blades; and syringes.

Street names for cocaine include: coke, snow, flake, white, blow, nose candy, Big C, snowbirds, and lady. Other names for crack are rock and freebase rocks.

Stimulants

Stimulants are a class of drugs that stimulate the central nervous system, and produce an increase in alertness and activity. They include amphetamines (dexadrine, benzedrine), methamphetamine, ephedrine and phenylpropanolamine (decongestants that are used in a variety of nasal inhalers and cold medicines); caffeine, nicotine, and some prescription drugs (methylphenidate, used to treat Attention Deficit Hyperactive Disorder). Cocaine also has stimulant effects.

People take amphetamines to feel alert, energetic, or to get high. They often report a euphoric sense of well-being. Regular use of amphetamines at high doses can cause drug dependence. Dependent users often feel that they need the drug to get by, and

they increase its use and dosage to avoid the "down" mood they experience when the "high" wears off.

Heavy and frequent doses of amphetamines can produce brain damage, resulting in speech disturbances and difficulty expressing thoughts. While limited amphetamine use generally does not compromise parenting, toxicity can produce a condition known as amphetamine psychosis; the user becomes extremely suspicious and paranoid, hallucinates, may become delusional, and frequently exhibits bizarre and sometimes violent behavior. Death can result from amphetamine overdose through injection.

Signs and symptoms of heavy amphetamine use can include restlessness; anxiety; mood swings; panic; paranoid thoughts; and hallucinations. Physical effects may include sweating, headache, blurred vision, and sleeplessness. Physical symptoms of long-term use includes acne resembling a measles rash; trouble with teeth, gums, and nails; and dry, lifeless hair.

"Ice" is a smokable crystal form of methamphetamine. Known also as speed or crystal meth, it is a powerful synthetic stimulant. The smoke is odorless and the residue that stays in the pipe can be resmoked. Methamphetamine is often smoked in "runs," periods of continuous use that last an average of five days, with an average of four days between smoking periods. The days of abstinence are

generally spent sleeping. Marijuana and alcohol are often used to "come down" from a methamphetamine high.

Users of methamphetamine report increased physical activity, restlessness, and anxiety. They repeat simple acts, become very talkative, and can be difficult to understand because of abrupt shifts in thought and speech. Impaired judgment, impulsiveness, and insomnia are also present. Methamphetamine is highly and rapidly addictive, and drug tolerance develops quickly. Drug-induced psychosis is also common with high doses of methamphetamine.

Withdrawal symptoms during abstinence from methamphetamine include severe depression, decreased energy, agitation, anxiety, and limited ability to experience pleasure. A "crash" often immediately follows a binge, characterized by extreme exhaustion and an overwhelmingly powerful need for more of the drug.

Street names for amphetamines include: speed, uppers, ups, black beauties, pep pills, copilots, bumblebees, hearts, footballs, crank, crystal methedrine, or crystal meth. Most stimulants are taken in the form of capsules, pills, or tablets. Methamphetamine crystal (ice, or crystal meth) is a large clear crystal that resembles a block of paraffin.

Depressants

Depressant or sedative drugs depress the central nervous system, causing relaxation, sedation, and producing sleep. Tranquilizers and sleeping pills are commonly used sedatives.

Barbiturates, the most commonly abused sedatives, include pentobarbitol (Nembutal), secobarbital (Seconal), and amobarbital (Amytal), all of which are legal prescription sleeping aids. Other nonbarbiturate sedatives include glutethimide (Doriden), meprobamate (Miltown), methyprylon (Noludar), and ethchlorvynol (Placidyl). Another category of depressants, the benzodiazapines, include Valium, Serax, and related drugs. Methaqualone (Quaalude, Sopor) was once commonly abused, but is no longer legally available in the United States.

The effects of depressants are in many ways similar to the effects of alcohol. Small amounts can promote calmness and relaxation, but larger doses lead to slurred speech, staggering gait, and altered perception. Very large doses can cause respiratory depression, coma, and death. Combining alcohol with depressant drugs can multiply the effects of both drugs, and increases the risks of side effects and overdose.

Depressants can be both physically and psychologically addictive, and tolerance is often developed. Infants of mothers who abuse

depressants during pregnancy can be born physically addicted, and can experience withdrawal symptoms shortly after birth. When used improperly, sedatives can be very dangerous; barbiturate overdose is implicated in nearly one-third of all reported drug-induced deaths. Nonlethal overdoses can cause a coma. Moderately large doses produce an intoxicated stupor. While many people have legitimate prescriptions for these drugs, they may take more than is prescribed, or they may share prescribed drugs with other persons. Some users obtain sedatives by using faked prescriptions. Withdrawal symptoms range from restlessness, insomnia, anxiety, to convulsions and death.

Street names for depressants include: downers, barbs, blue devils, red devils, yellow jackets, yellows, ludes, and sopors. They are orally-administered tablets and capsules. The red, yellow, blue, or red and blue capsules give the barbiturates their common names.

Narcotics / Opiates

Narcotics are drugs that relieve pain and often produce a sense of well-being and a sedative effect. They include opiates such as opium, morphine, codeine, and heroin, and certain synthetic chemicals that have a morphine-like action, such as methadone. They also include meperidine (Demerol), and other narcotic pain killers (Percocet, Percodan, Oxycontin, Fentanyl, Norco).

Prescription painkillers (opiates) and heroin are the most widely abused narcotic drug, and continued use of either can quickly cause addiction. Tolerance to the drug develops quickly, and dependence is likely. Addiction in pregnant women can lead to premature, stillborn, or addicted infants who experience severe withdrawal symptoms.

Heroin is normally injected intravenously, inhaled through the nose or smoked. Other narcotics can be taken orally or injected. Overdose through intravenous injection can cause death. Unsterile syringes and needles can transmit disease, including HIV (AIDS) and forms of hepatitis.

When an opiate or heroin-dependent person stops taking the drug, withdrawal begins within four to six hours after the last ingestion of the drug. Withdrawal symptoms can become severe in 12 to 16 hours from the last dose, and include shaking, sweating, vomiting, runny nose and eyes, muscle aches, chills, abdominal pain, and diarrhea.

Methadone is a synthetic narcotic often used to treat heroin addiction. When given in daily measured and decreasing doses to relieve the physical craving for heroin and prevent withdrawal symptoms, methadone can allow the heroin addict to both withdraw from his heroin addiction and lead a more normal life. However, methadone itself causes physical dependence, and it is

under strict regulation to prevent misuse. Some heroin addicts must also be eventually withdrawn from methadone. Drugs typically used to treat opiate addiction include buprenorphine and naloxone (Suboxone).

Signs and symptoms of narcotic use include euphoria, drowsiness, sensitivity to pain, nausea and vomiting, watery eyes, runny nose, cold clammy skin, and constricted pupils that fail to respond to light (pinpoint pupils). Other signs include needle marks on the insides of the arms, syringes, needles, and spoons. Heroin is sold as a white to dark brown powder or tar-like substance. Prescription narcotic pain killers come in tablet, capsule, or liquid form, including injectable solutions.

Street names for heroin include: smack, horse, brown sugar, junk, mud, Big H, and black tar.

Hallucinogens

Hallucinogens, also called psychedelics, affect sensation, perception, thinking, self-awareness, and emotion. Common hallucinogens are LSD (lysergic acid diethylamide); mescaline, peyote, and psilocybin.

LSD, mescaline, and psilocybin cause delusions and hallucinations, changes in time and space perception, and alterations in an

individual's sense of self. The perceptions of sensation may be reported as experienced across sensory modes; that is, users report that music is seen, or color is heard. Physical reactions include dilated pupils, rise in temperature, changes in heartbeat and blood pressure, and tremors. Some illusions and hallucinations may cause panic, confusion, and loss of control, or may lead the person to dangerous delusions, such as the belief that he or she cannot be harmed. This may promote irresponsible, self-destructive behavior. Longer-term harmful reactions include anxiety, depression, or more pervasive emotional disturbance. Delayed effects, or "flashbacks," can occur long after use has ceased. There have been reports of diverse and significant brain damage from the abuse of these drugs.

PCP (phencyclidine), sometimes categorized as a hallucinogen, is a very dangerous drug. Also called "angel dust," PCP was developed as a surgical anesthetic in the late 1950s, but its use was discontinued because of its unusual and unpleasant side effects. Effects vary among individuals and according to dosage levels. Low doses often provide euphoria and a feeling of numbness. Increased doses result in excitement and confusion, muscle rigidity and incoordination, loss of concentration and memory, visual disturbances, delirium, convulsions, speech impairment, violent behavior, fear of death, and changes in the users' perceptions of their bodies. Chronic PCP users report persistent memory problems and speech difficulties.

