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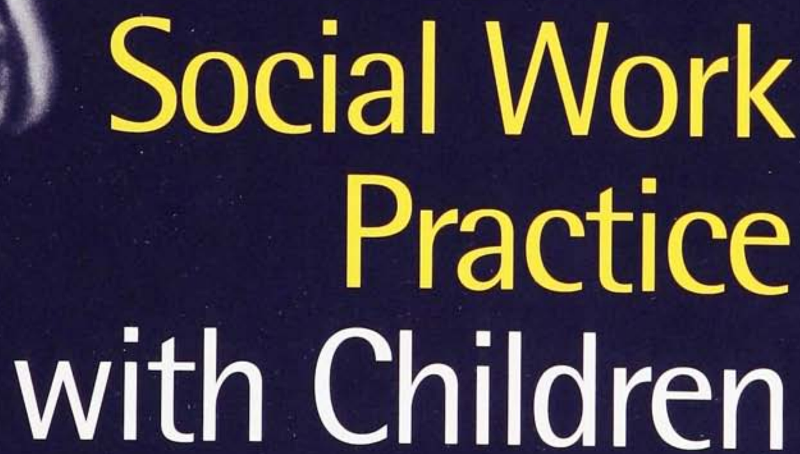

Social Work Practice with Children

Nancy Boyd Webb

SOCIAL WORK PRACTICE WITH CHILDREN

Second Edition

Social Work Practice with Children and Families
Nancy Boyd Webb, Series Editor

SOCIAL WORK PRACTICE WITH CHILDREN
Second Edition
Nancy Boyd Webb

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SOCIAL WORK PRACTICE WITH CHILDREN

Second Edition

NANCY BOYD WEBB

Foreword by
Cynthia Franklin

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In tribute to three Deans of the Graduate School
of Social Service, Fordham University:

James R. Dumpson, Dean of the School 1967–1974
Mary Ann Quaranta, Dean 1975–2000
Peter Vaughn, Dean 2000–present

Each, in distinctive ways, has contributed to the development of social work practice with children and therefore provided behind-the-scenes support and inspiration for this book. As recipient of the James R. Dumpson Chair in Child Welfare Studies, I am committed to continue Dean Dumpson's important work on behalf of poor and disadvantaged children.

About the Author

Nancy Boyd Webb, DSW, BCD, RFT-S, is a leading authority on play therapy with children who have experienced loss and traumatic bereavement. Her bestselling books are considered essential references for clinical courses and with agencies that work with children. These include *Mass Trauma and Violence: Helping Families and Children Cope* (Guilford Press), *Helping Bereaved Children, Second Edition: A Handbook for Practitioners* (Guilford Press), *Play Therapy with Children in Crisis, Second Edition: Individual, Group, and Family Treatment* (Guilford Press), *Culturally Diverse Parent–Child and Family Relationships* (Columbia University Press), and the first edition of *Social Work Practice with Children* (Guilford Press). In addition, she has published widely in professional journals and produced a video, *Techniques of Play Therapy: A Clinical Demonstration,* which won a bronze medal at the New York Film Festival's International Non-Broadcast Media Competition. Dr. Webb is the editor of The Guilford Press book series Social Work Practice with Children and Families. She is a past board member of the New York Association for Play Therapy and on the editorial advisory board for the journal *Trauma and Loss: Research Interventions.*

A board-certified diplomate in clinical social work and a registered play therapy supervisor, Dr. Webb presents frequently at play therapy, social work, and bereavement conferences in the United States and abroad. She has been a professor on the faculty of the Fordham University School of Social Service since 1979, and in October 1997 was named University Distinguished Professor of Social Work. In 1985, she founded Fordham's Post-Master's Certificate Program in Child and Adolescent Therapy to meet the need in the New York metropolitan area for training in play therapy. In April 2000, Dr. Webb appeared as a panelist in a satellite teleconference *Living with Grief: Children, Adolescents, and Loss,* sponsored by the Hospice Foundation of America. Hosted by Cokie Roberts, the conference was beamed to more than 2,100 sites. Dr. Webb was appointed to the endowed James R. Dumpson Chair in

Child Welfare Studies at Fordham in 2002, and the same year was honored as Social Work Educator of the Year by the New York State Social Work Education Association. In 2004 she was named a Distinguished Scholar by the National Academy of Practice in Social Work and was presented with the Clinical Practice Award of the Association for Death Education and Counseling. And in 2005 she received the Sue Katz Humanitarian Award, presented by the East End (New York) Hospice for her writing and clinical practice with bereaved children.

In addition to teaching, writing, and consulting, Dr. Webb maintains a clinical practice and supervises and consults with schools and agencies. She lectures and conducts workshops throughout the United States, Canada, Australia, Europe, Hong Kong, and Taiwan on play therapy, trauma, and bereavement.

Foreword

What are the issues facing children and families at the beginning of the 21st century, and what is the role of the social work profession in trying to assist with these? Problems of homelessness, family and community violence, foster care placement, divorce and remarriage, substance abuse, and death present compelling challenges that social work services attempt to address. Practitioners and students must be knowledgeable about their clients' diverse needs and have the necessary training to help them. Family issues affect each family member differently, and children, because of their youth, often suffer from lack of understanding and lack of attention. This book rights the balance and ensures that children receive their due consideration both as individuals and as family members.

The second edition of *Social Work Practice with Children* is an outstanding practice text for both undergraduate and graduate students in social work and allied helping professions. The scope of the book is broad enough to serve as a general text for undergraduates and yet offers the type of skills and in-depth understanding of practice issues that make it a useful graduate text for clinical classes on children and adolescents. *Social Work Practice with Children* is very comprehensive, integrating diverse knowledge and practice skills needed to successfully practice and provide services to children across multiple settings. One of the many strengths of this book is its ability to place children in the context of their lives in family and community settings. The ecological systems and developmental theory is used as an organizing framework to help practitioners envision the biopsychosocial assessments and interventions that are needed. Through the use of the systems theory perspective, Nancy Boyd Webb shows that children cannot be separated from their living contexts and that practice interventions can be successful only if those contexts are considered.

Social Work Practice with Children brings the living contexts of children to the forefront so that students and practitioners can experience, through text and illustrations, the difficulties that often surround the lives

of children. The applied practice cases and Dr. Webb's own practice experiences illustrate the lives of children and describe the multifaceted roles and practice skills that are needed to effectively help them. In the case presentations, she is able to communicate the emotion and passion often evoked in working with children. Although the first edition of this text had this type of content, the new edition goes even further in providing applied practice materials and case scenarios, making the book even more readable for practitioners and practice students.

The organization of the book is also excellent for teaching. In the first part of the book, Dr. Webb provides an ecological–developmental framework for working with children, which is concisely communicated with diagrams and case illustrations. The book makes a compelling case for the erosion of social and behavioral competencies due to poverty, violence, drugs, and other social maladies that affect children and their families. At the same time, however, *Social Work Practice with Children* addresses strengths, resiliencies, and cultural diversity so that the book does not overpathologize children and their families. From the very beginning, the book advocates a diverse knowledge base for practice skills and the need for all helpers to be culturally competent. Both descriptive and case content on culturally diverse practice skills are woven into the fabric of the text.

In the second part of the book, Dr. Webb turns to knowledge and skills for client assessment and practice. She discusses clinical process, as well as specific interventions that a practitioner can use. This section covers how to build relationships with systems, doing assessments, intervention planning and monitoring, and evaluating case process. The chapters are filled with assessment tools, questioning techniques, and questionnaires that can be used in practice. The book also offers practice illustrations and information on how to assess risk and protective factors of children. In addition, Webb provides in-depth knowledge for how to work with common dilemmas in practice, such as strategies to use with the "involuntary" child client.

After a thorough discussion of case process, the third section of the book turns to specific methods for helping children, such as family work, individual counseling, group work, and work within school settings. These chapters provide excellent suggestions and tools for helping children.

The final section of the book serves as a kaleidoscope of diverse knowledge, skills, and "transformational" information that will be helpful for working with children. Each chapter is written from the perspective of helping children in a variety of life situations that may impact them adversely or require special assistance. Topics such as kinship and foster care, divorce and reconstituted families, family illness and death, and family and community violence are covered. These chapters are schol-

arly but also filled with gems of practice wisdom. They provide the background knowledge and skills needed to serve children in diverse life circumstances.

The last chapter of the book is "transformational," because discussions that place children in the global context of human rights and oppression are not often found in a clinical practice text. This chapter speaks to the need for governmental and policy interventions, worldwide advocacy, and the merging of work between advocates and clinicians. It also addresses homelessness, immigration, HIV, and a host of other issues confronting children. It serves as an excellent introduction to the welfare and empowerment of children, and presents a strengths and resiliency perspective. This chapter vividly illustrates the need for improving the living conditions of children and complements the ecological philosophy that is at the heart of the text. The values and message embedded in *Social Work Practice with Children* are reinforced in this ending chapter. Children cannot be removed from their life contexts. Instead, these contexts must be improved and changed with the help of caring adults. Children are like precious gifts that may be misused, ruined, or cherished. Nancy Boyd Webb has presented us with an excellent practice text that shows practitioners how to cherish children while working to resolve their mental health and social problems.

CYNTHIA FRANKLIN, PHD
The University of Texas at Austin

Preface

The first edition of this book was written in 1996 with great hope and conviction, as I had then completed almost 20 years as a social work educator and more than 30 years as a child and family social work practitioner. Then, as now, my mission was to draw attention to the special needs of children and to the necessity for using helping methods that are appropriate for child clients. At the beginning of the 21st century we find that many problems continue to affect children and families, despite all our best professional efforts. Unfortunately, violence—family, community, and throughout the world—has escalated, creating tension and trauma in the lives of many children. Professional intervention will be needed as never before, both to alleviate ongoing conflicts and to counteract the negative effects of living in a world that cannot guarantee safety to its families and children.

Social work education, regrettably, continues to neglect the needs of young children as *individuals*, erroneously assuming that work with the family will adequately encompass the needs of its children. Major texts on child welfare, for example, ignore or discuss only briefly the use of play therapy as the method of choice in working with children under 12 years of age. In addition, the emphasis on upholding the principle of family preservation, although based on a worthy goal, unfortunately serves to push the unique needs of the individual child in the family even further into the background. Children who have been abused and neglected, as many of those in the child welfare system have been, require attention over and beyond that devoted to helping their families resolve the various difficulties that resulted in the need for their placement. In truth, *both* family and individual work with the children in the family will be necessary to address their problematic situations adequately.

This book emphasizes the necessary training of social work students to employ methods of helping children that are appropriate to children's developmental age and ability to understand. Helping young children,

while they are children, serves an important preventive purpose that may avert many years of future problems for the individual children, for their families, and for society.

At the end of the 20th century, social work education made a commitment to address the needs of people of color and of all sexual orientations across the life cycle. This commendable goal implicitly includes children but fails to spell out either the nature or the extent of course content essential to train students adequately for practice with children. The Council on Social Work Education permits each school of social work to carry out its own curriculum design, provided that a focus on these designated client populations is included.

This textbook contains content useful for courses at both the baccalaureate and master's levels; it is designed to provide both basic and advanced material. The first three sections of the text present a theoretical framework, using an extended case example to depict the overall process of helping children, and then describes different methods of helping. The fourth and longest section of the book deals with helping children in special circumstances. Case examples and the accompanying discussions in the chapters of this final section address such topics as working with children in kinship and foster care; the challenge of helping children in the midst of custody disputes; and work with children who have post-traumatic stress disorder and attachment difficulties as a result of witnessing family and community violence. Many of these cases illustrate cutting-edge issues for social workers trying to help children in desperate situations, such as those growing up in chemically dependent families or those who have been orphaned by war or traumatized by terrorism. Because I focus on children in the most difficult of circumstances, social workers and other practitioners who are struggling in their daily work to find ways to help such children may find new approaches in this book.

Although I began the book intending it as a text for direct practice with children and families, larger-scale political and economic issues have consistently and inevitably presented themselves. Advocacy approaches are urgently needed in order to improve and resolve many children's problems that accompany the spiraling effects of chronic poverty. Nothing would satisfy me more than to have this book used to link "micro" and "macro" approaches to helping children. If we are to be truly helpful, this linkage must occur, and social workers can and should play a leadership role in this compelling effort.

Acknowledgments

This book reflects reverberating influences from a number of sources. At the risk of seeming sentimental, I wish to acknowledge my parents, Earl and Angie Boyd, who always supported my desire to read and learn. My father, a mathematics teacher with a daughter ill-adept in math, set an example for a future play therapist in recognizing the need to tune in to a child's anxiety. And whenever I begin to form a relationship with a child, I think about my mother's innate capacity to play and to communicate with children of all ages.

I cannot possibly name all the significant influences in my life who contributed indirectly to this book. However, I must indicate my intellectual debt to Erik Erikson and to Carel Germain, whose view of individual "problems" included a wide-ranging appreciation of the contributing factors in the social environment, as well as of the reciprocal influences of the individual, the family, and the society on one another. This ecological perspective permeates my own assessment and work with children and families.

For the most part, this book represents my work during the course of the past 20 years with children and families. All the case material has been disguised to protect client confidentiality, except in instances in which this privilege was previously waived. A few cases are composites of children and families in particular situations. In most instances, clients (including children, whenever possible) gave their written permission. The profession owes a tremendous debt of gratitude to these parents and children, who permitted the use of their personal situations to benefit future social workers and other practitioners in their efforts to help children and families.

I am especially grateful to the filmmaker Kathryn Hunt, whose documentary film, *No Place Like Home*, portrayed the case of Barbie and her family that served as the basis for Chapters 3, 4, and 5. The staff of the First Place School in Seattle, Washington, provided consultation and assistance in writing the chapters about the "Smith" family. The assistance of Deb Brinley-Koempel and Eugene Harris was especially appreciated. I sincerely hope that professionals working in shelters for homeless families around the United States will learn from this case example. I also thank both Barbie and her mother, who continued to be willing to share their lives when I

contacted them 7 years later about this new edition. Their openness in this regard means that countless others will learn from their experience.

My dedication of the book to the three deans of the Fordham University Graduate School of Social Service recognizes both their philosophical and realistic support of this book, including facilitating the flexibility of my work schedule to permit its completion. I am grateful for their friendship and their inspired leadership and commitment to improving the lives of children.

The first edition of this volume was the first in The Guilford Press's series Social Work Practice with Children and Families. Since 1996, three additional volumes have been published in the series, and I want to acknowledge the commitment made by this commercial publishing house to the issues confronting social work practice. I continue to be grateful for Seymour Weingarten's endorsement of a venture that connects Guilford to cutting-edge issues in social work practice in the 21st century. Over the course of this book's production, I have benefited from the consultation and wisdom of Jim Nageotte, Senior Editor at Guilford, and from the careful work of the copyeditor, Elaine Kehoe, and production editor, Anna Brackett, whose efforts always permit the best intent of my work to reveal itself.

Several social work educators and practitioners in different fields have offered consultation, contributed case materials, and/or read portions of the manuscript. These include Nadine Bean, Meg Schneider, Kay Scott, Celeste Theis, and Madeline Zevon. I am very grateful to them for their expertise and generosity in offering their ideas and experience and in permitting me to edit and modify their cases in order to conform to the focus and emphasis of the overall book.