PCP can produce violent and bizarre behavior, even in people not otherwise prone to such behavior. PCP interrupts the functions of the neocortex, the higher cognitive centers which keep aggressive behavior in check. Violent behavior may be self-directed, or directed at others, and often results in serious injuries or death. More people die from the erratic and unpredictable behavior produced by the drug than from the drug's direct effects on the body. The drug also blocks pain receptors, and violent PCP episodes may result in self-inflicted injuries. In addition, a temporary, schizophrenic-like paranoid psychosis may occur which lasts from days to weeks. Users may be excited, incoherent and aggressive, or they may be uncommunicative, depressed, and withdrawn.

The hallucinogens can all be taken orally (chewed, swallowed, licked off paper). PCP can also be injected or smoked. LSD in liquid form can be put in the eyes. Mescaline and peyote can also be smoked.

Street names for PCP include: angel dust, loveboat, lovely, hog, and killer weed. Names for LSD include acid, green or red dragon, white lightning, blue heaven, sugar cubes, and microdot. Names for mescaline and peyote are mesc, buttons, and cactus. Psilocybin is known as magic mushrooms or 'shrooms.

Prognosis for Treatment

Currently, the prognosis for the treatment of substance abuse is quite equivocal. Different treatment programs report widely differing degrees of success with addiction to different drugs. Further, the need for drug abuse treatment far exceeds the availability of treatment resources. For example, in 1990 it was estimated that of the 105,000 pregnant women who needed drug treatment annually, only 30,000 received it [Nunes-Dinis & Barth 1993].

The prognosis for treatment of crack cocaine addiction is, at present, limited. Howard [1994] reports that most of the mothers in their study continued to use drugs, despite efforts by program staff to help their clients identify, enter, and stick with drug treatment. Only 15% of the mothers in the study remained abstinent for one year. Besharov [1994] concurs, suggesting that with crack cocaine addiction, "relapse is the rule, not the exception," and treatment success is defined as successfully increasing periods of remission, and controlling the damage done during relapses, rather than achieving permanent abstinence.

Wald [1994], however, cites a growing body of evidence to support the claim that the lack of success in treating crack cocaine addiction is at least partially related to the inadequacy of available treatment programs.

Substance abuse is difficult to treat because of the complexity of conditions and factors related to drug use. Several studies have noted the high percentage of drug-abusing mothers whose personal histories included physical and/or sexual

abuse, neglect, drug use, violence, multiple separations, discontinuous relationships, and other physical and emotional hardships [Howard 1994; Kearney et al. 1994; Chavkin, Paone, Friedmann, & Wilets 1993]. It is posited that the euphoric mood and feelings of well-being that are typical effects of many drugs may be used as an antidote to anxiety, depression, hopelessness, and shame. However, the etiology of drug addiction is not that simple, and the effects of individual personality, physiological make-up, environmental factors, and social factors must be considered concurrently with the user's history.

The prognosis for individual drug users varies considerably, depending upon several factors: the type of drug used; the scope and frequency of drug use; the longevity of the user's habit; the degree of tolerance or dependence; the individual's personal, and interpersonal strengths and resources; and the supportiveness of the user's family and social environment. The following "strength" conditions would, in general, increase the likelihood of successful treatment. The "risk" conditions, in general, are likely to make treatment more difficult.

Strengths

- Parents acknowledge their substance abuse, and fully understand the negative impact it has on their children.

- Parents are willing to engage in some form of substance abuse treatment, and attempt to remain involved in a treatment program. This may

include self-help and peer-help organizations such as Alcoholics Anonymous and Narcotics Anonymous.

- Parents make alternative caregiving arrangements for their children when they recognize themselves to be incapable of providing proper care.

- Parents are willing and able to separate themselves from friends, family-members, spouses, or others who continue to use drugs and support their continued use by the parent.

- Parents have a strong support network of family and friends who do not use drugs, and who support their attempts to discontinue drug use.

- Parents have a history of adequate social, occupational, and personal functioning prior to the onset of drug use.

- Parents are able to recognize when a relapse is likely, and make plans for their children, call in friends or family members to provide care for the children, or seek help.

- Parents exhibit shame and distress about the effects of drug use on their parenting.

- Parents have a history of successful parenting prior to the onset of drug use, and have a strong identity as a parent.

Conditions That Increase Risk

- Parents whose drug abuse seriously impairs their judgment, reliability, and ability to meet their children's needs.

- Parents whose involvement in a drug culture lifestyle places their children at continuous and serious risk of harm.

- Drug abusing parents who deny the existence of the problem, and refuse to consider treatment, or who verbalize a desire for help but never follow through.

- Parents with no history of adequate social, occupational, and personal functioning prior to the onset of drug use.

- Parents whose primary social contacts and support networks are also habitual drug users; parents with no social support network of nonusing family or friends.

- Parents with little or no history of successful parenting prior to onset of drug use, and limited identity as a parent.

Services

Highly specialized treatment must be provided to address the problems related to substance abuse. When substance abuse is a primary contributing factor to child maltreatment, little change in the home situation can be expected until the substance abuse problem has been dealt with and resolved.

Self-help and step programs such as Alcoholics Anonymous have reported considerable success in helping persons with alcoholism remain sober. A similar program, Narcotics Anonymous, utilizes the same strategies to help drug users remain drug free. Pharmacological interventions are helpful in treating some addictions. Methadone is often used to treat opiate addiction, particularly heroin. Disulfiram deters alcohol abuse because drinking while on the drug causes severe headaches and protracted vomiting. Antidepressants may be used to combat the depression that often precedes, and may be exacerbated by, the use and abuse of some drugs.

Most theorists contend that successful treatment for drug addiction must be multifaceted and ongoing. Nunes-Dinis and Barth [1993] suggest that outpatient drug treatment programs should include multiple weekly contacts with peer-support groups; family or couples therapy; treatment contracts for activities related to abstinence; urine monitoring; education sessions; and individual counseling. They also suggest treatment programs must help users learn to prevent relapse. Strategies might include "predicting situations in which relapse risk is high; rehearsing avoidance strategies; changing lifestyle; developing a drug-free network of social contacts; and developing memories of the negative

consequences of abuse to counteract memories of drug euphoria." The authors contend, however, that while these strategies are known to be effective for the treatment of other drugs, their ultimate effectiveness with crack cocaine remains unknown.

Drug treatment must also directly address parenting, if recovering users are to retain custody of their children [Schottenfeld et al. 1994]. Chavkin et al. [1993] reported that for many drug-using mothers, their concern for their children's well-being motivated them to enter drug treatment, and their preferred treatment modality was family therapy aimed at strengthening their relationships with their children. Since many drug programs have focused on treating male addicts, and have not incorporated improved parenting as goals of treatment, they have not always been appropriate treatment for addicted mothers [Nunes-Dinis & Barth 1993; Zuckerman 1994]. Mothers often feel stigmatized by attending drug treatment programs, and they avoid residential treatment because they do not wish to put their children in foster care, or are fearful of losing custody [Zuckerman 1994].

Zuckerman [1994] describes a community-based outpatient program with a parent-child focus. A pediatric primary care clinic was chosen as the setting, as it was nonstigmatizing, and supported the mothers' interest in their children. The services provided were pediatric child care, child development services, and drug treatment, including a weekly clinic session, a relapse prevention group, and a mother-child group. Schottenfeld et al. [1994] describe a community-based day treatment program, with interventions occurring both on-site at the center and in the families' homes. The program offers six hours of structured

daily activities including group, family, and individual therapy; relapse prevention training; leisure and exercise activities; and education about pregnancy, parenting, and the effects of drug use. Contingency contracting is used. Abstinence, documented by twice-weekly urine screening and self-reports, is strongly rewarded. On-site child day care permits recovering women to observe trained teachers interact with the children, and learn parenting skills in a nonthreatening setting. The on-site day care also removes a significant barrier to accessing treatment for many mothers. The recovering mother is also paired with a trained family support worker. These women are recruited from the community. This "buddy system" provides the women in treatment with a consistent and ongoing relationship with a caring and concerned advocate, who helps the recovering women with all aspects of life and child management. This also helps recovering women develop a drug-free social network.

Barth [1994] recommends multi-faceted approaches to treatment that include the following service components:

- Prevention of subsequent unwanted pregnancies through education and family planning;

- Intensive family preservation services as an initial response for drug-involved families. Many families will also need a much longer-term program than is usually provided through an intensive services model;

- Ongoing case management to assure aftercare. In cases where risk to the children has been sufficiently reduced to warrant closing of the case, the

child welfare agency should not be responsible for the long-term provision of services. Families should be referred and maintained in other community-based and developmentally-focused services. The child welfare agency should be informed if these service providers continue to have concerns about the protection of the user's children;

- Developmental and protective day care services to afford immediate protection to the children, while making it possible for mothers to attend treatment programming; and

- If children cannot be sufficiently protected at home, the mother and her children should be placed in a residential treatment group home to provide intensive family treatment without separating children from their families.

Multi-faceted treatment approaches, such as those found to have had some treatment success for drug-abusing mothers, are complicated and costly. Unfortunately, in times of diminishing resources, it is difficult to see how social service systems in general, and child welfare programs in particular, will be able to find the resources to address this growing need.

Placement Issues

Whether, and when, children of substance-abusing parents should be placed into substitute care should depend upon a comprehensive assessment of the risks to the child of remaining in the care of the drug-involved parent. As with all child

welfare cases, agencies should first consider services that strengthen the family and protect the child in the home. Only when the child cannot be sufficiently protected at home with intensive family support services should placement be considered.

However, the complexity of cases involving substance abuse, and the unavailability of community-based and outpatient drug treatment programs, can limit an agency's success in preserving families, and placement of the child outside the home may become necessary. But, the manner in which the agency approaches this can have significant effects on the outcomes of the case. Kearney et al. [1994] report:

> "Custody loss and its properties – voluntary vs. involuntary, and short term vs. long term – in turn affected a woman's identity as a mother. Those who voluntarily found a better place for their children were sorrowful, but retained relatively intact self-images as mothers. When children were forcibly removed, women harbored anger, fatalism, guilt, and images of failure as mothers. Women who believed in their ability and integrity as mothers were more likely to attempt to pull away from drugs in order to regain custody, whereas those who saw this central social role as shattered beyond repair were less likely to make this effort... In the most negative scenario, a woman who had lost custody, felt herself to be a failed mother, and believed her children were happier and healthier with an alternate caregiver, was very unlikely to fight for reunification. In a more positive interaction, a mother who had

> voluntarily relinquished custody, had successfully cared for her children for a number of years and had confidence in herself as a mother, and whose children were unhappy or improperly cared for in a substitute care situation, would be likely to take steps to maintain her mothering influence and regain custody."

This would suggest that if drug use seriously compromises a parent's ability to care for her children, the parent should be encouraged and empowered to develop a safety plan for the children. This might include protective day care, and/or kinship or family-based care. Where parent-child group home placement is available, it should be strongly considered. If foster care is necessary, the parent should be engaged to participate in all aspects of placement planning (See Section IX-B, "Empowering Families to Participate in Placement Activities.") Workers should also stress the importance of the parents' continued involvement with their children while in placement, and support this through regular visits. By supporting continued parental involvement, combined with a family-focused treatment intervention, reunification may be more likely.

It appears that the converse is also likely; if the child welfare agency adopts a punitive approach, and removes the children without first trying to engage the parent, the most powerful motivator for drug-abusing mothers to seek and stay in treatment is removed. It can then be assured that reunification will be more difficult. Wald [1994] also claims that when social workers take a punitive view toward drug-involved parents, expecting them to "do everything on their own," and courts and agencies make unreasonable demands with regard to treatment "success," this greatly reduces the success of interventions.

Finally, our overriding concern for children with drug-abusing parents is permanence in a safe environment. In spite of our best efforts, some drug users will not be able to provide their children with safe and nurturing environments. We must then strongly consider permanent alternative placements through kinship care or adoption.

(Refer to related discussion related to placement of cocaine-exposed infants in Section VII-C, "The Primary Developmental Disabilities: Identification and Early Intervention.")

Safety Issues for Child Welfare Caseworkers

Because of the unpredictability of behavior when people are using certain drugs, workers should take steps to assure their own safety when interviewing persons suspected to be under the influence of dangerous drugs. Some strategies for self-protection are:

- Do not conduct interviews in the kitchen, where knives, pots, pans, and other utensils that could be used as weapons are in easy reach.

- Do not accept an offer for a hot cup of coffee or tea that could burn you if spilled or thrown.

- Do not be accusatory or demanding. Moods of drug and alcohol users can be volatile and quickly become dangerously aggressive.

- Do sit around a barrier, such as a dining room table or a coffee table in the living room, so that a boundary is established between you and the client.

- Do maintain a position close to an exit, and make sure there are no barriers to quick exit.

- Do anticipate problems, and "expect the unexpected." Determine early who else is in the house and where they are.

- Do carefully observe the client's physical appearance and behavior. Look around for evidence of drug use... empty vials, bottles, or cans and drug paraphernalia.

- If you believe that drug dealers live in the home, or that the level of drug use makes the neighborhood dangerous, request accompaniment by law enforcement.

Case Example: The Forrester Family

The following example describes the family assessment process conducted by Carol Johnson, caseworker, with the Forrester Family. (See previous case examples in Section IV-A, "Integrating Casework and Protective Authority," and Section IV-B, "The Casework Relationship: The Foundation of Family-Centered Child Welfare.")

For purposes of illustration, this assessment was condensed into two interviews. While this may be an unrealistic time frame for some families, an initial assessment can be made in a few interviews, when the caseworker is skilled, and the client family is easily engaged into the casework process.

The format utilized in this assessment dictation includes the dialogue between Carol and Ms. Forrester (in regular type), and Carol's thoughts about what was occurring (in italic type, indented.) Carol's thoughts are included to illustrate the conclusions she drew from their interaction, how she decided to choose the direction of the interview, and her rationale for her interviewing and intervention strategies.

The case plan interview, which followed the assessment interviews, and the case plan document developed by Carol and Ms. Forrester in response to this assessment can be found at the end of Section IV-D, "Developing the Case Plan.")

Family: Forrester, Susan, age 29
Forrester, Jon, age nine
Forrester, Wendy, age four

Worker: Carol Johnson

Summary To Date:

Jon remained in the hospital overnight and was released to Carol and Ms. Forrester. Carol had determined that Ms. Forrester's four-

year-old daughter, Wendy, was at no risk of imminent harm. Carol and Ms. Forrester jointly placed Jon at Ms. Forrester's sister's house for the weekend, and Carol indicated she would meet with Ms. Forrester at her home on Monday, after Ms. Forrester returned from her job training class. Carol offered to pick her up, since the training class was located near the agency, and this would save Ms. Forrester an hour in travel time on the bus.

Purpose of Current Contacts:

The purpose of these contacts was to strengthen the casework relationship, and to begin the family assessment. Carol had laid the groundwork for a collaborative relationship with Ms. Forrester at their previous meeting three days earlier. However, she fully expected that Ms. Forrester might still be angry and defensive, and she would probably continue to test Carol. Carol and Ms. Forrester had agreed that they would begin to explore the circumstances that led to Jon's injuries, and develop a safety plan for Jon.

Assessment Interview #1

Carol picked Ms. Forrester up at her training program as planned. Ms. Forrester rode most of the way without talking. Carol asked her more about her job training. Ms. Forrester answered in monosyllables, and volunteered very little information. This was notable, since she had talked openly with Carol about her training program while they were waiting at the hospital.

Carol noted Ms. Forrester's reticence to talk. Ms. Forrester would not look directly at Carol, but stared out the side window as they drove. Her body posture was stiff. She did not fidget. Carol considered the possibility that Ms. Forrester was angry, and made note to continue to explore this later, if it continued at the house.

They drove first to the day care center to pick up Wendy. When Wendy saw her mother at the door to her classroom, she immediately left her activities and ran to her mother for a hug. Ms. Forrester related to Wendy with affection, and stroked her head while talking to the day care provider. On the ride home, Wendy chatted amiably with her mother about the zoo animals that had visited the center that day. Carol's initial impression, that Wendy was developmentally at age level, was reconfirmed by her observations.

When they arrived at the house, Ms. Forrester unlocked the door and walked straight to the back of the house with Wendy, allowing Carol to find her own way in. Carol took off her coat and waited in the living room. About five minutes later, Ms. Forrester returned to the living room, and said Wendy was playing in her room. Carol asked Ms. Forrester if she wanted to talk at the kitchen table again. Ms. Forrester said she didn't care, but walked toward the table and sat down.

Carol asked Ms. Forrester how her weekend had gone. She said fine. Carol asked if she had seen Jon. She said yes. Carol asked when she had seen him, and Ms. Forrester said Sunday afternoon. Ms. Forrester still would not make eye contact with Carol. Carol then said, "You don't seem to want to talk." Ms.

Forrester looked at Carol and in a terse, hostile tone of voice said, "Just what is it you want me to say?" The question was issued as a challenge.