My former social work doctoral student assistant Roxia Bullock competently retrieved numerous references as my research assistant. Recognition and thanks should also be given to Barbara Nussbaum of the State Education Department, The University of the State of New York, for her assistance with legislative updates related to special education. In the international sphere, the United Nations senior reference librarian, Dana Loytved, gave me timely and efficient service in providing materials on the Convention on the Rights of Children. The Fordham support staff at Tarrytown, New York, Marla Mendillo and Nivea Pellicier, tirelessly and cheerfully helped with assorted matters, including making copies and mailing books and research materials to me in Florida and Vermont, where I wrote most of this book.

Once again, my husband, Kempton, has provided concrete assistance and psychological support during this process. His steady optimism and respect for the value of my work is inspirational. As our family has increased over the past few years to include three grandchildren, my lifelong commitment to children and their basic rights has taken on special meaning.

List of Tables

TABLE 4.1. Suggested Play Materials for Assessment Sessions with Children of Different Ages
TABLE 4.2. Assessment of the Child's Behavior in Play Sessions
TABLE 4.3. Developmental History Outline
TABLE 4.4. Individual Factors in the Assessment of the Child
TABLE 4.5. Situational Factors in the Assessment of the Child
TABLE 4.6. Assessment of the Child's Support System
TABLE 4.7. Common Risk and Protective Factors for Serious Childhood Social Problems: An Ecological and Multisystems Perspective
TABLE 6.1. Ground Rules and Guidelines for Family Session
TABLE 6.2. Selected Interventions for Children with ADHD
TABLE 9.1. Classifications of Disabilities
TABLE 9.2. Components of a Comprehensive Evaluation
TABLE 10.1. Factors Precipitating Placement Decision
TABLE 10.2. Individual and Family Factors Related to Placement
TABLE 11.1. Tripartite Assessment of Family Circumstances
TABLE 12.1. Children's Cognitive Development and Understanding of Death
TABLE 12.2. Individual Factors in Childhood Bereavement
TABLE 12.3. Death-Related Factors in Childhood Bereavement
TABLE 12.4. Family/Social/Religious/Cultural Factors in Childhood Bereavement
TABLE 12.5. Recording Form for Childhood Grief Reactions
TABLE 13.1. Effects of Different Categories of Substances on Individuals
TABLE 14.1. Physical and Behavioral Indicators of Physical Abuse
TABLE 14.2. Physical and Behavioral Indicators of Sexual Abuse
TABLE 15.1. Losses Confronted by Immigrant Children
TABLE A1. Individual Factors in Childhood Bereavement
TABLE A2. Death-Related Factors in Childhood Bereavement
TABLE A3. Recording Form for Childhood Grief Reactions
TABLE A4. Family/Social/Religious/Cultural Factors in Childhood Bereavement
TABLE A5. Crisis Situation Rating Form
TABLE A6. Individual Factors in the Assessment of the Child in Crisis

List of Figures

FIGURE 1.1. Interactive influences of child, family, and environment.
FIGURE 2.1. Eco-map of José.
FIGURE 3.1. Barbie Smith, as she and her family were packing for yet another move.
FIGURE 3.2. Eco-map of the Smith family.
FIGURE 3.3. Equipping the "average" office for work with children.
FIGURE 4.1. Interactive components of a tripartite assessment.
FIGURE 4.2. Willie's Draw-A-Person.
FIGURE 4.3. Natalie's Draw-A-Person.
FIGURE 4.4. Natalie's Draw-A-Family.
FIGURE 4.5. Natalie's optional drawing.
FIGURE 5.1. Goals contract.
FIGURE 6.1. Tim's Draw-A-Person.
FIGURE 6.2. Tim's Draw-A-Family.
FIGURE 6.3. Tim's weekly graph for the first month of the graph/star system intervention.
FIGURE 7.1. Floor plan of Linda's house.
FIGURE 7.2. Floor plan of Linda's bedroom.
FIGURE 7.3. Linda's drawing of her "before" and "after" dreams.
FIGURE 7.4. Linda's "good night's sleep" drawing.
FIGURE 8.1. A sample confidentiality contract.
FIGURE 8.2. Example of comments elementary students wrote on the Graffiti Wall.
FIGURE 8.3. "Push-me-pull-you" drawing for use in a Banana Splits group.
FIGURE 8.4. Child's drawing in a debriefing group following an earthquake.
FIGURE 9.1. The special education process in New York State for children and youths ages 5–21.
FIGURE 10.1. Interactive components of a tripartite assessment when a child is placed out of the home.
FIGURE 10.2. Form for a letter to a person who died.
FIGURE 11.1. Interactive components of a tripartite assessment of a child in a divorcing family.

FIGURE 11.2. 10-year-old girl's Draw-A-Person.
FIGURE 11.3. Malcolm's Draw-A-Person.
FIGURE 11.4. Squiggle presented to Malcolm and Malcolm's drawing of the boat.
FIGURE 11.5. Squiggle presented to Malcolm and Malcolm's drawing of the tornado.
FIGURE 12.1. Sabrina's Draw-A-Person before her mother's surgery.
FIGURE 12.2. Therapist's drawing of a person in a hospital bed with IV stand and tubes.
FIGURE 12.3. Sabrina's Draw-A-Person (a princess), 2 months after her mother's surgery.
FIGURE 12.4. Interactive components of a tripartite assessment of the bereaved child.
FIGURE 12.5. Sabrina's drawing of John.
FIGURE 12.6. Sabrina's drawing of a sad face.
FIGURE 12.7. Sabrina's Body Map of Feelings.
FIGURE 13.1. Feelings-in-the-Bottle drawing by an 8-year-old girl.
FIGURE 13.2. Feelings-in-the-Bottle drawing by a 12-year-old girl.
FIGURE 13.3. Feelings-in-the-Drug-Syringe drawing by a 15-year-old girl.
FIGURE 13.4. Vernon's drawing of Feelings-in-a-Beer-Can.
FIGURE 13.5. Vernon's list of Feelings-in-a-Beer-Can.
FIGURE 13.6. Vernon's drawing of his happy face (feelings on the outside).
FIGURE 13.7. Vernon's drawing of his disappointed face (feelings on the inside).
FIGURE 13.8. Vanessa's drawing of Feelings-in-a-Bottle.
FIGURE 13.9. Vanessa's drawing of her uncle's drinking.
FIGURE 13.10. Vanessa's drawing of her happy face (feelings on the outside).
FIGURE 13.11. Vanessa's drawing of her tired, stressed face (feelings on the inside).
FIGURE 14.1. Interactive components of a tripartite crisis assessment.
FIGURE 14.2. Outline for drawing a happy face in the Feeling Faces exercise.
FIGURE 14.3. The Body Map of Feelings.
FIGURE 14.4. Child listening to parents fighting.
FIGURE 14.5. A therapy dog named Diamond, who is trained to interact with children and adults in crisis situations under the guidance of an animal handler.

List of Cases

Chapter 1. The Case of Jacob, Age 10, and Damien, Age 14
Chapter 2. The Case of José, Age 6½
Chapter 3. The Case of Barbie, Age 10
Chapter 4. Applying Developmental History/Tripartite Assessment Principles: The Case of Barbie
Chapter 4. A Sample Biopsychosocial Assessment Summary: Barbie Smith
Chapter 5. Update on the Smith Family: 1995
Chapter 5. Update on Barbie: 2002
Chapter 6. The Case of Tim, Age 7
Chapter 7. The Case of Anna, Age 5
Chapter 7. The Case of Tammy, Age 4
Chapter 7. The Case of Linda, Age 10
Chapter 8. Banana Splits Groups for Children of Divorce
Chapter 8. Case Example 1: The World Trade Center Bombing, February 26, 1993
Chapter 8. Case Example 2: The World Trade Center Attack, September 11, 2001
Chapter 9. The Case of Johnny, Age 5
Chapter 9. The Case of Eli, Age 7
Chapter 10. The Case of a Foster Child with a History of Abuse: Dave Pelzer
Chapter 10. The Case of a Foster Child Who Is HIV-Positive: Maria
Chapter 10. The Case of a Child Living with His Grandparents: Ricky
Chapter 10. The Case of a Child Living with Her Grandmother: Kayla
Chapter 11. The Case of Malcolm, Age 11
Chapter 12. The Case of Sabrina, Age 5¾
Chapter 12. Interventions with Sabrina and Her Parents after John's Death
Chapter 13. The Case of Vanessa, Age 9, and Vernon, Age 10
Chapter 14. The Case of Elisa Izquierdo, Age 6
Chapter 14. The Case of Marta, Age 5, Whose Father Died in the New York World Trade Center Terrorist Attack
Chapter 15. The Case of Alexa, Age 8

Contents

I. AN ECOLOGICAL–DEVELOPMENTAL FRAMEWORK FOR HELPING CHILDREN

1. Children's Problems and Needs 3

The Social Context of Children's Lives 3
The Case of Jacob, Age 10, and Damien, Age 14 4
Increased Rates of Emotional and Behavioral Problems 8
An Ecological Perspective on Etiology 11
Current Issues in Social Work with Children 13
Concluding Comments 16
Discussion Questions 16

2. Necessary Background for Helping Children 17

Understanding the Multifaceted Role of the Social Worker 17
The Case of José, Age 6½ 18
Commitment to a Core of Values and Code of Ethics 21
The Essential Knowledge Base for Work with Children 26
Necessary Competences in Work with Children 32
Avoiding Potential Pitfalls in Work with Children 33
Supervision and Self-Monitoring of Practice 34
Discussion Questions and Role-Play Exercises 35
Recommended Texts on Child Biological, Psychological, and Social Development 36

II. THE PROCESS OF HELPING CHILDREN: A RUNNING CASE ILLUSTRATION OF A CHILD IN A SINGLE-PARENT HOMELESS FAMILY

3. Building Relationships with All Relevant Systems 41

The Case of Barbie, Age 10 42
Identification of the Need for Services 44

Interagency Collaboration on Behalf of Children and Families 48
Establishing Professional Relationships 52
Concluding Comments 57
Discussion Questions and Role-Play Exercises 58

4. The Biopsychosocial Assessment of the Child **59**

What Is an Assessment? 59
The Assessment Process 61
Determining Who/What Is to Be Assessed 61
Obtaining Collateral Information 63
Order and General Guidelines for Assessment 64
Assessment Tools 74
Summarizing the Relevant Data 91
A Sample Biopsychosocial Assessment Summary: Barbie Smith 92
Feedback/Review with Parents and Other Professionals 97
Concluding Comments 98
Discussion Questions and Role-Play Exercise 99

5. Contracting, Planning Interventions, and Tracking Progress **100**

Contracting: Engaging Clients and Identifying Their Needs 100
Planning Interventions 103
Tracking Progress and Terminating 111
Update on the Smith Family: 1995 112
Update on Barbie: 2002 114
Concluding Comments 115
Discussion Questions 116

III. DIFFERENT METHODS OF HELPING CHILDREN

6. Working with the Family **119**

Two Distinct Helping Approaches: Child-Centered and Family Therapy 119
An Integrated Child and Family Model 121
Different Levels of Family Involvement 122
Ethical Challenges in Family Work 130
Working with Children with Attention-Deficit/Hyperactivity Disorder and Their Parents 131
The Case of Tim, Age 7 131
Update on Tim, Age 14 141
Concluding Comments 141
Discussion Questions and Role-Play Exercises 142

7. One-to-One Work with the Child 143

Rationale for Working Separately with the Child 144
Selected Play Therapy Techniques 149
Using the Child's Play Therapeutically 153
Different Child Therapy Approaches 155
The Case of Linda, Age 10 159
Concluding Comments 166
Discussion Questions 166

8. Group Work with Children 167

Rationale for Use of Groups 167
Different Types of Groups for Children 169
Considerations in Planning a Group for Children 172
Banana Splits Groups for Children of Divorce 178
Crisis Intervention Groups for Children 181
Case Example 1: The World Trade Center Bombing, February 26, 1993 184
Case Example 2: The World Trade Center Attack, September 11, 2001 186
Concluding Comments 188
Discussion Questions and Role-Play Exercise 189

9. School-Based Interventions 190

School–Home–Community Partnerships 190
Overview of the Role of the School Social Worker 193
Issues in Interprofessional Collaboration 198
Children with Special Needs 202
The Case of Eli, Age 7 206
Concluding Comments 211
Discussion Questions 212

IV. HELPING CHILDREN IN SPECIAL CIRCUMSTANCES

10. Children Living in Kinship and Foster Home Placements 215

Beliefs about the Best Interests of the Child 215
Determining the Need for Placement 217
Different Levels of Care 223
Typical Issues for Children in Placement 226
Interventions with the Children 227
Interventions with the Foster Parents 232
The Role of the Social Worker in Child Welfare 232
Concluding Comments 234
Discussion Questions and Role-Play Exercise 234

11. Children in Divorcing and Reconstituted Families 235

Issues of Loss and Multiple Stressors *236*
Assessment of the Impact of Family Circumstances on the Child *239*
Goals in Helping Children in Divorcing and/or Reconstituted Families *240*
Custody Disputes: Children "Caught in the Middle" *245*
The Case of Malcolm, Age 11 *247*
Ethical Issues for Practitioners *255*
Concluding Comments *257*
Discussion Questions and Role-Play Exercises *258*
Resources for Children in Divorced and Reconstituted Families *258*

12. Children in Families Affected by Illness and Death 259

The Case of Sabrina, Age 5¾ *259*
Developmental Influences on Children's Understanding of Death *265*
The Tripartite Assessment of the Bereaved Child *266*
Issues in Sibling Death *272*
Selected Helping Interventions for Bereaved Children *276*
Update: Eight Years Later *284*
Concluding Comments *285*
Discussion Questions and Role-Play Exercises *285*

13. Children in Substance-Abusing Families 287

Clarification of Terminology *287*
Impact of Growing Up in a Substance-Abusing Family/Environment *288*
Ethical Dilemmas and Pressures on Practitioners *292*
Combining Individual and Family Helping Methods *296*
Groups for Children of Substance-Abusing Parents *300*
The Case of Vanessa, Age 9, and Vernon, Age 10 *304*
Concluding Comments *311*
Discussion Questions and Role-Play Exercises *312*
Resource Materials *313*

14. Child Victims and Witnesses of Family and Community Violence 315

Definition and Scope of the Problem *316*
Impact of Exposure on Children and Implications for Treatment *317*
The Assessment of the Child Victim and/or Witness of Family Violence *319*
The Case of Elisa Izquierdo, Age 6 *320*

The Assessment of the Traumatized Child: Posttraumatic Stress Disorder in Children *324*
Selected Helping Methods *328*
The Case of Marta, Age 5, Whose Father Died in the New York World Trade Center Terrorist Attack *334*
Group Approaches *337*
Preventive Approaches to Family and Community Violence *338*
Concluding Comments *339*
Discussion Questions *340*

15. A Changing World's Impact on Practice with and for Children **341**

The Need for Shared Responsibility for Children *342*
A Global Perspective on Children's Rights *344*
The Case of Alexa, Age 8 *345*
Trends in Direct Practice with Children *349*
Concluding Comments *355*
Discussion Questions and Role-Play Exercise *357*

APPENDICES

Child-Related Professional Organizations 361
Child-Related Professional Journals 362
Training Programs and Certifications 365
Suppliers of Play Materials 367
Bereavement Resources 368
Forms for Assessment of the Bereaved Child 369
Forms for Assessment of the Child in Crisis 375

References **379**

Author Index **405**

Subject Index **411**

❖ PART I ❖

An Ecological–Developmental Framework for Helping Children

❖ CHAPTER 1 ❖

Children's Problems and Needs

The birth of a child sets in motion a chain of inevitable responsibilities for the parents, the rest of the family, and even the community, because all at some future time will be expected to provide in varying ways for this dependent and growing new life. When the parents cannot care for their child, relatives may do so; and when the extended family is unavailable, the state steps in. Society therefore maintains a vested interest in the adequacy with which families meet children's needs.