Carol recognized Ms. Forrester's tension, which confirmed her earlier suspicion that Ms. Forrester was angry beneath her controlled and distant demeanor. Carol attempted to acknowledge and understand Ms. Forrester's anger, rather than ignore it, or pretend it wasn't important.

Carol said, "You know, you seem pretty angry to me." Ms. Forrester responded, testily, "What of it?" Carol said, "I'd like to hear what you're angry about." Ms. Forrester said, "Yeah, like you don't know." Carol responded, "Well, I'd guess, since it's me you're angry at, it must be related to what happened on Friday." Ms. Forrester was silent. Carol said, "I meant it when I said honesty was important, and that includes honesty if you're angry at me. Can you tell me what made you so angry?" Ms. Forrester was quiet for several seconds, and then said, "You suckered me." Carol waited. Ms. Forrester said nothing. Carol continued to encourage her. "Tell me what you mean." Ms. Forrester said, "You come in here and act so nice, and pretty soon I'm agreeing to let you take my son. I don't know how you did it, but I know I'll never get him back now."

Carol knew this kind of delayed anger was neither abnormal nor unexpected, and Ms. Forrester's anger likely resulted from a combination of feelings. Ms. Forrester might feel embarrassed and ashamed at having been "caught" mistreating her child. She may have had second thoughts about letting Jon go to her sister's, and she may still mistrust Carol's intentions. Other people may have told her not to trust the caseworker. Carol also wondered whether, perhaps, Ms. Forrester generally expected

other people to harm her. Carol needed more information. She started by responding directly to Ms. Forrester's last statement about never getting Jon back. She did this by summarizing and reiterating her purpose and intent, and her commitment to working collaboratively with Ms. Forrester. Then she used an open-ended question to encourage Ms. Forrester to tell her why she was hesitant to believe this.

Carol said, "Well, as I told you on Friday, I want you to have Jon back. My job is to help you so Jon can live at home without risk of being hurt. And, I'll tell you again that it's very important that you and I work together on this, because the decisions will be better, if you are involved in making them. I've said all this before... but, for some reason, you don't seem quite convinced. Can you tell me why?"

Ms. Forrester said, "I just don't trust you, or your damned agency. And why should I? Everyone I know says you people take kids, and their parents don't see them for months... and some never see them again. Even my neighbor said I was a fool for talking to you. She said I should have gone to court right away and fought for Jon. You're probably no different from the other social workers I know. I don't know why you would be!"

Carol summarized what she had understood Ms. Forrester to say. "I guess you don't really believe I'm going to help you keep Jon. I can assure you, again, that <u>is</u> my intent. I also understand I'll have to prove it by my actions. But I can't promise you that Jon can come home no matter what, because I can't let Jon stay at home if he's at risk of being hurt. However, if we work together.... and I think we made a good start on Friday... we can help you understand what caused Jon

to get hurt, and help you learn how to prevent it. As soon as you're able to do that, and he can live safely with you, he'll come home." Ms. Forrester was listening quietly, but her facial features still reflected anger.

Carol continued. "So the real issue is whether we can work together to keep Jon from being hurt again. Do you understand what I'm saying?" Ms. Forrester nodded. Carol then said, "I'd like you to tell me, in your own words, what you think I just said. I want to be sure we both understand the same thing." Ms. Forrester said, "You want to help me learn how Jon gets hurt, and learn how to stop it from happening, and if I can do that, I can keep him." Carol said, "That's basically it. Now, let's talk about the second thing I heard... that part about my being just like all social workers, and how that's a problem for you."

Carol wondered whether Ms. Forrester had begun to doubt whether her concession to work with Carol was really a good idea, particularly when Ms. Forrester's neighbor implied that she had been a fool to trust Carol. Carol was able to reengage her and restate her contract, but Carol expected that the issue was not settled, and would need to be revisited. Carol decided to explore how her position of social worker posed a barrier in Ms. Forrester's ability to trust her.

Ms. Forrester said, "When I was younger, I had to see the social worker at the court house. You all can't be trusted. I've known that all my life. So why should I trust you? But, it looks like I don't have much choice in the matter." Carol said, thoughtfully, "Well, trust is very important to me, and I work hard to be worthy of trust. You don't know me well enough yet to trust me. But, it sounds like you have a bad history with social workers." Ms. Forrester said, "You got that one

right!" Carol said, "Can you tell me about it?" Ms. Forrester said, "What business is it of yours?" Carol said, "I'm not just being nosy. If we're going to work together, you need to feel confident that I'm on your side. If I understand how you feel, I'll be less likely to do something to hurt or upset you. I also want you to feel comfortable telling me when I've done something you don't like."

Carol has acknowledged that her being a social worker could pose a barrier to their collaboration if not dealt with. In encouraging Ms. Forrester to discuss this, she is communicating that she is supportive and accepting of Ms. Forrester's feelings, rather than becoming angry or defensive. Carol clarifies that trust and honesty are important to her, and she gives Ms. Forrester permission to be honest, even if that means confronting Carol. This both defines the parameters of their relationship, and potentially strengthens it. Carol also sees this discussion as an entree into assessing Ms. Forrester's feelings about relationships and people in general, both of which are important to the family assessment.

For the next 15 minutes, Ms. Forrester talked angrily about how often she'd been "suckered" by people, who "make all kinds of promises, and then never do what they say." She first talked about the "welfare people" and "court people" who worked with her family while she was growing up, and then the "counselors" at the juvenile detention center. She said they had all claimed to want to "help," but never did anything but harass her. Carol said it seemed like Ms. Forrester had some bad experiences with "helpers." She then asked Ms. Forrester about her trust of people in general. Ms. Forrester shrugged and said, "In this world, you're dumb to trust anybody. It just comes back to haunt you."

Carol saw this as an opening to discuss issues related to trust, but also saw it as a way to learn about Ms. Forrester's personal history. Carol knew that parents who could trust other people to provide guidance and support had a valuable resource in preventing future maltreatment. Conversely, a lack of ability to trust often results in self-imposed isolation, which can greatly increase the risk of future maltreatment. Carol knew an assessment of Ms. Forrester's ability to trust others would be important in determining the ongoing risk to Jon in his mother's care. However, since it was very early in their relationship, Carol decided to use open-ended questions to encourage Ms. Forrester to talk about her past, which would be less threatening than directly confronting the issue of trust.

Carol said, "Do you feel that way about everybody?" Ms. Forrester said she did, in general, and that the only people you could trust were small children. They were innocent and loving. When they grew up they got devious and hurtful. With Carol's encouragement, she gave several examples of people who had fit this description, including several boyfriends and her ex-husband. She said her husband had a good job, and promised he'd look after her. It was only after they were married that he "showed his true colors." Ms. Forrester said she kicked him out after she learned he had been seeing another woman. She said her husband drank a lot, and they always fought. "It really was better after he left... we weren't fighting all the time. The fighting really upset Jon... and Wendy would just scream and scream, and it took me hours to get her quieted down after a fight. Most times I know he was doing it just to hurt me. He'd get me so mad, and then he'd say he couldn't stand it at home any more, and he'd go out and have a good time and leave me home with screaming kids. I think he just wanted to go to the bar with his buddies all the time." Then she said, "Jon's a lot

like him." Carol asked, "How so?" Ms. Forrester responded, "He can act so sweet, and the next thing you know, he's doing something behind your back, or not doing what he's supposed to do, or he's lying about something or other."

Carol made a mental note that Ms. Forrester saw Jon as "a lot like" his father. Carol wondered whether this might contribute to her feelings about Jon, including the strength of her anger at his behavior. Carol felt it was too early in their relationship to deal with this topic directly, and continued to examine trust issues from a broader perspective, instead.

Carol asked if there were anyone Ms. Forrester trusted and confided in. Ms. Forrester said she had one girlfriend who always listened and was helpful. When Carol asked Ms. Forrester about her relationships with her family, Carol began to hear a pattern of ambivalence and conflict. Ms. Forrester said her mother and older sister were the only family she had, and they both continually criticized her for what she called her "failures at life." Carol asked Ms. Forrester about her father, and learned he had left the family when Ms. Forrester was four. He would visit every few years, hang around for a while, make promises to her, and then disappear again. Ms. Forrester had been a poor student, and was often suspended and in detention because of her temper. "I just couldn't put up with it. Finally I just quit. Then things got really bad." She said her mother told her she'd never make anything of herself if she didn't finish school. Ms. Forrester said, "Talking to me was like talking to the wall." She said her mother "tried everything ... she even tried to beat it out of me."

After she dropped out of school, she tried working, but couldn't keep a job more than a few weeks... she kept getting mad at the boss and quitting, or flying off the handle and getting fired. She was "in trouble with the law all the time," used drugs, was arrested twice for shoplifting, and eventually stole a car with a boyfriend. She'd had a baby when she was 16. The child was adopted by her aunt in another state. The child was now 13, and didn't know Ms. Forrester was her biological mother. She said, "I couldn't even make a marriage work, and now, the welfare people are after me." At this point, her eyes began to fill and she turned away angrily, as if embarrassed. Carol said, "You seem really angry, and you also sound depressed." Ms. Forrester said nothing. Carol said, "Well, it sounds like you've had a whole lifetime of feeling like you can't do anything right. Now I understand why doing well at this job training program is so important to you, and I understand why having children's services involved is such a problem for you. It must feel like just one more thing in a whole line of problems." She was quiet for a minute. Then Ms. Forrester said angrily, "I haven't got any problems that I can't handle. Life was never meant to be easy. I'd say I do pretty good, considering what I've been handed."

Carol recognized considerable hurt beneath Ms. Forrester's testy facade, but Ms. Forrester also was defensive about acknowledging it to Carol. Carol felt this was to be expected at this stage of their relationship. Ms. Forrester had implied that she had little support, and that few people had ever acknowledged her abilities. Carol recognized that while her comment about "not having any problems she couldn't handle" was basically defensive, in many respects, she had done well. Carol believed it was important to communicate this.

Carol said, "Well, I'd have to agree with you. You appear to have handled a lot and done pretty well. You seem to have strengths that we can use to help resolve the problems with Jon. I'd be interested to know what you think those strengths are." Ms. Forrester wiped her eyes, composed herself, thought for a minute and said, "I guess I've never much thought about it." She paused for several seconds. "I'm a survivor... I've been through a lot, and I'm still here. I guess that counts for something." Carol said she thought it did, too.

Carol noted that while Ms. Forrester staunchly defended herself and her worth, she couldn't articulate anything she saw as a personal strength, other than the fact of her survival. Carol concluded that Ms. Forrester was not aware of her strengths, or was unable to consider or communicate them. Carol summarized what she had observed and believed to be strengths.

Carol said, "Having survived is only a small part of it. You've kept a home for your children. You live on a very limited income, yet your home is very comfortable and nicely furnished." Ms. Forrester half-smiled and said, "Salvation Army and garage sales." Carol said, "It doesn't look it. I'm impressed." Carol then said, "You already know how much I admire your going back to school. That had to take guts, after dropping out the way you did. Was it hard?" Ms. Forrester said, "Yeah, sort of. I was scared at first, but after a while, I figured I was just as smart as anyone else there, and if they could do it, so could I." Carol then said, "What do you think you do well as a parent?" Ms. Forrester said, "I don't know... my kids are always fed, they're always clean. Heaven help them if they go out of here with dirty clothes. And I teach them to respect people, to do good in school, and I try to teach them to be kind." She paused, and looked at

Carol. "Why do you want to know all this?" Carol said, "Because I'm interested. Do you doubt my intentions?" Ms. Forrester said, "Well, it's like you're trying to get me to tell you things so you can decide if I'm a fit parent." Carol said, "I'm trying to get to know you, to understand your strengths, and to help you recognize areas where you may need help. We need to consider both, if we're to help you get Jon home."

Ms. Forrester appears to be trying to discern Carol's tactics. This is typical early in the development of a casework relationship, and is also common for people who are cautious and suspicious of other people. Ms. Forrester expects people to be devious. Carol responds with honesty, further strengthening her previously stated commitment to be straightforward with Ms. Forrester. She also picks up on Ms. Forrester's lead.

"Since you brought it up, can you tell me what kind of parent you think you are with Jon?" Ms. Forrester said emphatically, "A good one. He's lucky that I put up with him. I could have thrown him out with his father, but I believe the Lord puts us on this earth to do good for others, and if it's the last thing I do, I'm going to get him to mind me and make him a better person for it. Of course, he doesn't see it that way. He just whines and complains for no good reason."

This brief exchange illuminates some important dynamics in the Forrester family. First, Ms. Forrester appears to have stringent expectations for Jon's behavior, and she seems to genuinely think that she has Jon's best interests at heart. She also intimates that Jon should be grateful for the care she's given him; after all, she could have thrown him out, but she didn't, and that he should somehow appreciate her efforts.

Carol recognizes these as common dynamics of many abusive parents. They may have overly demanding, sometimes rigid expectations for their children's behavior, and may believe their children's behavior is a direct reflection of their own self-worth and parenting ability. Jon's willfulness is a challenge to Ms. Forrester's self-esteem, and his lack of "appreciation" for her is perceived as inconsiderate.

Ms. Forrester also alludes to a power struggle when she talks about getting Jon to mind her "if it's the last thing I do." This battle for control is also common in abuse situations. The parent interprets the child's willfulness as a personal assault on the parent's authority, and an indication of the child's dysfunction. The more the child subverts or thwarts the parent, the stronger the parent's need and determination to regain control. This, then, escalates the struggle. Carol recognized that this dynamic might be important in assessing the roots of the abuse in this family.

Carol also knows the interview could go two directions from here. She could ask Ms. Forrester to elaborate on Jon's behavior. This would probably result in a lengthy description of all Jon's problematic misbehaviors, which would not be productive, since Carol believes that Jon's behavior is largely governed by his mother's interactions with him, and if her attitudes and behavior can be changed, Jon's will likely change, also. Information from Jon's teacher suggests that while willful, Jon can be brought around with firm, but gentle guidance. Carol notes that at some time, if Jon's behavior appears to be particularly extreme, a psychological assessment could be utilized to identify or rule out emotional disorders.

Carol believes a better approach to the assessment would be to further explore how Ms. Forrester interacts with Jon, how she responds to his behavior, and how she feels

when she tries to parent him. To do this, Carol needs to keep the interview focused on Ms. Forrester's beliefs and feelings rather than Jon's behavior. However, this will take more time than remains in this interview, and Carol does not want to begin and have to end before completing the discussion. She summarizes her thoughts, contracts with Ms. Forrester for topics to discuss at their next meeting, and closes the interview.

Carol explained to Ms. Forrester that the time was up. She said, "I have to leave now, but I think I understand some things better. You've evidently had some very hard times in your life. But, I believe you've done a lot that's right. I also think you're really trying to do the right thing for Jon, and that's a good place to start next time. Perhaps you can help me understand what happens when you try to guide and discipline him. Maybe we can figure out what happens that leads to his being hurt. Would you agree?" Ms. Forrester shrugged and said, "I guess." Carol decided not to confront her ambivalence. The small concession was a step in the right direction. Carol then spent several minutes arranging for Jon to continue to stay at Ms. Forrester's sister's house until their next meeting, and agreed to meet with her several days later to continue talking. She also said that the next time they met, they would begin to think about a plan for services to help Jon and her.

Assessment Interview #2

Carol met with Ms. Forrester in her home several days later. She was sullen and withdrawn, in spite of Carol's efforts to draw her out. Finally, after considerable prodding, Ms. Forrester told Carol she was angry because she had failed a test at

job training. Carol asked her why she thought she had failed; Ms. Forrester lashed out in an accusing voice, "Everything – especially you being on my case, and Jon being at my sister's; I've just been too upset to study." Carol ignored Ms. Forrester's accusatory tone, and said gently that she wasn't surprised, since she knew Ms. Forrester was under a lot of stress because of the agency's involvement. She asked what the failed test meant. Ms. Forrester said, "They'll probably kick me out." Carol said, "Why would you think that?" Ms. Forrester said she didn't know... it always worked that way. Carol said firmly that it <u>didn't</u> always work that way, and suggested it might help to talk with her advisor, explain that she had been under extreme stress due to family problems, and ask to take a make-up test. Ms. Forrester said she really doubted it would work. Carol said she would help Ms. Forrester talk to her advisor, if Ms. Forrester wanted her to. Ms. Forrester said, brusquely, that she could do it herself, that she wasn't incompetent. Carol agreed with her, and asked if she wanted to take a few minutes and phone the school before they started talking. Ms. Forrester shrugged, said, "I guess," and went into the kitchen. A few minutes later, she returned and said, "They said okay, but just this once." Carol said "Good. Do you have enough time to study?" She said she did, but she still didn't feel like studying. Carol said, "I can understand that. I know this whole thing is weighing heavily on you. So, I'd suggest that we keep moving and try to get it resolved. What do you think?"