THE SOCIAL CONTEXT OF CHILDREN'S LIVES

Garbarino, Stott, and Associates (1989) list the basic needs of children as nurturance, responsiveness, predictability, support, and guidance. Meeting these needs may be extremely difficult for unmarried mothers and others living below the poverty line.

The incidence of children under age 18 living in a one-parent family in 1990 was 25%, as compared with 10% in 1960. By 1999, 45% lived in female-headed households, and this number increased to 59% in 2000 (Children's Defense Fund, 2000). In addition, the number of children entering foster care doubled between 1987 and 1991 and increased 35% during the 1990s (Children's Defense Fund, 2000). In 1998 nearly one out of every five children in the United States lived in poverty. Almost half of these children lived with their single mothers, who were three times as likely to be poor as other adults (Children's Defense Fund, 2000).

What is the impact on children of living in impoverished environments that are characterized by unemployment, pervasive substance abuse, inadequate health care, poor-quality childcare, and high levels of child abuse and neglect? Some studies have found that these socioeconomic disadvantages can contribute to higher incidences of impairment

in children's social, behavioral, and academic functioning (Achenbach, Howell, Quay, & Conners, 1991; Duncan, Brook-Gunn, Klebanov, 1994; Institute of Medicine, 1989; Schteingart, Molnar, Klein, Lowe, & Hartman, 1995). Obviously, poverty is a serious social and personal crisis, and interventions to help poor children and families will require broad-based efforts that press for political and economic remedies, in addition to helping children with their emotional–behavioral difficulties.

In the first edition of this book, I mentioned the efforts of the American Bar Association to call attention to the need for legal reform to assist U.S. children at risk (American Bar Association Working Group, 1993). This document addressed children's essential needs in the areas of income, housing, education, health, juvenile justice, and child welfare. Similarly, the Children's Defense Fund (1992, 2000, 2001) issues annual reports on the state of U.S. children and argues for political agendas targeting the well-being of children and families. Unfortunately, the hoped-for political pressure for action has been overshadowed in recent years by economic and national and global defense concerns. Significant improvement in the quality of life for families and children at risk remains a future goal. Meanwhile, children are responding with self-destructive and antisocial behaviors that echo the frustrations and conflicts of their parents and communities.

This book focuses on methods for helping children with mental, emotional, and behavioral problems and their families. Because of the interplay of influences between children and their social environments, it is essential to consider *simultaneously* a troubled child's biological/temperamental/developmental status, the surrounding familial cultural context, and the physical and social environment (see Figure 1.1). Although political advocacy may be essential for long-term improvement of the insidious effects of poverty, substance abuse/dependence, and violence, immediate supportive assistance must be offered to children and their families who live in the midst of these conditions. Children demonstrating troubled and troubling behaviors require prompt, direct services, even when these are provided in less than ideal social environments.

THE CASE OF JACOB, AGE 10, AND DAMIEN, AGE 14

This information is taken from a front-page article in *The New York Times* (Wilkerson, 1994). In preparing the second edition of this book I wondered if this case would seem out of date 8 years later. Sadly, it is not; the situation of urban children who live in high-crime, drug-infested neighborhoods is as bad as ever.

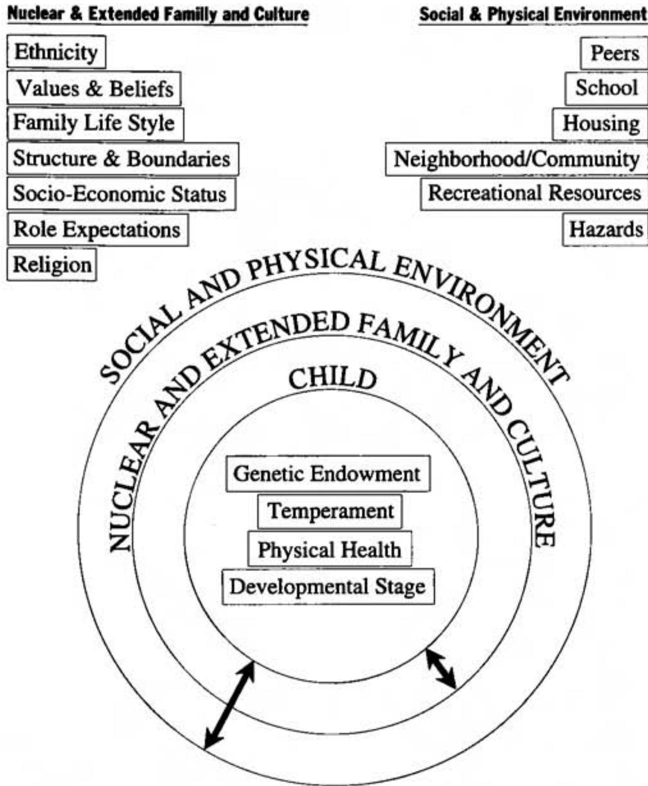

FIGURE 1.1. Interactive influences of child, family, and environment.

Presenting Problem

Damien, age 14, and Jacob, age 10, were arrested for armed robbery in the shooting death of a pregnant woman who refused to hand over money she had withdrawn from an automated teller machine. Jacob gave the go-ahead signal for the robbery, and Damien, a drug dealer who was trying to obtain money to pay drug debts, carried out the shooting. Damien pleaded guilty to second-degree murder, and both boys received the maximum sentence for juveniles—remaining in state custody until the age of 21.

Family Information

Both boys were born to mothers on welfare, each of whom had first given birth at age 14. Damien's father had abandoned his family, and Jacob's

father was shot to death in a bar fight when the boy was 4 or 5 years old. Both boys grew up in an atmosphere of physical abuse; Jacob's father used to beat his mother, and Damien said that he ran away from home because his mother beat him. Both boys lived in crack houses, and Jacob's mother had a history of alcohol and crack dependence.

Jacob was the youngest of eight children, in a family in which he saw relatives and friends use guns to settle disputes. He saw his sister shot in the face when he was 4 or 5. Another sister introduced him to marijuana when he was 9. His mother did not appear for Jacob's first court hearing on the armed robbery charge, and when she subsequently came to testify, she was drunk and could not remember Jacob's birthday.

Damien dropped out of school after the seventh grade and went to live with an older teenage brother, who was a drug dealer and who initiated him into the drug trade. (Damien had earlier been a ward of the court after his mother was accused of beating one of his brothers. He apparently had no contact with his father.) Damien took the gun used in the robbery/murder from his brother's house; in preparation for the attack, in Jacob's presence, Damien sharpened the bullets.

Discussion

It is not difficult to identify the familial and social factors that coalesced in the behaviors resulting in this tragic murder. An overview of the information available in this case summary reveals the presence of the following negative influences in the lives of these boys:

Family disintegration:
- Female-headed households
- Absent fathers (Jacob's was killed; Damien's abandoned the family)
- Youthful runaway behavior (Damien)

Poverty (both families were supported on welfare)

Exposure to violence and abuse:
- Witness to spouse abuse (between parents—Jacob)
- Witness to child abuse (parental abuse of sibling—Damien)
- Personal experience of child abuse (Damien)
- Witness of gun fights within family (Jacob)

Exposure to substance abuse:
- Residence in crack houses
- Parental alcohol and crack dependence (Jacob)
- Sibling drug dealing (Damien)

Drug abuse/dependence in the neighborhood
Encouragement to use drugs

Jacob's lawyer summarized his young client's situation by stating that "Jake is the product of his environment. He comes from a dysfunctional family. The older neighborhood boys were his heroes. They sold drugs. They had guns. They were his role models. He wanted to be like them" (quoted in Wilkerson, 1994, p. A-14).

Charles Patrick Ewing, a lawyer and forensic psychologist, comments in his book *Kids Who Kill* (1990): "Juvenile killers are not born but made. . . . Virtually all juvenile killers have been significantly influenced in their homicidal behavior by one or more of a handful of known factors: child abuse, poverty, substance abuse, and access to guns" (p. 157). Certainly these conditions do not *always* produce child killers; many youngsters manage to survive the ravages of noxious familial and social environments without succumbing to antisocial acts. Some even achieve great success, against all odds (Anthony & Cohler, 1987). Nonetheless, when the cards are stacked so heavily against healthy development, as they were for both Jacob and Damien, the outcome in terms of antisocial behavior is understandable. Furthermore, in addition to Ewing's list of factors contributing to homicidal behavior, we should consider the possibility that Jacob may have been born with fetal alcohol syndrome and/or the effects of his mother's crack addiction, and that Damien may have suffered head injuries as a result of the serious and repeated beatings he received. In addition, both boys' seeming lack of empathy may be related to insecure attachment due to the abuse and neglect they both suffered in the first 2 years of their lives (Karr-Morse & Wiley, 1997; Perry, 1997). We know nothing about either boy's academic performance—possible learning or hyperactivity problems or individual areas of achievement.

This case illustrates how the cumulative influence of individual, familial, and social factors can culminate in juvenile criminal behaviors. Even when social and familial factors appear to predominate as causal, however, remediation will necessitate intensive work with such youths on an *individual* basis. It is likely that after years of abuse and neglect, youngsters such as Damien and Jacob internalized and then replicated the dysfunctional behavior they witnessed and experienced during their formative years. Rehabilitation will require more than environmental change to significantly alter such youngsters' sense of personal identity, their sense of self-respect and competence, and their views about future goals for their lives. I wrote to the *New York Times* reporter who wrote this feature article (Wilkerson, 1994), suggesting that she do a follow-up article on how the boys had responded to their respective treatment pro-

grams. Unfortunately, she did not respond. At this writing, 8 years after the original report, Damien would now be 22 years old and presumably no longer in state custody, and Jacob would be 18, with 3 more years of custody. Hopefully, they have received some intensive treatment during the 8 years, and we will not see their names on the front page of our newspapers again. Chapter 14 discusses the treatment of children who witness family and community violence.

INCREASED RATES OF EMOTIONAL AND BEHAVIORAL PROBLEMS

There is a growing perception, both among the general public and in the professional literature, that children's problems are getting worse. LeCroy and Ryan (1993) state that "severe emotional disturbance in children and adolescents is a national problem requiring immediate action" (p. 318). Knitzer (1982) and Hewlett (1991) have documented the adverse effects of deteriorating social conditions on children's emotional and physical well-being. Special concern relates to children's exposure to violence in their homes, communities, and the media (Osofsky, 1997).

In an attempt to answer the question "Are American children's problems getting worse?", Achenbach and Howell (1993) compared scores on the Child Behavior Checklist (CBCL) from 3 different years: 1976, 1981, and 1989. The CBCL (Achenbach & Edelbrock, 1983) is the most widely used measure of its kind in the world for documenting children's everyday problems, according to Goleman (1993). In each of the 3 years, a random sample of more than 2,000 children from 7 to 16 years of age was rated. Achenbach and Howell (1993) found that, in 1989, problem scores were somewhat higher on the 118 items describing behavioral and emotional problems and competence scores were lower than they had been in the earlier assessments. Teachers' ratings agreed with those of parents in showing small increases in problem scores and decreases in competence scores. Therefore, Achenbach and Howell (1993) answered "Yes" to the question, although they could not determine why this was so. No significant differences to explain the findings could be attributed to age, gender, socioeconomic status, or black–white ethnicity.

Another important finding among Achenbach and Howell's 1989 sample was a significant rise in the proportion of children scoring in a range indicative of a need for clinical services (18.2%), despite the exclusion from this sample of 8.3% who had already received mental health services in the preceding year. Children in foster care showed rates of significant problem behaviors that were 3 to 4 times higher than the rate of 10%

expected in the general population of children, and children in residential treatment showed as much as twice the rates of disturbance (Shennum, Moreno, & Caywood, 1998).

Specific Problem Syndromes

The following groupings of problems, derived from parent, teacher, and self-report forms of the CBCL as administered to the 1989 sample, were presented in *The New York Times* (Goleman, 1993). Each specific item appears on the CBCL.

Withdrawn or social problems:
Would rather be alone
Is secretive
Sulks a lot
Lacks energy
Is unhappy
Is too dependent
Prefers to play with younger kids
Attention or thought problems:
Can't concentrate
Can't sit still
Acts without thinking
Is too nervous to concentrate
Does poorly on schoolwork
Can't get mind off certain thoughts
Delinquency or aggression:
Hangs around kids who get into trouble
Lies and cheats
Argues a lot
Is mean to other people
Demands attention
Destroys other people's things
Disobeys at home and at school
Is stubborn and moody
Talks too much
Teases a lot
Has hot temper
Anxiety and depression:
Is lonely
Has many fears and worries
Needs to be perfect

Feels unloved
Feels nervous
Feels sad and depressed

All of these behaviors worsened over the 13-year period from 1976 to 1989. Achenbach stated that "it's not the magnitude of the changes, but the consistency that is so significant" (quoted in Goleman, 1993, p. C-16). He went on to suggest that multiple factors probably contribute to such widespread increases in children's problems. Among these, he cited children's exposure to violence; reduced time with parents and reduced parental monitoring of children; more families with both parents working; more single-parent families; and fewer community mentors to help children learn adaptive social and emotional skills. All of these possible contributing factors continue to be relevant in the first decade of the 21st century, so it is logical to expect that there has been a continuing increase in children's problems.

Children's Emotional Problems and Resilience

Experts in the field agree that behavioral/emotional/developmental difficulties in childhood occur in an estimated 14% to 22% of all children (Brandenberg, Friedman, & Silver, 1990; Mash & Dozois, 2003). The more severe forms of disorder occur in approximately 8% to 10% of all children (Boyle et al., 1987; Costello, 1989; Offord et al., 1987; Rutter, 1989). Moreover, in contrast to the poor advice given by some pediatricians, many children do *not* outgrow their difficulties (Mash & Dozois, 2003), and they *can* benefit from treatment. As I discuss more fully in the next chapter, it is essential for practitioners who are treating children to be knowledgeable about different types of problematic behaviors seen in children and their recommended treatments. It is also important for practitioners to be able to identify not only the child's problematic behaviors but also his or her areas of strength and positive adaptation. We know that different children respond differently even in the same families. For example, all children in a multiproblem family could be considered "at risk" of developing problems themselves. This is not a simple equation, however, as a significant proportion of children who are at risk do not develop later problems (Mash & Dozois, 2003). "Resiliency" is a concept that describes children who not only survive adversity but also somehow become stronger in the face of it (Davies, 1999).