Carol intervened in a constructive way to help eliminate a source of stress. This communicated several things to Ms. Forrester: Carol really was there to help; her suggestions were useful; and, she empathized with Ms. Forrester's problem without being critical. She then reaffirmed her contract with Ms. Forrester, and helped her

understand how resolving the issue with Jon would alleviate considerable stress. To do this, they must fully assess the scope of the problem and its causal factors, then identify strategies to address them. Carol shares her thoughts with Ms. Forrester, summarizes their agreement from the previous interview, and describes the next steps.

"First we have to understand how Jon gets hurt, and why it happens. Every family is different, and until we both understand exactly what happens in your family, we won't be able to choose the best solutions. Will you tell me how it happened this last time?" Ms. Forrester was silent, but began to fidget nervously with a button on her sweater. Carol noted her nervousness, and commented on it. "You seem really nervous and tense. Are you worried about talking about this?" Ms. Forrester said angrily, "Of course not. I didn't do anything wrong. I was just keeping him out of trouble." Carol did not respond to her outburst and continued. "That's what I'd like to hear about. How you do that, and what happens. And in spite of what you say, most people <u>are</u> very nervous talking about this. I know it's not easy. Why don't you tell me in your own way. I won't question you to death, and I won't force you to tell me anything you're not ready to tell me, okay?" She nodded.

Carol has made the purpose of the interview clear to Ms. Forrester. She has also noted Ms. Forrester's nervousness and anxiety about disclosing this personal information, and Carol has reassured her. Carol understands that if she pushes too hard, Ms. Forrester will resist and withdraw. By letting her tell her own story in her own way, Carol gives Ms. Forrester more control of the interview. Carol expects Ms. Forrester will probably initially skirt the issues, or she may test Carol by disclosing

less significant information first. Carol will use clarifying and supportive interviewing methods to help get to the underlying issues.

Ms. Forrester began by telling Carol that she was feeling a lot of stress. Carol asked her why. Ms. Forrester rattled off the list of stresses in her life – the divorce, trying to raise two children by herself, the constant interference from her mother, trying to pass the job training, worry that she wouldn't be employable, even with the training. She was always running behind, never getting on top of things. Just surviving the day was hard. Carol agreed that it truly could be stressful, just getting by. She asked, "Do you sometimes feel more stressed than other times?" Ms. Forrester said she did. "What makes the difference?" Carol asked. Ms. Forrester thought for a minute, and then said, "I guess on some days, it all just builds up at once." Carol asked her how she reacted when she was feeling really stressed. She said, "I get mad." Carol said she remembered Ms. Forrester had told her about her temper, and how easily it flared. Carol asked what happened when she got mad. Ms. Forrester said, "It depends." Carol asked, "What's the worst." Ms. Forrester said, "I lose it. I know I shouldn't, but I just can't help it." Carol asked gently, "What do you mean, 'lose it.' Can you describe it?" Ms. Forrester was quiet, and then said, "I yell and scream, or swear. Sometimes I throw things. If people get up in my face, I might shove them away, and every so often I've been known to take a swing at them."

Ms. Forrester chose to begin talking about stress. Carol didn't say, "Let's not talk about stress. Let's talk about your relationship with Jon." Instead, using open-ended and clarifying questions, Carol helped Ms. Forrester consider how she felt and acted when under stress, and related these feelings to her temper outbursts. Carol knows if

Ms. Forrester can understand this connection, she has the capacity for insight. This is a critical piece of information. If Ms. Forrester is able, even on a rudimentary level, to eventually see a connection between her feelings and her behavior toward Jon, she will have a valuable tool toward controlling the abuse.

Carol asked, "What kinds of things make you so mad that you lose it?" Ms. Forrester thought for a long time, and said, "I don't know, just everything." Carol said, "Everything?" She nodded. Carol then said, "Does it make you mad when Wendy comes home with a happy face on her school paper?" Ms. Forrester rolled her eyes and said, "Of course not." Carol then said, "What do you feel then?" Ms. Forrester said, "Pride. I'm really proud of Wendy. She's a good girl." Carol said, "She is awfully cute. Seems smart to me, too." Ms. Forrester smiled. Then Carol asked, "So, what kinds of things make you <u>really</u> mad?" Ms. Forrester paused and thought, then said, "When people treat you badly. Act like they don't care about you. People who take advantage of you. They walk on you when you're down. They do what they want, and don't care who they hurt. They turn on you, after you've given them everything. When you try so hard and they're never satisfied." Carol asked, "Who do you think isn't satisfied with you?" Ms. Forrester said, "Nobody ever is. My mother, for example. No matter what I do, she's never been satisfied. I don't even talk to her about my job training any more; she just says, "Well, it's about time. You're only about ten years late!"

Carol then said, "And what do you feel when people are like that?" She said, "I don't know, like I said, mad." Carol said, "Anything else?" Ms. Forrester said,

"Well... I don't feel too good. I feel," she paused, thinking, "like it's hopeless. Like nobody really gives a damn about you. Like you have to look out for yourself." Carol prompted, "There's that issue again... of not being able to depend on other people. That must feel pretty lonely, to think you're completely on your own." Ms. Forrester thought about that for a moment.

Ms. Forrester has told Carol that disappointment in interpersonal relationships precipitates her anger. Carol wonders if Ms. Forrester feels disappointment in Jon, and whether this is a factor in precipitating her anger at him. Ms. Forrester has also demonstrated that she can identify feelings, and can talk about what prompts them. This is a significant strength. Carol decides it is important to give her this feedback. In doing so, she is pointing out process-level issues, and helping Ms. Forrester learn to pay attention to these. She summarizes what she has heard Ms. Forrester say.

"I want to point out something important. It may not seem to be important to you, but it is. I asked you how you felt, and you were able to tell me. You were also able to tell me what makes you feel that way. Not everybody can do that. I think it's a valuable ability in helping to solve problems." Then she said, "I also want to see if I understood you. It sounds like a lot of your anger comes from feeling disappointment, or hurt by other people. Is that right... somebody does something that really hurts you, and you get angry?"

Carol is using summarization and clarification to help Ms. Forrester establish the connection between hurt and her anger. This connection is more subtle. Ms. Forrester already understands the connection between people's behavior and her

anger, but her feeling of being hurt is actually the intervening variable that sparks her anger.

Ms. Forrester said, "No, they can't hurt me any more. I learned a long time ago not to let people hurt you. You wouldn't survive."

Carol realizes Ms. Forrester is not ready to fully acknowledge her hurt. It is too soon to confront her with this directly, but Carol will let her know she believes Ms. Forrester is hurting, and that she will continue to support her.

Not surprised by Ms. Forrester's denial, Carol said, "Sounds like you're saying it hurts too much to hurt, and you've gotten tough to protect yourself. It may make you stronger, but it doesn't always make the pain go away." Ms. Forrester said quietly, "No, it doesn't." Carol was pleased that Ms. Forrester had gotten the point, even if she didn't directly acknowledge it. Carol returned control of the interview to her. "Okay, what else can you tell me that might help us understand what happens with Jon?"

Ms. Forrester thought for a minute and said, "I guess I get mad at Jon more than I should. But, he really asks for it sometimes! And sometimes he deserves what he gets!" Carol said, "Tell me more about that. What do you mean?" "Well, it's like he does things on purpose, just to get me mad. It's like he's not satisfied unless I'm yelling at him. I talk to him, and he just stands there and looks through me, like I'm the wall or something. I tell him red, and he says blue. I tell him run, and he sits down. I don't know how he got to be that way. I never taught him to be like that. Must be in the blood." She paused. "He is a lot like

his father. I really want Jon to be a good boy... nice, respectful.... I thought maybe with his father gone, he'd listen to me better. You know, they say how you treat a child is important... helps them grow up better. But I'm not sure it matters... seems like it's born in them. You can't fight it." Then she laughed and said, "Wouldn't you know, I sound just like my mother talking about me! She always said I was too much like my own father for my own good."

Carol noted the similarity between Ms. Forrester's own experience as a child and her perceptions of Jon. But Carol felt exploring this issue would divert discussion away from Ms. Forrester's feelings about Jon, and so she continued to gently push Ms. Forrester to explore them.

Carol then said, "Can you tell me what it's like for you when Jon acts that way toward you?" Ms. Forrester was quiet, and then shrugged. Carol helped prompt, "Let me tell you what some parents feel. Like you're not really worth listening to. Like he doesn't respect you ... like he doesn't much care about what you think. Help me out... I'm guessing." Ms. Forrester said, "All of that." Carol nodded.