Therefore, a comprehensive understanding of any child requires that practitioners assess both the child's maladaptive and adaptive responses. The foundation of this assessment rests on knowledge of normal child

development and of the many ways children can respond to stressful situations.

Implications for Social Workers

The fact that millions of children are suffering from serious mental health problems means that social workers, teachers, and others will encounter these children in schools, in child welfare institutions, in jails, in foster homes, and on the streets (LeCroy & Ashford, 1992). Their presence is by no means restricted to mental health clinics, as only about half of the children who need mental health services receive them, and many who do receive inappropriate services, according to Saxe, Cross, and Silverman (1988). Important decisions about what services to offer and which family members to include and in what setting depend on a careful biopsychosocial assessment that takes account of cultural and other factors. This issue is discussed in Chapters 4 and 5. It is essential that those working with children have basic knowledge about child development (Davies, 1999), about cultural variations in child rearing (Webb, 2001), and about the various deviations from children's usual developmental course that can occur in order to evaluate a presenting problem in a manner that fully considers the inner world of the child, in addition to all relevant external factors. An understanding of the concepts of risk and resiliency (Fraser, 1997) can help practitioners avoid a linear view of causality.

AN ECOLOGICAL PERSPECTIVE ON ETIOLOGY

The Need to Consider Multiple Factors

Nothing in life is simple, as we quickly realize when we are attempting to ascribe causality to human behavior. "The task of unraveling causes and determinants of childhood mental disorders is formidable because of the complexity of interactions between biological, psychological, social, and environmental factors" (Institute of Medicine, 1989, paraphrased in Johnson & Friesen, 1993, p. 27). The current view of the etiologies of mental and emotional disorders in children and adolescents has been summarized as follows:

> Support for multifactorial or systems understanding of the etiology of mental disorders has been accruing rapidly during the past two decades. Systems views are replacing univariate and stage theory models in all mental health disciplines, including social work, psychiatry,

> special education, clinical psychology, and others. (Johnson & Friesen, 1993, p. 27)

Of course, social work has a long history of employing extensive psychosocial assessment, as pointed out by Lieberman (1987); the addition of "bio-" to "psychosocial" represents increased awareness of the importance of innate factors (whether genetic or acquired) that can influence how an individual copes with a problem.

The concept that a child himself or herself may be an active agent influencing the systems of family, school, and government was first proposed by Bronfenbrenner (1979). It has subsequently been elaborated in the works of Stern (1985) with regard to the infant–mother interaction and in the publications of the Erikson Institute (Garbarino et al., 1989), which stress the mutual influences between children and their physical, social, and cultural contexts. The implications of this dynamic view lead to more complex understandings about social interactions, which are no longer viewed as unidirectional.

For example, when a highly active, intensely reactive, distractible child is adopted by a low-key, calm mother, she may believe that the child is "hyper" because of her own inability to soothe and quiet the baby. However, temperamental differences between parents and children, whether the children are biological or adopted, attest to the notion of "match" or "goodness of fit" between parent and child as the appropriate unit of attention, rather than the maladaptation of the individual parent or child (Thomas, Chess, & Birch, 1968; Shapiro, Shapiro, & Paret, 2001). Simplistic, single-cause explanations no longer suffice in a systems perspective that attempts to consider "the continual, mutually influencing forces of biology, culture, behaviors of significant others, organizational processes, economics, and politics" (Johnson 1993b, p. 86). If this wider view seems cumbersome and broad, it certainly avoids the previous overemphasis on parental pathology as *the* cause of children's problems. Germain and Gitterman (1987) state that "neither the people served, nor their environments, can be fully understood except in relationship to each other" (p. 493).

The Need to Consider Cultural Factors

It is also essential that social workers understand their own cultural biases and learn about the culturally based beliefs of their clients regarding role expectations, typical ways of expressing feelings, and patterns of social exchange (Webb, 2001). For example, a male child who has been taught both implicitly and explicitly that being "macho" means "Stand

up for yourself and don't let anyone get away with insulting you or your family" cannot be criticized for initiating a fist fight with a bully who called him a "wimp" and his sister a "tramp." To label this child "aggressive" misses the child's compelling motivation to defend his family's honor in a culturally sanctioned manner. This situation challenges the school social worker, who may be brought in to devise a creative response that respects the child's cultural identity even as it discourages fighting on the school premises. Different cultures have different beliefs about child behaviors that are acceptable and those that are not. Furthermore, attitudes about accepting help in the form of social or mental health services vary greatly among cultures, and practitioners must be sensitive to the implications of discussing a child's "problem behaviors" with a parent who may feel that the child's behavior reflects directly on the quality of her parenting and on the family's honor (Webb, 2001).

Children and adolescents in immigrant families are often in conflict between two competing sets of values and norms, which may require them to follow one set of behaviors in the family setting and another in the school and community (Huang, 1989; Wu, 2001). This situation will require concerted attention from school social workers and others who deal with increasing numbers of immigrant children.

CURRENT ISSUES IN SOCIAL WORK WITH CHILDREN

Historical Overview

A consideration of current issues will have more meaning when these are viewed in a historical perspective. The practice of social work with children has taken many forms—from its beginnings in court-affiliated clinics for juvenile delinquents in 1909, in which social workers studied cases and treated families, to agency and private practice in the 21st century, in which social workers may work with families, with children in groups, or with individual children (using play therapy and other methods appropriate for young clients). Parent counseling has always been an essential component of working with children, even when children reside with extended family members or live in foster homes. Intervention with a child's biological parent(s) remains central to the work with the child, because of social work's enduring belief about the importance of family identity to the child's sense of personal identity and because of the profession's commitment to the concept of family preservation (to be discussed in the next chapter).

During the early decades of this century, social workers intervened with families according to their understanding of the problem, which took the form of a "diagnosis" of social factors contributing to the problem situ-

ation (Richmond, 1917). During the next phase of more specialized and regulated practice, many social workers worked under the guidance and direction of psychiatrists in child guidance clinics; the psychiatrists treated the children while the social workers "guided" the parents, thus introducing the concept of "parent guidance." In situations in which a family failed or was in danger of failing to meet the child's basic needs, the child welfare system assumed the role of parent surrogate, "doing for the deprived, disadvantaged, dependent child what the effective family does for the advantaged child" (Kadushin, 1987, p. 267). During the 1950s and 1960s, child welfare enjoyed special recognition and status as a specialty area within social work. More recently this elite status has diminished somewhat, as other professionals have become involved in child placement decisions, abuse investigations, and adoption procedures (Kadushin, 1987).

After the promulgation of family therapy in the 1970s and later, social workers tended to view a child's problems as symptomatic of a troubled marriage; therefore, intervention tended to focus on the marital dyad or on the family unit, rather than on individual members of the family. As a result, the child's presenting problem might be downplayed or ignored by family therapists, who considered it just the tip of the iceberg. An important goal in family therapy has been to remove the child from the role of the "identified patient" (Satir, 1983). More recently, there is growing recognition that symptomatic children may have internalized problems and therefore require individual help, regardless of whatever assistance is offered to the parents or to the family unit. Social workers increasingly utilize specialized methods such as play therapy (including the use of art, sand play, music, and storytelling) in their work with young children. It is notable that the American Board of Examiners in Clinical Social Work (ABE) plans to adopt a specialty and to credential practitioners in child and adolescent therapy as a practice specialty of advanced clinical social work. This action recognizes the body of specialized knowledge in this field as a precedent for the formal recognition of child and adolescent clinical social work.

Current Cutting-Edge Issues

Practice at the beginning of the 21st century must take major account of the social environment, which has a very heavy impact on many families and children, even as social workers continue to pay attention to children's biological and emotional condition. Methods of intervention must be grounded in a thorough understanding of *all* relevant contributing factors and adapted to both the internal and external needs of children with problems.

The following list of cutting-edge issues, though by no means exhaustive, represents matters of concern to my students, my colleagues, and myself in our mutual efforts to provide relevant and helpful service to children and families at the beginning of the 21st century. The chapters that follow address these issues through case examples and literature reviews, as well as through my own experience of almost 30 years as a social work practitioner and educator.

1. *The impact on children of deteriorating social conditions, such as violence, poverty, and substance abuse/dependence.* Where and how can we intervene for the purpose of protecting children and enhancing the quality of their lives? Many children, especially in urban areas, report that they fear going to school because of possible outbreaks of violence involving guns and knives. The trip from home to school may be marked by episodes of gang warfare in which innocent bystanders are injured or killed. When children's basic safety is in jeopardy, how can they concentrate and learn in school and complete their basic developmental tasks as well?

2. *Selecting intervention alternatives at multiple levels* (with the child, with the parent[s], with the extended family, with the community, and with government [political advocacy]). How can individual social workers be expected to intervene in *all* areas simultaneously, as might best serve the needs of a particular situation? In view of extensive individual, family, and social needs, should the profession focus on developing subspecialty areas of expertise? For example, should specially trained practitioners carry out lobbying/advocacy efforts, while family practitioners work with family units and child specialists work with individual children? What would be some advantages and disadvantages of this approach? Whereas we might like to do it all, the maxim "jack of all trades, master of none" bears careful thought as demands for more specialized practice increase.

3. *Providing culturally sensitive practice.* How can social workers develop sufficient knowledge about numerous ethnic groups to practice effectively? The immigrant population is increasing rapidly, and based on predicted birth and immigration rates, "minorities" will become the majority by the middle of the 21st century (Shinagawa & Jang, 1998). Because most practitioners are Caucasians of Anglo-European heritage (Gibelman & Schervish, 1997), they must learn how to engage and interact with parents who have diverse beliefs about parent–child roles and about how to obtain help for their children. Practitioners need to develop attitudes of "cultural curiosity" regarding expectations for parent–child behaviors in other cultures and be willing to learn from their clients (Webb, 2001). An understanding of one's own beliefs forms an essential foundation of practice with diverse clients.

4. *Working with severely traumatized children with posttraumatic stress disorder (PTSD) and other responses to trauma.* Children are increasingly suffering the effects of exposure to traumatic events, such as community and family violence, terrorism, and war. Some children respond with symptoms of PTSD, and others express their anxiety through other symptoms such as depression, generalized anxiety, conduct disorders, and somatization disorders (Jenkins & Bell, 1997). The symptoms of PTSD represent dysfunctional, defensive coping responses to environmental assaults on an individual's level of anxiety tolerance. Social workers who have special training in crisis intervention and treatment of traumatized children can assume the leadership in helping these at-risk children. As a corollary, social workers can also lead in efforts for *early* intervention with such children, to prevent the development of future problems (which often become more entrenched with the passage of time).

CONCLUDING COMMENTS

Social work with children is a demanding, all-inclusive field of practice. No longer can a practitioner focus primarily on a child's inner world, nor will it suffice to intervene exclusively with the child's family or social environment. A multifaceted approach is essential to understanding, just as it is essential in planning and carrying out helping interventions.

Social workers must learn to scan a child's world and see the broad picture before determining where and how to initiate the helping process. The skills of listening, observing, and empathizing will assist practitioners, who must be able to see through a child's eyes in order to comprehend the child's situation with both head and heart.

DISCUSSION QUESTIONS

1. How can a social worker avoid becoming discouraged when faced with a child who has been victimized by physical and emotional abuse and neglect in a home in which both parents use multiple substances?
2. What services would be appropriate to offer, within a school setting, to recent immigrant children and their families for the purpose of assisting with their adjustment and integration into the community? What form of initial contact would make the children and families most comfortable?
3. Review and discuss the selected cutting-edge issues presented in this chapter, indicating how social work education can respond to the needs. Which issues do you think will prove the most difficult to resolve? Why?

❖ CHAPTER 2 ❖

Necessary Background for Helping Children

This chapter begins with an overview of the varying social work roles and functions related to helping children. It then reviews the value base, knowledge base, and practical skills that are essential for this work and concludes with some guidelines for avoiding pitfalls that sometimes confront social workers in this field of practice. An annotated bibliography of texts on child development is appended to the chapter.

UNDERSTANDING THE MULTIFACETED ROLE OF THE SOCIAL WORKER

A social worker attempting to help a child does not work in a vacuum. Many different adults often participate in the helping effort, and frequently the social worker serves as self-appointed case coordinator to facilitate sharing of information and to promote collaboration in the child's best interests. Each setting has its own group of professional experts who have input regarding the child's problem. In addition, each situation dictates its own unique protocol for the involvement of special personnel to evaluate and treat a child with problems. For example, when an 8-year-old third grader threatened to throw himself out of a window at school, the social worker at the emergency walk-in psychiatric clinic to which the child was brought consulted with the staff child psychiatrist, the school guidance counselor, and the child protective services (CPS) worker who was investigating allegations of child abuse in this family (Price & Webb, 1999). These contacts, some "in-house" and others collateral, were as essential for understanding the situation as were interviews with the child and his mother. Because the social worker had a broad view of the problem situation, she understood the importance of contacting other professionals for their input.

A team approach to helping often serves a child and family well, because each specialist's expertise can contribute to a fuller understanding of the child's situation. When the social worker subscribes to a multifacted view of etiology, as discussed in Chapter 1, the participation of other professionals with different perspectives about the child's situation is welcomed and valued. Usually the social worker synthesizes all the relevant information obtained from various sources and organizes it into a biopsychosocial summary, which later will be discussed with the parent(s) and with the child (when feasible) as part of the treatment planning and contracting. This assessment process is reviewed in detail in Chapters 4 and 5.

The following case illustrates the different social work roles of clinician, case manager, consultant, and advocate.

❖

THE CASE OF JOSÉ, AGE 6½

Presenting Problem

José, a 6½-year-old Hispanic foster child, was referred for counseling by the committee on special education of his school because of his traumatic and chaotic background. José had both witnessed and been subjected to domestic violence, child neglect, abuse, and abandonment prior to being placed in foster care at age 4½ with his two younger brothers. When the foster mother later found it too difficult to manage the care of the three active boys, José's brothers (ages 3 and 5) were moved from the home. At that time, José was enrolled in a special day school. He became very oppositional, both at home and at school, and began having delusions of characters from horror movies telling him to kill himself and hurt others. When José proceeded to act on these violent commands, he was admitted to a psychiatric hospital.

Family Information

Both of José's parents were drug addicts, and all three of their sons had been exposed prenatally to drugs and alcohol. The father was incarcerated for stealing, and the mother for selling drugs. Before the mother's incarceration, when the boys resided with her, they were often left alone and neglected. Their initial placement in foster care occurred after the police found them wandering alone in the streets at midnight.

Case Overview

José spent 2 months in the psychiatric hospital, during which time the social worker from the special education school visited him weekly for counseling. She wanted to maintain continuity in their relationship, because she assumed that he would return to the same school program upon discharge. She also knew that José would be placed in the same foster home with his brothers following discharge and that his mother was due to be released from prison 6 months later.

Discussion

Even the bare outline of this case permits us to appreciate the complex, multifaceted role of the school social worker who faced the challenge of gathering together the unraveling threads of this child's life. She wanted to create some sense of unified purpose among the various professionals involved with this child, in order to coordinate the planning and to clarify future goals.