Carol understands that Ms. Forrester perceives Jon's behavior as deliberate, and intended to thwart her. She also believes his oppositional behavior is inborn, and therefore, not affected by his environment. In both beliefs, Ms. Forrester is communicating that she feels powerless to control Jon, or to guide him to become the kind of person she herself values. This helps to support Carol's earlier suspicion that Jon does not live up to Ms. Forrester's expectations, and she views him as a problem child. Carol also knows she can't logically argue away Ms. Forrester's misperception

by explaining that all children behave in a belligerent manner at times, and that good parenting can make a difference. Some of Ms. Forrester beliefs are defensive – if she perceives Jon to be at fault, she can avoid blaming herself. Carol's other suspicion, that Jon and his mother are locked in a battle of wills, may also be correct. She tries to explore this further.

"Well, it sounds as if Jon is a difficult child for you to handle, and you get really frustrated. Actually, it sounds like you may feel pretty helpless to deal with him – like whatever you do, nothing seems to work." She said, "Yeah, that's about it." Carol then said, "Tell me what you can about how he gets hurt."

Carol knows they are at a watershed point. She has tried to demonstrate her empathy and support. She has talked around the abuse up until this point. She has led Ms. Forrester to acknowledging her anger at Jon, and her difficulty in managing him. The logical next step is to talk about how she behaves in response to her feelings. If she is able to acknowledge the maltreatment, Carol knows this is a strong indicator that she can be helped. If she continues to be defensive and deny her role in the maltreatment, Carol will have to reconsider her strategies.

Ms. Forrester was silent for a long time. Carol said, "Let me say something first. If we understand what leads up to Jon's being hurt, it gives us better control, we can then figure out how to stop it. And that's my goal... stopping Jon from being hurt... not taking him away from you."

"Second, I want to tell you, again, my job is not to punish, but to help. And I guarantee you that's what I'll try my best to do. But, I can't do it alone. You'll

have to help me. But, you're a strong lady. You've survived a lot. You understand how you feel about things, and you are willing to talk about it. However you feel about what's happened, however bad you may feel about what you may have done, you need to know that I believe you have the ability to make it different." Ms. Forrester said, "How can you know that?" Carol said, "Just from what I've learned about you as we've talked. Of course, I can't say for sure, but I'd bet in your favor. So, why don't you tell me what happens." Ms. Forrester was quiet for a long time, and then quietly said, "I give him too many whippings, and I guess I hit him too hard."

Carol breathes a sigh of relief at this point. She has apparently earned Ms. Forrester's confidence sufficiently to warrant this initial acknowledgment that she hurt her son. Carol knows they have work to do, but she has helped her take the first step toward taking responsibility for a safety plan.

Carol said, "That makes sense. It explains the bruises. And what about Jon's head injury?" Ms. Forrester said, "Oh, that... that wasn't my fault. He fell off his bike." Carol looked directly at Ms. Forrester and said gently, "It's really important that you tell me the truth about that, too. It's difficult for us to work together on this until you tell me." Ms. Forrester started to protest, then stopped, and said, "No mother worth anything would hurt a child like that!" Carol said, "You're wrong. Do you think you're the only parent who has ever harmed a child? I feel lucky with Jon. We caught it early. There are families where we don't get to it soon enough, and children die. We're very lucky. Jon's okay, and we can still do something about it. So, please tell me how it happened."

Ms. Forrester started to cry, and said, "He'd been on my nerves all day. All day. I'd had a terrible day. My mother had been yelling at me. Wendy had been sick. I didn't feel great myself, and I didn't feel like cooking. So I made those frozen fish sticks. Wendy likes them, and they're easy. Well, first off, Jon didn't come home from his friend's on time, and everything was getting cold. When he finally came in, dinner had been sitting for an hour. I told myself I wouldn't get mad. I got him a plate, and he began to whine that he wasn't hungry. I told him he had to eat something. I was standing at the stove, ready to take the fry pan to the table when he yelled, 'You never cook anything that's any good. I HATE FISH STICKS!!! Why don't you ever cook real food?' That did it. I lost it. I threw the whole frying pan at him, fish sticks and all." Ms. Forrester began to sob. "I didn't mean to hit him in the head with it, I really didn't. Like I said, I just lost it."

Carol said, "So that's what happens. Jon says and does things that set off your anger, and you can't control it." Ms. Forrester nodded and said, "That's why I think you're wrong about me changing. I've been like that all my life, and it's never changed." Carol said, "Well, it's very hard to change something like that by yourself. But, you're not the only person in the world with a violent temper, and there are ways to help." Ms. Forrester continued to cry quietly. Carol said, "You know, I'd guess that your feelings about Jon are pretty mixed up." She nodded. "I get so mad at him, I really think I hate him. How can you hate your own child? What's so funny is how much I wanted him. And when he was little, he was so sweet. I do love him. I can't believe it's come to this."

Carol feels Ms. Forrester has been through enough for one interview. She has the information she needs to help Ms. Forrester begin to develop a safety plan for Jon, and a case plan for continuing services. She knows Ms. Forrester needs considerable support, and will probably worry after Carol leaves about repercussions from her admission. Carol needs to reaffirm her confidence in Ms. Forrester and outline her next steps, including stating clearly what she will not do. Carol also wants Ms. Forrester to call her, if she has any second thoughts. She does not want Ms. Forrester to worry and change her mind without talking to Carol first.

Carol said, gently, "As rough as that was for you, I know it took courage to do it. Admitting it happened is the hardest part. I think, since this all began, you've acted like a very strong and responsible parent. You didn't run away. You didn't make a million excuses." She paused, and smiled. "And you've put up with me." Ms. Forrester smiled. Carol continued. "The next time I come, we'll start talking about what we can do to help, and we'll work on a plan for services. I'd like you to think about what might help you be a better parent to Jon. Will you?" Ms. Forrester nodded. She then said, "Can Jon stay with your sister for a while longer?" Ms. Forrester said she thought so. Carol asked Ms. Forrester for permission to talk directly with her sister, and invited Ms. Forrester to be present, if she wanted. She also asked Ms. Forrester's permission to talk further with Jon's teacher. She thought the teacher might help them both understand some effective ways to handle Jon's behavior. Ms. Forrester agreed to sign a release of information so Carol could talk with the teacher.

Then Carol said, "Once before, when we'd agreed to a plan, in the space of the weekend, you had second thoughts. When I got back here, you were angry at

me, and felt you'd been suckered. I'm worried that you might feel that way after I leave. After all, now you've told me a whole lot more. I want to know if you trust that I'm here to help you, and whether you'll be all right until I get back here?" Ms. Forrester said she thought she would. Carol gave her a card with her phone number, and said, "I'm serious about this. If you start worrying, call me. I'd rather you call than find you worried and angry with me the next time we meet." Ms. Forrester nodded her agreement. Carol scheduled an appointment for early the following week.

Summary of Additional Contacts

Carol talked with Jon's teacher, Ms. Forrester's sister, and Ms. Forrester's advisor at her job training program, all with Ms. Forrester's written permission.

Jon's teacher reiterated that Jon was generally a good child. He occasionally became obstinate and willful, but it was not difficult to talk with him and engage him to be more cooperative. He often seemed distracted, and at times, uninterested in school activities. He fought with peers on the playground, and had been seen bullying younger children. The teacher thought that he was developmentally on the lower side of normal, but couldn't tell if this was because of lack of interest, distraction, or emotional problems. She said Jon had moments where he was very affectionate, couldn't do enough for her, and wanted to sit next to her. She said she had met Ms. Forrester only twice, but both times, the mother was concerned about her son's education, asked about his classroom behavior, and wanted to be sure he was doing as well as he could.

The training program advisor said Ms. Forrester worked harder than anyone in the school, and was always afraid she wasn't doing well enough. She had moments when she would become very frustrated, and "have a tiff," but she always settled down, and tried again. The advisor said she was intermittently appreciative of support and assistance, and then appeared to become embarrassed and tried to manage on her own.

Assessment Summary and Conclusions

Who Is Included in the Family?

The Forrester family includes Ms. Forrester, and her two children, Jon and Wendy. Ms. Forrester's mother and older sister play an active part in her life. She has not mentioned other family members, a boyfriend, or other close friends. Jon's father does not appear to be involved with him at present. Carol needs to further explore other extended family resources.

Environmental Stressors and Resources

Ms. Forrester is living on limited income, but appears to manage fairly well. She is a skilled shopper, and had furnished her home nicely from garage sales and Salvation Army stores. Her home is comfortable, her children are fed, and dressed cleanly and appropriately for the season. She is attending school to enable her

to get a job that will help increase her income. Economic issues do not appear to be of serious immediate concern.

Psychological Factors of Parents

Ms. Forrester displays no evidence of mental illness, mental retardation, or serious personality disturbance. She does have a volatile and explosive temper, which she cannot always control. The violence against Jon is clearly related to this lack of emotional control. The intensity and volatility of her anger appear to be significant.