The following list identifies the array of personnel who were involved with José's life either directly or indirectly and whom the school social worker attempted to involve in this planning:

- Foster care worker
- CPS worker
- Psychiatric hospital staff (psychiatrist, social worker, nurses, psychologist)
- Mother's prison caseworker and/or future probation officer
- José's special education teacher
- José's speech and hearing specialist
- José's pediatrician

An eco-map (see Figure 2.1) was used to diagram these different helpers; it also included the genogram and relevant family members. (See Hartman, 1978, for details about the construction of an eco-map and a discussion of its use.)

Different Roles

In her role as *case manager*, the school social worker obtained reports from the professionals involved with José and convened a case conference to which all were invited. Learning more about the nature of José's

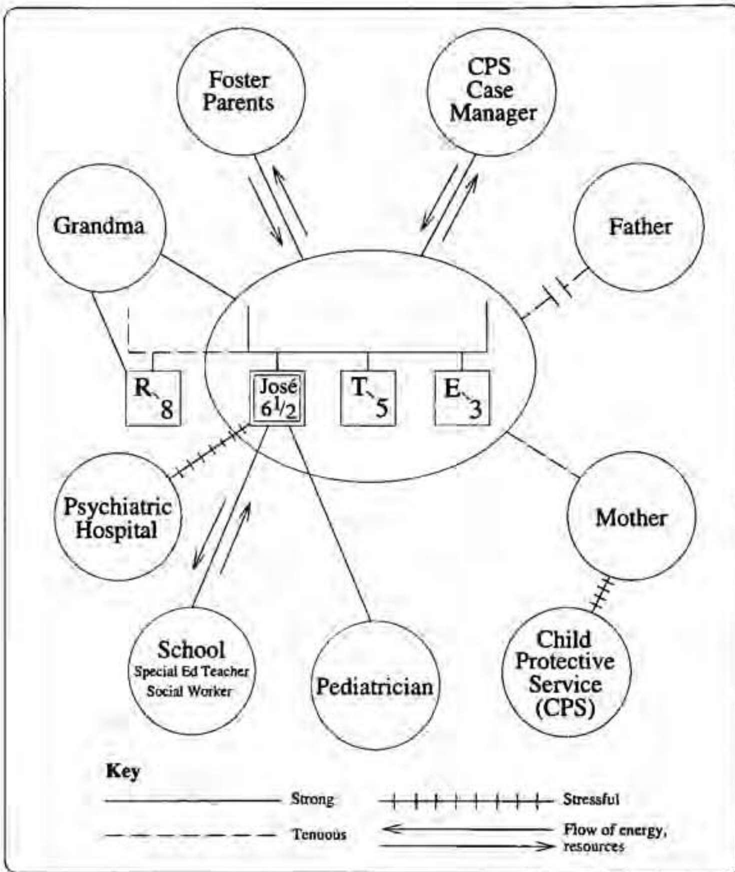

FIGURE 2.1. Eco-map of José.

psychiatric diagnosis and prognosis helped prepare the worker for her ongoing involvement with this child in her role as his *therapist*. The worker also more clearly understood José's untrusting manner of relating to her and others at the school when she heard details from the CPS worker about the mother's history of abandonment and abuse of her children. By contrast, the worker served as *consultant* to the hospital staff when she visited José during his stay: She provided information to the personnel there about the boy's hearing loss in one ear and about his hyperactivity and short attention span, which had become apparent to his teacher.

Because of the worker's concern about José's mother's rehabilitation, she took on an *advocacy* role in regard to the need for the mother to re-

ceive counseling and parenting education in prison and drug and alcohol treatment prior to her discharge. The worker also advocated for the children to begin visiting their mother on a regular basis to prepare them for possible future reunification of the family.

Different Settings

In addition to working with many collaborators in a variety of roles and functions, the professional social worker involved with children must also demonstrate versatility in working with clients in a wide range of locations. The tenet of "meeting clients where they are" usually refers to tuning in to their psychological/emotional states. However, it can also refer to meeting the clients on their *physical* terrain. This means that social workers who deal with children's problems work in all locations where children live, learn, and play and where they receive care and counseling when they are injured, neglected, abandoned, or otherwise troubled. Thus social workers help children in hospitals, schools, foster homes, residential treatment centers, family agencies, mental health clinics, and shelters for the homeless. Although each setting has its particular focus and specific procedures for helping, certain basic principles and a core of knowledge about child and family behavior and needs must guide the practice of all social workers who help children, regardless of the setting in which they provide services.

COMMITMENT TO A CORE OF VALUES AND CODE OF ETHICS

Professional social work education trains students to become practitioners who demonstrate disciplined "use of self," appropriately applying theoretical knowledge and practice skills. However, knowledge and skills, though necessary, are not sufficient for the task of helping. The situations in which social workers are engaged often require difficult decisions in which no single "right answer" applies. The workers must consider ethical principles and weigh the pros and cons of various possible outcomes in the effort to serve everyone concerned most effectively.

The Code of Ethics

Values serve as guides or criteria for selecting good and desirable behaviors. Most social workers agree about the basic values of client participation, self-determination, and confidentiality (Lowenberg & Dolgoff, 1996).

However, the complexity of a client's situation can often make decisions very difficult. Ideally, clients participate in decisions affecting their own lives; however, when interests of family members conflict, and/or when abuse and neglect of a minor is a possibility, then the social worker may have to make a recommendation based on his or her judgment regarding the best interests of the child.

The National Association of Social Workers (NASW) its adopted first code of ethics in 1960, to provide social workers with principles to help them resolve ethical dilemmas encountered in practice (Reamer, 1999). This code of professional ethics identifies and describes the ethical behavior expected of professional practitioners (Lowenberg & Dolgoff, 1996). Among the principles emphasized are those of confidentiality, self-determination, and expectations pertaining to standards of professional behavior. The most recent code of ethics (NASW, 1996) continues the general tone of the previous version, therefore requiring sensitive interpretation and case-by-case application in ambiguous conflict situations.

Although the code articulates the value base of the social work profession, it does so with a high level of abstraction that fails to provide specific guidelines for the resolution of ethical dilemmas. Thus, although students and practitioners are expected to subscribe to this code, its implementation may be unclear and subject to differing personal interpretations. The code (NASW, 1996, p. 5) states this plainly:

> This code offers a set of values, principles, and standards to guide decision making and conduct when ethical issues arise. *It does not provide a set of rules that prescribe how social workers should act in all situations.* Specific applications of the code must take into account the context in which it is being considered and the possibility of the code's values, principles, and standards. *Ethical responsibilities flow from all human relationships, from the personal and familial to the social and professional.* . . . Ethical decision making is a process. There are many instances in social work where simple answers are not available to resolve complex ethical issues. (emphasis added)

Issues of Confidentiality/Consent in Work with Children

With regard to children, questions of ethics often become especially thorny. For one thing, neither society nor the helping professions have taken a stand regarding whether children have the same rights of privacy and confidentiality as do adults, especially with regard to parents' access to information about their children's counseling/therapy.

Actually, the federal Family Educational Rights and Privacy Act (Public Law 93-380, 1974) gives parents the right to inspect their chil-

dren's medical and school records; therefore, social workers cannot legitimately promise confidentiality to children. Moreover, because social work with a child *always* involves work with a parent or guardian, the issue of confidentiality becomes entangled with the question, Who is the client? The parent or guardian has both a need and a right to know in a general way about the course of the child's progress and ongoing problems. In addition, the seasoned practitioner realizes that it is counterproductive and impossible to promise a *child* confidentiality. Ironically, this type of promise is the last thing many children would expect anyway, as they know that their parents or guardians "check up" on their work in school and other areas of involvement. Why should counseling/therapy be any different?

My own view about confidentiality as applied to children is that it is a concept more relevant to work with youngsters over 12 years of age, and even then it has the same limitations with regard to parents' legal right to access the records of their children under the age of 18. I believe that it is far more useful to encourage the sharing of information between a child and parent, albeit in a sensitive and general manner that does not divulge details that would be embarrassing to the child. Sometimes the achievement of improved parent–child communication represents a major goal in the helping process.

Another ethical issue pertinent to working with children is whether a child has the "right" to refuse treatment in the same manner as does an adult who is not a danger to self or others and who is not legally mandated to receive treatment. Can a 5-year-old decide what is in his or her own best interests? At what age *can* a child decide?

Anyone who works with children knows that almost *all* children begin as involuntary clients. They may realize that they are unhappy, but in most cases they have no idea that there are people who can help them with their worries and troubles; furthermore, they are wary of adult strangers and uncomfortable about talking with them. When the social worker introduces him-or herself to the child as a "worry person" or "helper" who knows how to help children with their troubles and worries, the child may begin to comprehend the nature and purpose of the helping process. Even then, a child who has been repeatedly disappointed or betrayed by adults may find the offer to help impossible to believe. Gaining such a child's trust will take time.

For all of these reasons, my personal recommendation is that the social worker request that the responsible adults continue to bring the child for appointments, even when the child seems unwilling. This initial "resistance" will almost always be converted into eager participation once the child experiences the reality of a relationship in which he or she is listened to and valued.

Ethnic/Cultural Sensitivity

When we meet someone for the first time, our initial impressions automatically register such personal characteristics as age, gender, and race, in addition to factors about the individual's personality and mood. When the person resembles ourselves, we may make certain assumptions about him or her, based on our own experiences regarding the shared characteristics. Of course, all middle-aged white women (for example) are not alike, but the likelihood of empathy increases with similarity of personal characteristics.

What does this mean, then, in view of the fact that "children of color are the most rapidly increasing group in the U.S. population, [that they] are the largest risk group for disabilities and developmental delay as a result of conditions associated with poverty[,] and that *most professionals who work with this population are from the dominant culture*" (Rounds, Weil, & Bishop, 1994, p. 12; emphasis added)? If, as predicted, by the year 2010 one of every four children in the United States will be a child of color, then social workers and other helping professionals must prepare themselves to work effectively with these children and their families (Gibelman & Schervish, 1997). Lieberman (1990, p. 101) states that "right from birth, babies become reflections and products of their culture" and notes that child-rearing traditions and values about parent–child roles and attitudes are strongly shaped by cultural beliefs.

Since 1973, the Council on Social Work Education (CSWE) has mandated that instruction concerning the lifestyles of diverse ethnic groups become an integral part of social work education (Devore & Schlesinger, 1996). Subsequent policy statements have reiterated and expanded on this position (CSWE, 1984, 1992a, 1992b, 2002), with the result that courses in the baccalaureate and master's curricula must reflect content regarding cultural diversity for groups distinguished by ethnicity and race, as well as by gender, age, religion, disablement, and sexual orientation (Carrillo, Holzhalb, & Thyer, 1993). The implementation of this mandate takes many forms; the work of Lieberman (1990), Rounds et al. (1994), Devore and Schlesinger (1987, 1996), Green (1999), Lum (1996, 1999, 2003), Congress (1997), and Webb (2001) contributes helpful guidelines for practice with children of color and their families.

These and other writers emphasize the importance of self-awareness regarding one's *own* culture as a foundation for understanding the culture of others. The core technique of the "conscious use of self" requires workers "to be aware of and to take responsibility for their own emotions and attitudes as they affect professional function" (Devore & Schlesinger, 1987, p. 103). This, of course, includes the worker's cultural beliefs. Honest, critical self-examination should occur in conjunction with

learning in social work courses and in the field practicum and should continue as the mark of professional behavior as long as a social worker engages in practice.

Tools for Self-Assessment and Improved Understanding of Cultural Differences

Some specific tools and references that can assist students and practitioners in examining their own cultural beliefs include Ho's (1992) "ethnic competence–skill" model, Cournoyer's (1991) overview of a variety of self-assessment measures related to cultural diversity, Chadiha, Miller-Cribbs, and Wilson-Klar's (1997) questionnaire of similarities and differences, and Paniagua's (1998) 10-item Self-Evaluation of Biases and Prejudices Scale. The latter two are reprinted in Webb (2001).

The "culturagram" (Congress, 1994) provides the social worker with a tool for understanding the unique cultural background, beliefs, and circumstances of diverse families. Use of the culturagram encourages appreciation of the impact of the culture on a particular family, even as it discourages stereotyping of members of a particular cultural group. Because children in culturally diverse families often struggle to reconcile the values and beliefs taught at home with those they observe in the wider community, it is important for social workers to understand such families' backgrounds and the belief systems to which the children have been exposed. The process of constructing and using the culturagram can result in the practitioner's greater empathy for ethnic/cultural differences.

Other steps toward improving ethnic/cultural sensitivity as summarized by Rounds et al. (1994) include acknowledging and valuing diversity, recognizing and understanding the dynamics of difference, and acquiring cultural knowledge.

Attunement to Cultural Differences

With regard to the recommendation that practitioners have an in-depth understanding of the cultural background of their clients, Lieberman (1990) reassures us that "it is impossible to be culturally sensitive as a general quality because this would demand an encyclopedic ethnographic and anthropological knowledge well beyond the reach of most of us" (p. 104). She suggests instead that we "think of cultural sensitivity as a form of *interpersonal sensitivity*, an *attunement* to the specific idiosyncracies of another person" (Lieberman, 1990, p. 104; first emphasis in original, second added). Insofar as social workers always try to imagine walking in the shoes of their clients, this attunement effort will result in practice that attempts to understand the clients' subjective world as it respects and

honors the clients' attempts to carry out the cultural/ethnic traditions that they have inherited and that form the intrinsic core of their identity. As Erikson (1963) has stated, "the ego identity is anchored in the cultural identity" (p. 279). Because of this we must adhere to Fong's (2001) recommendation to include culture habitually and systematically as an integral part of making assessments and planning interventions.

THE ESSENTIAL KNOWLEDGE BASE FOR WORK WITH CHILDREN

We have all been children ourselves, and many social workers also have firsthand experience with children in their role as parents. To assume, however, that personal life experience will prepare one for the type of complicated work described in the case of José is as foolhardy as suggesting that anyone who likes to eat can prepare a gourmet five-course meal! Liking food on the one hand, and memories of childhood on the other, can provide the motivation and even the foundation for success in either venture, but specialized training and study are necessary to move beyond the novice stage of either cooking or work with children.

A solid foundation of basic knowledge is essential for social workers and other practitioners whose work deals with young children and their families. This base of essential knowledge, as mentioned in Chapter 1, includes a grounding in the "normal" course of child development, as well as in deviations from this course (i.e., childhood mental and emotional disorders). The knowledge base also includes information about the ways family dynamics, developmental phases, and events affect children (and vice versa). With this foundation, for example, the practitioner will be in a position to evaluate the significance of severe nighttime fears when they occur in a 9-year-old child as opposed to a 3-year-old. The knowledgeable practitioner who understands the importance of attachment relationships and appreciates the interplay between the child's temperament and stressful events may discover through skillful questioning that the 9-year-old may have overheard arguments between the parents after she went to bed that led her to the conclusion that a parental divorce was imminent. This "discovery" of the source of the child's fear is not made by accident; it occurs because the social worker is well versed in normal child development milestones, which indicate that nighttime fears are atypical of a 9-year-old child in the absence of traumatic experience or upsetting family events. Nighttime fears, by contrast, are typical in 3-year-olds, and the knowledgeable social worker will counsel the parents of the 3-year-old about their common occurrence at this age, at the same time offering guidance about ways to comfort the child so as to keep the anxiety within tolerable limits.