Ms. Forrester's anger is often precipitated by situations in which she perceives other people as hurting her. She is quick to find fault with people, and interprets their behavior as malicious or intended to harm her. Her perceptions of people are heavily influenced by her past experiences, in which she has felt herself victimized by many people. Her perceptions of other people's motivations may, at times, be distorted by her past experiences.

Ms. Forrester interprets the typical behaviors of a nine-year-old boy, such as selfishness, doing what he wants, occasionally lying, trying to get out of doing chores, etc., as comparable to the purposeful devious and hurtful behaviors of the adults she has known, and this is probably a significant contributor to the abuse.

Other than her explosive temper, she appears to have good ego strengths. She provides a stable home for her children. She is able to delay gratification, and she is not generally impulsive. She follows through with things she chooses to do. In general, she accepts responsibility. She has more strengths than she is aware of. Despite her lack of confidence, she makes autonomous, good choices, and is self-directed in managing her own life.

Ms. Forrester has low self-esteem, and often feels herself to have failed at everything she's tried. However, she continues to try to better herself, in spite of her lack of confidence in her own abilities. Her job training program is one example. Her ability to maintain a home and provide for her two children is another. These are strengths.

Ms. Forrester may have been abused as a child. She referred to her mother trying to "beat it out of her." She certainly seems to have been the victim of emotional abuse. This needs to be further explored.

Nature of Interpersonal Relationships

Ms. Forrester's interpersonal relationships are ambivalent at best. She openly acknowledges her distrust of people. During the three interviews, she mentioned one woman, in passing, whom she considered a friend because "she listens," apparently without

criticism or censure. She is suspicious and hesitant to trust. Her worker will have to earn her trust by being sincerely supportive. It will be very important that Ms. Forrester's worker and other agency contacts be honest and realistic in their communications, and talk openly and acknowledge if, and when, they make a mistake.

Her relationships with family members are conflictual. Her one friend does not appear to play a significant role in her life. Yet, despite her initial strong protestations, suspiciousness, and considerable resistance, she was engaged into the casework relationship, suggesting that her relationship ability may well be intact. This is a significant strength. She may need help to learn who she can and cannot trust, and perhaps to help her rebuild a more positive relationship with her mother and sister.

Coping Skills and Strategies

Ms. Forrester has significant coping strengths. She has managed two children, school, and day care, and maintained a home with little external support. She appears to budget her money well, and provides well for herself and her children. She is self-directed, and acts successfully to meet her wants and needs.

Ms. Forrester has few dependable interpersonal support systems, and this probably contributes to her stress. Her family

relationships are antagonistic and conflictual. Her suspiciousness of other people probably contributes to her isolation. However, the relationship with her sister is intact, albeit ambivalent. It appears that she is receptive to help, even though she may challenge and intermittently avoid a counselor. It will be important to help Ms. Forrester develop supportive and nurturing relationships. Linking her to services in her own community might open up other resources for her.

Ms. Forrester's sister could potentially be an ally in helping Ms. Forrester. So could her friend. Including these people in assessment and treatment planning might be a valuable intervention.

Parenting Skills

Ms. Forrester appears to have good general parenting skills with Wendy. Her relationship with Wendy appears warm and affectionate. Wendy seems bright, and her development is typical for a four year old. She shows no emotional or physical signs of maltreatment. Her day care provider reports no problems, and states that Wendy appears to be a happy, well-adjusted child.

Ms. Forrester appears to yell frequently and demand compliance from both children, but particularly from Jon. She says she spanks her children as a primary means of discipline. In the limited time

the worker observed Ms. Forrester with her children, she was nurturing and warm with Wendy, and somewhat reserved, controlling, and edgy with Jon. However, additional information on the parent-child relationship is needed before conclusions can be drawn.

She does not appear to have a realistic perception of the normal, typical behaviors of a nine-year-old boy, particularly regarding oppositional behavior. Her expectations for Jon's behavior are more appropriate of an older child or adult than a nine year old. This contributes to her misinterpretation of Jon's behaviors as being deliberate attempts to get back at her.

Cognitive Ability

Ms. Forrester is at least of average intelligence. She is verbal and capable of insight. She correctly identifies her own feelings, and she can describe how other people feel. While she currently has limited insight into her own feelings about Jon and how they affect her care of him, this is probably due more to the emotional threat of such acknowledgment than to a lack of cognitive ability. With the proper supportive counseling, she may further explore and eventually understand this.

Child's Special Needs

Ms. Forrester's description of Jon suggests oppositional behavior. The teacher confirms this, but claims she can engage Jon to cooperate by using gentle reasoning and encouragement. It is not known how Jon has been affected by the family fighting, his father's abandonment, and his mother's abuse. The teacher's description of Jon suggests some early signs of emotional distress. A psychological assessment may be indicated, and depending upon the assessment findings, Jon may need counseling.

Summary of Strengths

Ms. Forrester's strengths include her intelligence; her motivation to continue to better herself; her warm and affectionate relationship with Wendy; her capacity for self-assessment and introspection; her ability to negotiate with service providers, such as the nurse at the hospital, the teachers at Jon's school, and the teachers in her own school program; and her willingness to participate in the helping relationship.

In spite of her vehement verbalized distrust of other people, and her initial resistance to meeting with Carol, she demonstrated a willingness to tell Carol a lot about herself in the first few interviews. While ambivalent, she appears able to take risks in new situations, even while expecting she may likely be hurt again. This

is a strength. However, it further underscores the importance of not violating her trust, and also suggests that Ms. Forrester needs help in learning to assess who is trustworthy, and who is not.

Conclusions about Risk

Jon remains at considerable risk in the sole care of his mother. While Ms. Forrester has numerous strengths, and has begun to consider how Jon's behavior triggers her rage, she has not learned to control it. Until she does, Jon should not go home. However, since Carol's hope is to reunite Jon and his mother as soon as feasible, she believes leaving Jon with Ms. Forrester's sister, with unlimited visitation at the sister's home, is the best safety plan. This needs to be formally arranged with Ms. Forrester's sister.

Problem Areas to be Worked on in Case Plan

1) Ms. Forrester has an explosive, volatile, and violent temper, which, when triggered, results in physical injury to her son.

2) Ms. Forrester utilizes physical discipline almost exclusively, which increases the likelihood of physical injury to her son when she is angry.

3) Ms. Forrester has little understanding of normal oppositional behavior in nine-year-old children, and has unrealistic expectations

for Jon. Her responses to oppositional behavior appear to escalate her struggle with him.

4) Ms. Forrester does not have adequate resources of emotional support. She is emotionally isolated. This greatly increases her stress level, and makes her more vulnerable to emotional distress and lability.

5) Regular visits between Ms. Forrester and Jon are necessary both to maintain the parent-child relationship, and to enable the worker to observe, more fully assess, and better understand their interactions.

Summary

This dictation was designed to illustrate the following principles of relationship building and family assessment:

- Carol used relationship-building strategies to defuse Ms. Forrester's anger and hostility, and to develop the relationship necessary to conduct an accurate and comprehensive family assessment.

- At several times during the assessment process, Carol had to back up and reengage or reassure Ms. Forrester, before the assessment process could continue.

- Carol used open-ended questions to gather as much general information as possible about the Forresters before she became more directive and guided the interview to topic areas needed for a comprehensive assessment.

- Carol did not force Ms. Forrester to "confess" her involvement in the abuse; but, she used the casework process to help Ms. Forrester reveal considerable information about her relationship with her son. Carol did not confront Ms. Forrester with her failure to fully reveal the circumstances of the abuse. She positively reinforced any information Ms. Forrester was willing to share. She did not press for an explanation until their relationship was well-established, and Ms. Forrester had already disclosed considerable personal information in a supportive and safe environment. Even then, Carol was supportive and encouraging, rather than demanding or accusing.

- Carol used the assessment process as a way to help Ms. Forrester consider her own strengths, problems, and needs, and Carol reinforced Ms. Forrester for being an active and contributing partner in the assessment process. Throughout the interviews, Carol helped Ms. Forrester recognize her own strengths, and stressed their value in helping Ms. Forrester deal with the current situation.

- Carol used clarifying questions and responses to move Ms. Forrester from "content" issues to "process" issues, and supported and reinforced her willingness to explore the dynamics underlying her situation.

- Carol used gentle warmth and honesty in dealing with Ms. Forrester. She was consistently friendly, sincerely interested in Ms. Forrester as a person, and was willing to reveal information about herself, without compromising her professionalism, or forgetting her primary purpose for being there.