Understanding of Child Development

Basic Information

Courses in social work with children usually do not teach the basics of child development, as instructors assume that students have acquired this knowledge in undergraduate psychology courses or the required core graduate courses in human behavior and the social environment. In the event that this content has not been adequately covered or mastered, an annotated list of references on child biological, psychological, and social development appears at the end of this chapter. In addition to these references in the professional literature, there are numerous works written for the general public that summarize basic information on child development. Some of these are included in the list at the end of the chapter.

Attachment and Bonding

The seminal writings of John Bowlby (1958, 1969, 1973, 1977, 1979, 1980, 1988) highlight the essential role of attachment and bonding "as a basic component of human nature" (1988, pp. 120–121). "Attachment" refers to an enduring, reciprocal bond of affection that focuses on a particular person or persons. The child's attachment figures are typically the parents or primary caretakers, who play a critical role in the nature and quality of the child's attachment relationships. For example, the child with a "secure" attachment relationship with his or her parents feels confident about leaving the safe proximity of this "secure base" to explore his or her environment, knowing that the parents will respond comfortingly when he or she returns and wants reassurance. However, in situations in which parents are inconsistent and/or unreliable toward the child, the resulting relationship may be characterized as an "anxious/resistant attachment" (Bowlby, 1988) or "ambivalent/resistant attachment" (Davies, 1999). This results in the child's exhibiting intense separation anxiety; when the parent /caretaker returns, the child resists contact and interaction. Bowlby also identifies another form of insecure attachment, "avoidant attachment," characterized by the child's actual *expectation of* rejection from his or her self-involved caretakers or parents, who may use threats of abandonment as a means of controlling him or her. The child defensively adopts a stance of self-reliance, as if the attachment is not important (Davies, 1999). This type of interaction understandably leads the child to become mistrustful of others, because he or she expects or fears abandonment in future relationships with other adults.

Still another form of insecure attachment, identified by Main and Solomon (1990) as "disorganized/disoriented attachment," refers to chil-

dren who seem confused and conflicted about attaching to the parent. Many of these parents, in turn, have histories of trauma, abuse, and violence, which may be somehow conveyed to their babies, who appear to be frightened by their anxious and fearful parent.

Many of the children known to social workers show signs of attachment difficulties. Children who have experienced inconsistent care and who demonstrate avoidant ambivalent, or disorganized attachment to their parents resist engagement with social workers because of their inability to trust adult strangers (James, 1994). These children, with backgrounds devoid of consistent loving relationships, require extreme patience, sensitivity, and understanding. Remkus (1991, p. 144) quotes the leading attachment theorists in stating, "failure to establish a secure attachment relationship limits the emotional, cognitive, and social development of the child (Sroufe & Waters, 1977; Sroufe, 1979a, 1979b; Ainsworth, 1979; Ainsworth & Bell, 1971; Mahler, Pine, & Bergman, 1975)." Davies emphasizes that the quality of attachment affects future development in a fundamental way.

Parents, usually mothers, bear a major responsibility for the quality of children's attachment (A. Freud, 1970). However, when parents are overwhelmed with multiple stresses, they may be unable to respond lovingly and consistently to their needy children. Indeed, a parent may not be able to bond to his or her own child because of the parent's *own* attachment-deprived history. Unfortunately, the parent–child relationship may become angry and abusive when the parent cannot focus on the child's needs.

The text revision of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) describes the criteria for the diagnosis of reactive attachment disorder of infancy or early childhood, which occurs as a result of deficient care and leads to marked disturbance in the child's social relatedness. This condition, which begins before age 5, causes the child to react in two different ways: (1) to be excessively inhibited or contradictory in responses or (2) to be indiscriminately sociable and apparently unable to attach selectively to attachment figures. James (1994) discusses some guidelines for working with these children. Students and practitioners who work with children with attachment and trauma disorders will benefit from studying the literature on trauma and its impact on development (Eth & Pynoos, 1985; Herman, 1992; van der Kolk, 1987, 1989; Wilson & Keane, 1997).

Mental and Emotional Disorders of Children

Social workers deal with children in a variety of circumstances (foster placement, underachievement in school, and a parent's terminal illness,

to name only a few). Referrals may occur because of the circumstances of the situation (e.g., foster placement) or because the child's extreme behavior alerts someone about the child's need for help.

Children express their anxieties in various ways, and the social worker or other practitioner to whom a symptomatic child may be referred must be knowledgeable about the different manifestations of childhood symptoms in order to make an assessment that will result in a helpful treatment plan. The worker's knowledge of normal child development serves as a baseline against which to evaluate the troublesome behaviors presented by the child. It is obvious that the more we understand about normal variations in development, the more we are able to determine which behaviors and reactions are indicative of problems in children.

In addition to understanding "normal" behavior, however, the practitioner needs to understand the deviations from the normal developmental course. The concept of "psychopathology" affixes a label to a set of behaviors; in the case of children, such labeling may seem pejorative and even ill advised in view of the reality of their rapid development. Nonetheless, practitioners must be familiar with the extremes of human behavior as manifested in children, so that they can recognize severely troubled children who require specialized interventions. An ability to apply the diagnostic categories of the DSM-IV-TR does not preclude understanding the multifaceted etiology of a child's problem. However, refusal to recognize that children can exhibit serious behavioral disturbances may lead to neglect based on the ill-founded resistance to applying medical/psychiatric classifications to children. Wachtel (1994) states that "fear of pathologizing children has led to an excessive 'normalizing' of children who could really benefit from . . . psychotherapeutic work" (p. 8). Chapter 4 includes further discussion of the process and tools of child assessment.

Resilience and Coping in Children

Because human behavior is the end product of multiple influences, we note with relief that a noxious environment does not *always* bring disastrous results to the children. The concepts of "resilience" and "coping" attest to the ability of some children to thrive and do well despite factors that defeat many of their peers in seemingly similar circumstances. The work of E. James Anthony demonstrates that some children not only survive but actually do well despite all odds to the contrary. Often, the influence of *one* adult makes enough impact to tip the balance of a negative environment in a child's life. Although these "invulnerable children" (Anthony & Cohler, 1987) are exceptional, their life experience argues for the positive impact of professional helpers on the lives of at-risk children who are "vulnerable." Davies's book on child development (1999) pre-

sents the concepts of risk and resilience/protective factors as a way to understand the balancing of multiple influences on development. Diverse applications of a resilience-based model of practice appear in Fraser (1997) and in Norman (2000). For example, Fraser gives examples of risk and protective factors in child maltreatment, in school failure, in the development of delinquency and conduct disorders, and in childhood depression.

Understanding of Family–Child Influences

Family Dynamics Affecting Children

The family's critical role in shaping a child is widely accepted by both professionals and the lay public. From the moment of birth, the mood and circumstances of the infant's mother and significant relatives provide the setting in which the child will feel safe and protected or insecure and threatened. The status of the family itself can influence the attitudes of various members about the infant's birth. For example, a first-born, planned child will experience a different reception than will a fifth-born, unplanned baby. However, birth order is merely one of many factors to be considered in evaluating the family's reactions to the infant. A first-born child of a 14-year-old unmarried mother may be resented because its birth was unwanted, whereas a fifth-born infant in some families may be highly valued for unique reasons having to do with the history of that family and the particular circumstances of the parents and the siblings at the time of birth. Every family is different, and the meanings of relationships cannot be assumed.

Developmental Stages of the Family

The family is an entity unto itself, with a course of development that has been charted by various theorists (Carter & McGoldrick, 1980; Duvall, 1977; Haley, 1973; Minuchin & Fishman, 1981; Zilbach, 1989). These writers refer to "beginning," "middle," and "late" stages of family development, with family tasks at each stage and significant family milestones occurring with the entry and departure of children. The importance of family developmental phases and of family factors in general in evaluating children cannot be overemphasized. Lidz (1963) describes the impact of the family on the child as follows: "The family forms the first imprint upon the still unformed child and the most pervasive and consistent influence that establishes patterns that later forces can modify but never alter completely" (p. 1).

The Reciprocity of Child and Family Effects

When a family is troubled (e.g., by marital conflict, health problems, or employment concerns), it passes along its tension to a child, who, in typical egocentric thinking, concludes that he or she created the difficulty. Sometimes the "problem" in a family *does* originate with the child; this may be true, for example, with a child who has attention-deficit/hyperactivity disorder and who presents management problems at home and at school (this kind of situation will be discussed in Chapter 6). When the family is viewed as a system, however, a problem for one member brings problems to all. Therefore, the practitioner needs to think about this reciprocity in trying to understand all the ramifications of the presenting problem. Wachtel (1994, p. 71) comments as follows:

> In assessing the role of family dynamics we try to determine what events may have shifted some stable patterns in the family or what might be going on developmentally in the lives of the children that is affecting family interactions. Understanding the effect of developmental or other changes on the family system involves having a well-articulated sense of the predominant transactional pattern of the family. . . . Understanding how the psychodynamic issues of the child relate to those of other family members is another important aspect of a systemic assessment.

In short, the family has an impact on the child, and the child has an impact on the family. We shall see various examples of both dynamics at work in the cases throughout this book. However, the facts that *all* families experiencing extreme stress do not generate problematic behaviors in *all* the children in their families and, conversely, that families with problematic children do not *always* exhibit disturbed familial functioning speak to the subtleties and vital importance of considering both individual and family strengths and resilience in evaluating the specific impact of events on different individuals and families.

The Effects of Family Crisis

Many children come to the attention of social workers and other practitioners at a time of family crisis, such as the divorce of their parents, the need for placement following an abusive experience, or their families' becoming homeless. It is essential that practitioners have an understanding of the impact of stress and trauma on children and know the principles of crisis intervention so that they will be able to help in a timely way. Such help may reduce the likelihood of later development of the serious symptoms of posttraumatic stress disorder. The use of the "tripartite

crisis assessment" (Webb, 1999) can assist the social worker in evaluating the resources in the social environment and in formulating appropriate long- and short-term goals.

NECESSARY COMPETENCES IN WORK WITH CHILDREN

Accessing the Network of Children's Services

Practitioners who work with children must know how to make appropriate referrals to meet the special needs of the children in their care. Anyone who has contact with children in a professional role, for example, may become aware that a child in his or her office shows signs of physical abuse; in addition, children sometimes disclose experiences of physical or sexual abuse to their social workers. Chapter 14 discusses the assessment of both physical and sexual abuse. It is mandatory for practitioners to report such evidence or disclosures. All social workers who have contact with children must be familiar with the laws in their states regarding their responsibility and the procedures flowing from a child's disclosure or suspicious evidence of physical or sexual abuse.

In addition, there may be times when referrals to crisis services, to CPS, or to hospital facilities will be necessary in order to meet the special needs of a child. Because of the unpredictable multiple needs of children, social workers must be familiar with referral policies of the relevant agencies in their locale, in order to make their clients' access to services as smooth as possible.

Blending Generalist and Specialized Practice

It is apparent that some of the tasks described in this chapter fall into the category of "basic skills," familiar to beginning-level social work students, whereas other skills require specialized knowledge, more typical of the training of the "advanced generalist" or "clinical" social worker. Unfortunately, many of those who work with children do not obtain specific levels of training, as is apparent in the child welfare field, in which "it has been found that many Child Welfare workers lack the specialized knowledge and skills necessary to function in complex case situations" (Maluccio, 1985, p. 743). The requisite ecological perspective and multifaceted role expectations implicit in work with children mean that practitioners must make extra efforts to offer services that balance focus on the family and the child (Walton, Sandau-Beckler, & Mannes, 2001).

Ideally, work with children combines simultaneous attention to the impact of the person on the environment and that of the environment on the person, as characteristic of generalist practice (Sheafor & Landon, 1987). In addition, it must be grounded in knowledge of "normal" child and family development and in familiarity with the deviations from the usual developmental course, as described previously. Practitioners must be able to refer children for more specialized services when these are indicated, as well as to convene case conferences including professionals from different disciplines. Clearly, this work is demanding and challenging. The next two sections discuss methods for helping workers meet this multifaceted challenge.

AVOIDING POTENTIAL PITFALLS IN WORK WITH CHILDREN

Children's dependence, honesty, playfulness, and openness have a special appeal for many social workers, who decide to work with children because they genuinely like young people and want to help them. This admirable motivation for helping can sometimes obscure the snares implicit in this work, which must be recognized and avoided by all practitioners whose work focuses primarily on children.

The "Rescue Fantasy"

Probably most social workers who are engaged in work with children have at one time or another experienced a strong desire to "rescue" a child from a situation that appears to be clearly detrimental to the child's healthy development. Perhaps a 10-year-old girl is cast in the role of the "parentified child," taking care of several younger siblings after school and trying to keep the peace when her alcoholic parents begin to argue at dinner. The social worker knows that the child should be more involved with after-school activities, peers, and schoolwork, and she resents the parents' obliviousness to their daughter's age-appropriate needs. The social worker knows that this child would love to be involved in cheerleading and that she has already qualified for the squad. However, this involves rehearsals every day after school, which would conflict with the child's family responsibilities. The social worker writes the mother a note, stating that she has arranged transportation home for the girl after daily practice and that she hopes the mother will support her child's special interest in this wholesome activity.

What is wrong with this scenario? Will it work? What did the social worker overlook in her eagerness to be helpful to the child client? At least

two errors threaten the success of this well-intentioned plan: (1) The worker has moved too fast, and (2) the worker has "taken over," without involving the child's parents in the planning. In cases such as this one, when workers want to help and can see a clear-cut method to do so, it is hard for them to slow down, put on the glasses with wide-angle lenses, and include significant others in "their" treatment plan. Remembering that the child is part of a family system in which he or she carries out a designated role, a worker must consider the impact on the entire system when that role changes. Obviously, in the example given here, the ability of this child to be away from home every day depends on someone else's providing babysitting, and any plan that does not allow for this cannot succeed.

Competing and "Triangulating" with the Parents

Another typical pitfall in work with children demonstrated in this example is the danger of the worker's aligning with the child and either consciously or unconsciously becoming the "good" parent in situations in which the child's own parent appears to be deficient or even "bad." This attitude is always doomed to failure, because the parent will soon begin to resent the worker and will find "reasons" to discontinue the child's counseling/therapy. Unfortunately, the worker is usually not aware of the impact of his or her actions until it is too late. Palombo (1985) states that "children may arouse intense infantile longings in the therapist [and] the therapist comes to be considered by [the child] as [a] substitute parent and induce in the therapist a parenting response rather than a purely therapeutic response" (p. 40). In my opinion, the more needy the child, the more likely it is the worker will respond to the impulses to become the "good" parent and rescue the child. In the absence of supervision and/or careful self-monitoring of practice, the countertherapeutic activity will proceed unchecked.

SUPERVISION AND SELF-MONITORING OF PRACTICE

Because the process of helping is interactive and involves the use of self in the helping relationship, and, furthermore, because it is difficult to be objective about one's own actions, supervision provides an opportunity for social workers to review their work and to learn about their own strengths and weaknesses in carrying out the helping process. As mentioned previously, the complexity of work with children makes supervision critically important, both for student social workers and for more

seasoned practitioners. The two current registries of clinical social workers require a minimum of 2 years of post-master's-level supervision, and it is not uncommon for workers who wish to enhance their learning to arrange peer supervision groups or to make arrangements for private supervision if their place of employment does not offer this opportunity.

When the worker/counselor/therapist becomes aware of a problem or impasse in the course of the helping process, it is the worker's responsibility to try to understand the reason for the breakdown. In a previous publication (Webb, 1989), I have reviewed some techniques that can be helpful in unlocking an impasse. Often such a difficulty stems from a similarity between the worker's own family background and that of the client he or she is trying to help. When these similarities are not recognized, the worker may unknowingly respond to the client (or to a member of the client's family) as if this person were a sibling or parent from the worker's own past. It must be emphasized that considerations of this type do not mean that supervision becomes therapy. "The *educational goal* of supervision argues against this occurrence and insists that the focus begin and end on the *work*" (Webb, 1983, p. 44; emphasis in original). Palombo (1985) challenges us to cast aside the past in our clients' best interests:

> We grow in our acceptance of our patients and we increasingly understand and accept ourselves. We grow also as with time and experience, our knowledge is transformed into therapeutic wisdom, but over and above that, we grow as we accept the challenge to question the old, the tried and the true when it no longer works. (p. 47)

DISCUSSION QUESTIONS AND ROLE-PLAY EXERCISES

1. How can the social worker best guide a parent whose child says that he or she does not want to go for "help"? How can the social worker try to engage this child, once the parent brings the child to the office? Role play both of these situations at least three different times, with different players illustrating different types of resistance.
2. If you have been assigned a new case involving a family from a culture about which you know nothing, what can you do in preparation for your first meeting with the clients? What can you do in the initial session with the clients to enhance your relationship with them? How can you know what the experience was like for the client?
3. Suppose that, in the case conference about José, it becomes apparent that the foster care worker is vehemently opposed to the possibility of future family reunification following the mother's discharge from prison. The

school social worker, knowing how much José misses his mother, favors a plan to reunite the family. How can the school social worker continue to collaborate with the foster care worker in the face of this disagreement about goals? Role play a case conference with the school social worker and the foster care worker in which they each express their objections and in which a compromise is finally reached.

4. How can a social worker best utilize supervision for his or her own learning? Please respond in terms of the "ideal" situation.

RECOMMENDED TEXTS ON CHILD BIOLOGICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT

Brazelton, T. B. (1992). *Touchpoints: Your child's emotional and behavioral development.* Reading, MA: Addison-Wesley.—This book summarizes Brazelton's several previous works for parents. Written by a pediatrician who has both medical and psychoanalytic training, it includes information about child development from physical, cognitive, emotional, and behavioral points of view.

Brazelton, T. B. (2001). *Touchpoints: Three–six. Your child's emotional and behavioral development.* Reading, MA: Addison-Wesley.—A more intensive review of the preschool stage of development.

Davies, D. (1999). *Child development: A practitioner's guide.* New York: Guilford Press.—This book applies developmental knowledge to the assessment and treatment of children and families; illustrated with numerous case vignettes, it emphasizes a transactional approach in discussing risk and protective factors in infancy, early childhood, and middle childhood.

Erikson, E. H. (1993). *Childhood and society* (Rev. ed.). New York: Norton.—Erikson's book outlines the eight stages of human development from birth to adulthood, emphasizing the developmental tasks at each stage. Erikson's conceptualization expands on Sigmund Freud's by viewing the individual in interaction with the social environment.

Freud, A. (1963). The concept of developmental lines. *Psychoanalytic Study of the Child, 18,* 245–265.—Anna Freud's view of child development emphasizes the push for growth that is intrinsic to human nature.

Freud, S. (1963). *The sexual enlightenment of children* (P. Rieff, Ed.). New York: Macmillan. (Original work published 1907)—Although many practitioners today consider Sigmund Freud's work culture-bound and sexist, he must be recognized as a pioneer who first gave attention to the concept that children can have sexual feelings and who formulated a theory of childhood psychosexual development based on his retrospective work with adult patients.

Fraiberg, S. (1959). *The magic years.* New York: Scribner's.—This classic work, written by a social worker/child analyst, gracefully conveys solid knowledge about the preschool years in a readable style that belies its wealth of information.

Greenspan, S. T., & Greenspan, N. T. (1991). *The clinical interview of the child* (2nd ed.). Washington, DC: American Psychiatric Press.

Ilg, F. L., Ames, L. B., & Baker, S. M. (1981). *Child behavior* (Rev. ed.). New York: Harper & Row.—This book is a classic guide and manual for parents, written by the cofounders of the Gesell Institute at Yale University.

Kagan, J. (1984). *The nature of the child.* New York: Basic Books.—An overview of child development by a child development specialist.

Piaget, J., & Inhelder, B. (1969). *The psychology of the child.* New York: Basic Books.—This work establishes the framework of cognitive development of the child, pointing out basic differences in the thinking of children that affect their understanding of the world and their communications with adults. It is *essential* that practitioners working with young children understand and apply this conception of children's cognitive development in their work with children.

Thomas, A., Chess, S., & Birch, H. G. (1968). *Temperament and behavior disorders in children.* New York: New York University Press.—This landmark work documents the intrinsic childhood temperamental qualities that endure throughout life and resist modification by parents and other caretakers.

❖ PART II ❖

The Process of Helping Children: A Running Case Illustration of a Child in a Single-Parent Homeless Family

❖ CHAPTER 3 ❖

Building Relationships with All Relevant Systems

Social workers often must reach out to needy children and families even when their attempts to help are ignored or refused. Families that are overwhelmed and burdened with survival concerns may prioritize their needs differently than do professional "helpers," who want to jump in and "rescue" dependent young children whose lives appear to be at risk because of adverse familial and/or environmental influences. The parents in such families may not agree with the professionals' views about their families' needs, thereby causing the helpers to struggle between a parent's right to self-determination and "the best interests of the child." Unfortunately, these are not always synonymous, and the practitioner may feel torn between conflicting responsibilities to two sets of clients—that is, the children and the parents.

These dynamics ebbed and flowed in the case of Barbie Smith, who grew to the age of 10 in a family with a mother who was in prison for extended periods, a father who was physically abusive to her and her mother, and no positive role model who could instill hope for a better future. Barbie's life had always been unstable, with homelessness and lack of schooling her prevailing realities. The girl's situation demonstrates the challenge of helping children when their everyday environment victimizes rather than nurtures them. These are the unfortunate circumstances for many children for whom social workers attempt to provide services. I use Barbie's case to illustrate the gap between the ideal and the possible as I describe, over the next three chapters, the process of helping children. This process begins with the challenge of establishing initial relationships with reluctant or resistant family members; it continues with formulating the biopsychosocial assessment of a child and with planning services to help in a manner that respects the family members' right to make choices in their own behalf.

THE CASE OF BARBIE, AGE 10

> The ache for *home* lives in all of us, the safe place where we can go as we are and not be questioned. It impels mighty ambitions and dangerous capers. . . . [We hope] that . . . home will find us acceptable or, failing that, *that we will forget our awful yearning for it.* (Angelou, 1986/1991, p. 64; emphasis added)

Even a child who has had only *brief* periods of time in a "home" can experience this feeling of longing. Barbie stated at the beginning of the videotape *No Place Like Home* (Hunt, 1992), "I'm afraid that we're never going to get a home again of our own. It scares me." Barbie's life as depicted in this tape consisted of a series of moves from one motel or shelter to another, with no stability. Barbie's older brother, David, age 16, said, "It's not that bad. Instead of renting a house, we rent our own motels." Barbie, however, complained that she was getting tired of packing. A photo of her hugging a doll as she buried her bowed head in the doll's clothing (Figure 3.1) conveys the sadness and resignation that permeated her life.

Background on the Case

At the beginning of the videotape, Barbie's mother confirmed that the family had moved seven times over a 6-month period, resulting in Barbie's attending *five different schools* during this time! When Barbie was eventually referred to a special school for homeless children, she came to the attention of a filmmaker, Kathryn Hunt, who obtained the mother's permission to tape the family and their various future moves over a period of time. I saw the resulting video at a professional meeting in connection with a presentation about the special school, First Place School in Seattle, Washington. Because I immediately recognized that Barbie's experience as a homeless child was like that of many disadvantaged children and that it would be useful for teaching purposes, I decided to establish contact with Barbie's family in order to obtain their permission to write about them in this book. Many months later, having finally obtained the signed releases and some of Barbie's school records, I struggled with the task of presenting the family members' situation in all its complexity, while also trying to depict their lives with sensitivity and compassion. Their *prior* decision to be videotaped resulted in full disclosure of their identity and life circumstances. None-

FIGURE 3.1. Barbie Smith, as she and her family were packing for yet another move. Photograph by James E. Nicoloro. Reprinted by permission of the photographer and the Smith family.

theless, I use only their first names and a fictitious last name, "Smith," in this discussion.

Family Information

Relatives in the home

Child client	Barbie, age 10, third grade; reading and writing below grade level. Physically abused in foster care at age 6.
Mother	Lori, age 34, unemployed, former bartender and drug abuser. Prison record for possession of drugs and firearms.
Brother	David, age 16, Lori's son by a previous partner (father's whereabouts unknown). School dropout; working on general equivalency diploma (GED).

Relatives outside the home

Sister	Donna, age 18, Lori's daughter by another previous partner (father died of kidney disease). School dropout. At time of referral, living away from family because mother disapproved of her boyfriend; later

returned to live with family. Had kidney and heart problems.

Father — Jim, age unknown, occupation unknown. Lived out of state; physically abused Lori and Barbie, according to Lori's and Barbie's statements on video. At time of referral, parents had been separated for 3 years and divorced for 1 year. Barbie had not seen her father since the divorce, although he maintained occasional telephone contact with her.

There were no known extended family members. The family was Caucasian; religious affiliation was unknown. Financial support came from Aid to Families with Dependent Children and food stamps.

Referral

The social worker at the shelter where the Smith family was then residing spoke to Mrs. Smith about a special school program for children like Barbie, who do not have permanent homes. Because this program provided transportation, Mrs. Smith agreed to take the bus with Barbie the next day in order to complete the necessary registration forms to enroll Barbie in the school. This school program was created to educate children who are "in transition" and to assist their families with counseling and other services. The application process, conducted by a social worker, includes a detailed history of the child and the family. Mrs. Smith cooperated fully with this process and openly shared information about her past incarceration and drug abuse, stating with pride that she had been "clean" since her release from prison 3 years earlier. She also revealed that Barbie and her siblings had each been physically abused in the separate foster homes in which they were placed while she was incarcerated.

IDENTIFICATION OF THE NEED FOR SERVICES

We can assume that homeless families have multiple problems and needs, including not only housing but also concerns related to welfare, schools, employment, and so forth (Phillips, DeChillo, Kronenfeld, & Middleton-Jeter, 1988; Choi & Snyder, 1999; Jackson, 2000; Vostanis & Cumella, 1999). In the case of Mrs. Smith, her reason for contacting the special school program for homeless children was to arrange for her daughter's educa-

tion, which had been highly erratic during the previous 6 months. Every time the family had relocated, Mrs. Smith had enrolled Barbie in the nearest school. Mrs. Smith was not aware that the First Place program was different from the others in that an array of services would now be available to her and her family.

Mrs. Smith as an "Unintentional" Client

Whereas a philosophy of support to *families* seems appropriate and necessary in order to meet the educational needs of homeless children, Mrs. Smith came to First Place to arrange for her youngest child's education rather than to obtain any other kind of help for herself and her other children. Her willingness to give family information to the intake worker reflected her belief that this was an expected part of the application procedure rather than that she was applying for counseling or other forms of help. Indeed, the filmmaker (who later gained Mrs. Smith's trust over a period of time) clarified that, because of the children's previous experiences of abuse in the foster care system when Mrs. Smith was in prison, she was wary and mistrustful of "the whole helping system." Thus it is understandable that she never attended any of the parent support group meetings that were held at First Place, even when transportation and babysitting were available. Another reason for her noninvolvement may have been her history as a former felon—a status that could have stigmatized and set her apart in the group and prevented her feeling comfortable in sharing parenting and other life concerns with other single mothers. Perhaps these obstacles could have been anticipated and resolved if the social worker had met individually with Mrs. Smith prior to the group's first meeting.

Necessary Focus on Clients' Perceived Needs

Mrs. Smith's failure to avail herself of counseling services at the school highlights how important it is for social workers to understand the *clients'* point of view regarding their own needs for service. We cannot assume that *our* views about the clients' needs match the individuals' own assessments of the kinds of services they need or want. In addition to schooling for Barbie, Mrs. Smith's top priority was to find permanent housing for her family. She succeeded in this goal approximately 2 months after Barbie began at First Place, resulting in Barbie's transfer to a neighborhood public school. In addition to housing, Mrs. Smith was concerned

about obtaining medical care for Donna, who had kidney and heart ailments and who lived with the family sporadically. Also, Mrs. Smith was obligated to meet regularly with her parole officer and to have contact with the local department of social services in order to receive financial assistance. Dore (1993) notes that in work with poor families, "assistance in obtaining concrete resources is central, not adjunctive, to the helping process" (p. 552). Mrs. Smith proved able and willing to seek out the help she wanted for her family without assistance from professional helpers. She did not, furthermore, identify a need for counseling for herself or for her children.

Figure 3.2 is an eco-map illustrating the various agencies with which Mrs. Smith had regular contact during the 2-month period that Barbie was enrolled at First Place School. None of these agencies, except the school, appeared to offer services related to helping with the emotional or interpersonal issues of individuals or the family unit. Because this family had experienced numerous problems—spousal and father–child physical abuse; divorce and subsequent absence of the father; lengthy and stressful periods of maternal separation and child placement; conflict between the mother and a daughter (Donna); two children who dropped out of school (David and Donna); and the mother's drug abuse, imprisonment, and felony record—it seems obvious that some type of counseling in the form of family intervention and/or parent support would have been appropriate in attempting to interrupt the intergenerational transmission of dysfunctional interaction patterns that lead to violence, unhappiness, and dependence. Although provision of concrete services was essential, it brought only short-term relief and did not address the prevention of future repetition of the same difficulties. The lack of *long-term* planning, goal setting, and counseling with the members of this family deprived them of the opportunity to extricate themselves from the cycle of homelessness and poverty that characterized their lives when they initially became known to First Place School.

How and by whom might counseling services have been offered and implemented in this situation? Certainly there was no lack of professional helpers involved in this case, as shown in the eco-map. Unfortunately, however, there was no collaboration in *goal setting* among the helpers, with the result that Mrs. Smith probably felt scattered and unfocused in her efforts to help her family. The discussion that follows presents the "ideal" management of this case, in the hope that this retrospective analysis will lead to more effective interventions with others like the Smiths, who have multiple problems, multiple needs, and few resources with which to cope with the difficulties of their lives.

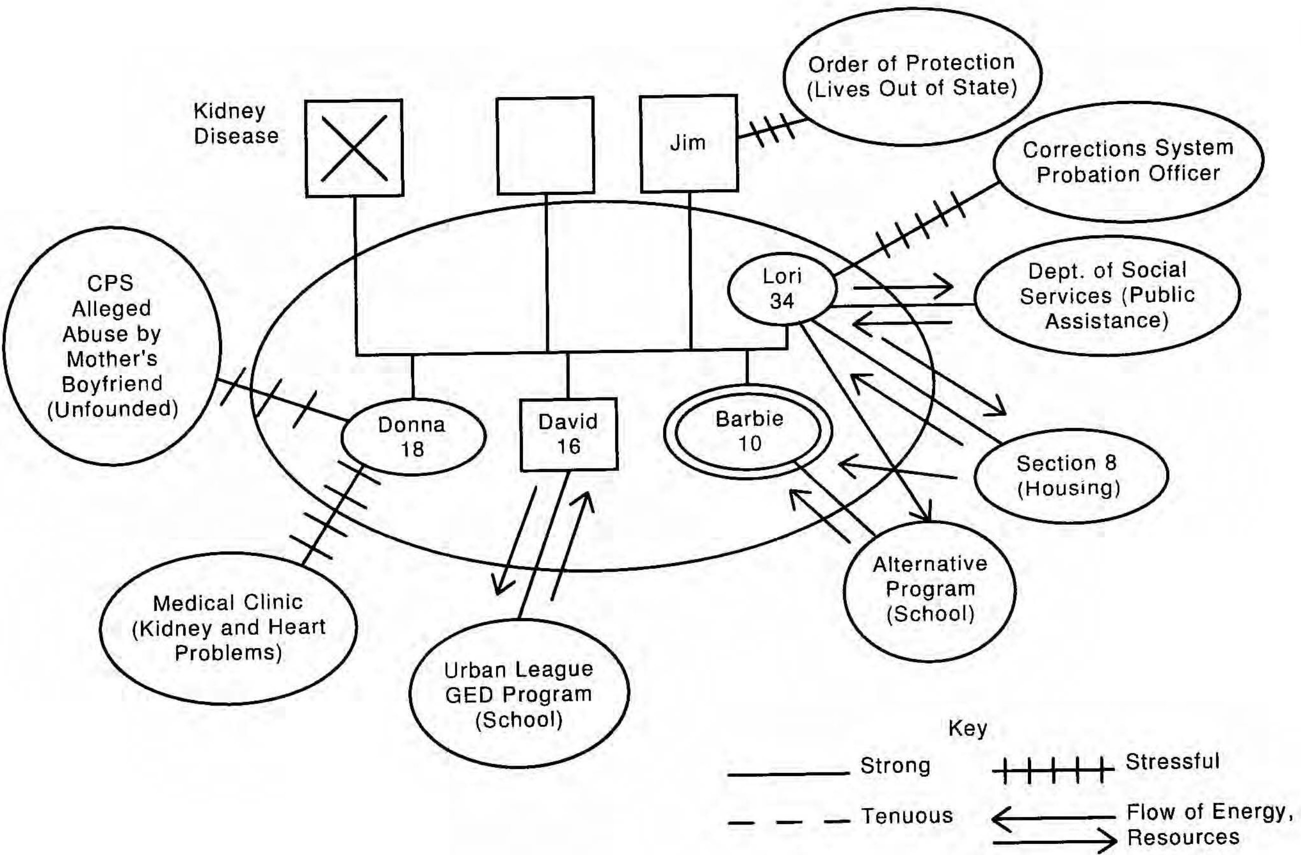

FIGURE 3.2. Eco-map of the Smith family.

INTERAGENCY COLLABORATION ON BEHALF OF CHILDREN AND FAMILIES

The move away from the philosophy of "child rescue" to viewing intervention as "family-supportive and family-strengthening" argues for delivery of services in a family's home or natural community environment (Whittaker, 1991; Tracy, 2001). Ideally, a model of intervention that avoids fragmentation of services while facilitating greater participation of parents in the care of their children would be desirable for homeless families (Lourie & Katz-Leavy, 1991; Choi & Snyder, 1999). How might services have been better coordinated in this case? In order to put that question in context, we need first to consider Mrs. Smith's degree of openness to receiving help.

Work with the "Unintentional" Client

Mrs. Smith appears to have been uninterested in *counseling* for herself and her family, although she did everything in her power to obtain financial, medical, and educational services on her family's behalf. Both of her daughters had received some form of counseling following their abuse in foster care 3 years earlier, and Mrs. Smith had participated in drug rehabilitation while she was in prison. She may have felt that these matters had been "taken care of."

Mrs. Smith was carrying the full weight and responsibility of meeting her family's needs, but although she may have felt burdened, she did not seem to perceive the need for counseling for herself. She may have associated this need with being "weak" or "mentally ill" or "addicted." It was also possible that she was overwhelmed and even depressed; we know that depression is more prevalent among persons at the lowest socioeconomic level (Dore, 1993). Moreover, Mrs. Smith's own childhood history of sexual assault (which she mentioned on the videotape) and her repeated experiences of victimization in her marriage could have resulted in learned helplessness (Hooker, 1976), feelings of hopelessness (Beck, Rush, Shaw, & Emery, 1979), and the inability to conceive of any improvement in her life (Browne, 1993). It certainly was sadly revealing when Mrs. Smith stated on the tape that she could not project what she wanted for Barbie's future, and Barbie, in turn, stated that she wanted to be just like her mom!

It was not clear whether Mrs. Smith's probation officer knew about her struggle to obtain housing or whether anyone had ever made any efforts to help her obtain employment. She indicated on the school intake form that her difficulty in obtaining permanent housing was related

to her "record." If this was indeed true, it would have contributed to feelings of discouragement and anger. This situation would have merited exploration with the probation department and the housing authority. One of the helpers involved in this case could have offered to make a phone call to clarify this matter.

Efforts to engage Mrs. Smith in counseling for herself would probably have failed unless they were tied directly to issues related to something of concern to *her*, such as Barbie's schooling. In presenting strategies for working with an "involuntary" client, Rooney (1988) suggests a "let's make a deal" proposal, in which something the client wants is paired with an issue considered essential by the worker. This permits the client to exercise some choice, thereby enhancing his or her autonomy and reducing possible resistance. An example of how this might have been presented to Mrs. Smith follows:

WORKER AT BARBIE'S SCHOOL: Mrs. Smith, we're concerned about Barbie's delayed skills in reading and writing. In addition, she does not have a very good sense of self-esteem, because her skills are not on the same level as other children her age. We're prepared to help her with the academics, but it will only work if you help her with her feelings about herself.

MRS. SMITH: How can I do that? I'll help in any way I can, but I don't really know what you mean.

WORKER: Maybe I can make a suggestion. I know how Barbie admires you; when we talk in school about what the children want to do when they get older, Barbie says that she wants to be just like you. That is a great compliment, since I know that your life has not been easy!

I wonder if we could help Barbie in a kind of roundabout way, by arranging some job training for *you*. A lot of the mothers of our students never had a chance to develop job-related skills, so we're going to have some special classes to help mothers just like you to figure out what kind of job training they want and then help them get it.

MRS. SMITH: I really don't like to go out at night and leave the kids alone in that place. It's full of pimps and addicts. Besides, I don't really see how doing this would help Barbie.

WORKER: Barbie needs to have more faith that girls can be successful in their lives. We don't want her to "give up" and think that she is "stupid" when she is only 10 years old and never had a chance to stay at one school long enough to learn.

We're going to have the job meetings in the morning. You can ride the bus with Barbie, and tell her that you're trying to figure out what

you want to do with the rest of your life because you want a better life. You'll not only be helping yourself, but you'll be helping Barbie.

MRS. SMITH: OK. Just tell me when the first meeting is and I'll be there.

WORKER: It's day after tomorrow. We're going to start Barbie's special tutoring the same day. It's really important for you to tell Barbie that you and she are both going to try your best to improve your lives. If she knows that *you* are enthusiastic, it will help her feel optimistic. And I'm going to keep track of how you like your class. So I'll meet you after your class finishes day after tomorrow.

School-Based and Shelter-Based Service Models

As the preceding dialogue suggests, the issue of job training for single mothers is critical for homeless women if they are to overcome poverty and move beyond the extremely limited financial assistance provided by welfare. It seems logical for such employment counseling and training to take place in a school setting, as statistics indicate that two-thirds of homeless parents never graduated from high school (Nuñez, 1994). Another option for intergenerational education is the model of shelter-based education programs as implemented by the Homes for the Homeless project and study (Nuñez, 1994), which have demonstrated that both children and parents become more enthusiastic about school and education after as short a period as 8 weeks in family-based educational programs. The project's philosophy is that "it is education, rather than housing, that holds the greatest potential for ameliorating the deplorable crisis" (of homelessness; Nuñez, 1994, p. 29). Other authors (Dupper & Halter, 1994) have pointed out the lack of parents' involvement in their children's schooling as a key factor in the poor school attendance of many homeless children. Therefore, stimulating mothers' interest in furthering their *own* education brings positive benefits to their children.

The facts that Mrs. Smith's two older children had both dropped out of school and that Barbie was absent for 15 out of 31 school days during the 2-month period in which she was enrolled at First Place suggested that Barbie was at risk of following in her siblings' footsteps. We do not have any information about Mrs. Smith's own schooling history. However, it seems clear that *all* of the Smiths would have benefited from educational counseling with regard to training for future employment. Shelter-based services as recommended by Nuñez unfortunately do not reach homeless families like the Smiths, who often reside in motels rather than shelters and who move frequently.

A school-based model of help, with the school social worker assuming an outreach role with homeless families in transitional housing, holds promise. However, it needs to be backed with transportation, career counseling, liaisons to welfare and probation counselors or officers, health services, and all social service providers with which homeless families have contact. It also requires that the social worker have a small enough caseload, as in the Homebuilders program (Kinney, Haapala, & Booth, 1991), to allow time to work intensively with each family for the period necessary to initiate some positive changes. Other intensive family-centered crisis models recommend that workers serve no more than six families at a time for an average of 8 to 10 hours per week (Tracy, 2001).

Commitment to Case Management and Collaboration

Homeless families headed by single women tend to have fewer and less stable support networks than do families headed by poor women with housing (Bassuk, 1993; Choi & Snyder, 1999). Because they may have exhausted the willingness or ability of their extended family members and friends to help them, these single mothers must rely on social agencies to meet their basic needs. Unfortunately, many agencies fulfill the minimal requirements of client service without considering a wholistic approach to their clients' situations. Thus, in Mrs. Smith's case, her probation officer tended to focus primarily on whether she was drug-free, without attending to her housing or employment circumstances or to her children's needs. Many practitioners would consider the coexistence of two unemployed teenagers in a shelter accommodation or a one-bedroom motel as a disaster waiting to happen! However, when agencies shortsightedly address only the narrow concerns mandated by their specific purpose, preventive goals fall by the wayside.

The need for a case coordinator or case manager in this situation is evident, just as it was in the case of José (Chapter 2). Without this coordination, in fact, the helping efforts the Smiths did receive lacked the combined positive impact the family members would have experienced from a group of social service professionals organized to mount a united effort on their behalf (Schlosberg & Kagan, 1988; Choi & Snyder, 1999).

There is no doubt that coordinating the various helpers in the Smiths' case would have taken time and effort. A single meeting, however, attended by the various personnel involved with this family, *together with the mother*, would have provided the opportunity to set realistic goals for each family member. The anticipated long-term benefits to the family of such collaboration would have made the effort worthwhile and ultimately

cost-effective. The lack of such planning and oversight deprived this family of the opportunity to benefit substantially from the separate helping efforts offered by the separate agencies involved with the family at the time of Barbie's referral to First Place School. (Updates regarding the circumstances of the family 2 years and 6 years later appear at the end of Chapter 5. They compellingly portray the chronicity of homelessness and its relentless intergenerational transmission in the absence of counseling and long-term educational/employment intervention for all family members.)

ESTABLISHING PROFESSIONAL RELATIONSHIPS

The Smiths' case, like most, would have required that the social worker relate to many different individuals—both clients and other professionals—in the process of carrying out the social work role.

Relationships with Clients

Several decades ago, Perlman (1979) identified the main features of professionals' relationships with clients as stemming from their purpose, their time-limited and client-centered nature, and the implicit expectation that the professional will exercise responsibility and self-control in carrying out his or her role. This means that the worker–client relationship is quite different from social relationships because it is essentially unbalanced, with the primary focus on the client and on the purpose of the contact. The power of the professional relationship flows from the client's experience of personal validation through being the full center of another person's attention.

Carl Rogers's client-centered approach to therapy (see Rogers, 1951) emphasizes the special qualities of warmth, acceptance, empathy, caring/concern, and genuineness as essential attributes of relationships. In a helping relationship, when the worker listens carefully to the client's concerns and communicates both verbally and nonverbally an attitude of acceptance, the client feels validated and "safe," thereby setting the foundation of the worker–client alliance. Fox (2001) sums this up by stating that "the relationship is the keystone of the helping process" (p. 53).

Initiating Relationships by Telephone

Face-to-face contact offers the best opportunity for two people to meet and begin the process of getting to know one another, because people communicate nonverbally through body language such as eye contact, posture,

gestures, and dress. In conversations on the phone, these visual cues are absent, and the speakers must rely primarily on words and tone of voice.

When I decided to contact Mrs. Smith to obtain her permission to write about her family, I obtained her phone number from the filmmaker, Kathryn Hunt, with whom the family had a very positive relationship. Because my call occurred on the evening before the family was being evicted from the apartment they had lived in for almost a year, they were in the midst of packing and preparing to move (the same situation Ms. Hunt depicted in the video). I had to make several calls before I reached Mrs. Smith, and in the process I spoke briefly with David and with Barbie. Ms. Hunt had told Mrs. Smith that I would be calling and what the purpose of my call was. Mrs. Smith had told Ms. Hunt that she would agree to my request, but I wanted to speak with her personally and ask her to sign release forms.

Because I had already seen all members of the Smith family in the videotape (Hunt, 1992), I had their physical appearance in my mind as I was speaking to them. My initial comments to Barbie, to David, and to Mrs. Smith when I spoke to each of them referred to the video and to my (telephone) relationship with Kathryn Hunt. My mention of Ms. Hunt's name was critical in the family's acceptance of me. I also identified myself as a professor of social work in New York, despite the risk that they might have negative feelings about social workers. This did not register as important in any way I could determine, because they (especially Barbie) were excited that I was calling from *New York*, and my association with Kathryn Hunt insured their willingness to speak with me.

My contact with Mrs. Smith surprised me in its intensity. When I said something to her about how impressed I was by her struggle to keep her family together, she began crying and spoke almost nonstop for at least 10 minutes. It was hard to understand everything she said because of her sobbing and her clipped, rapid speech; nonetheless, I sensed her strong need to reveal some of her own sad history and to vindicate herself. I shared with her my feelings of regret that I was so far away and therefore unable to offer any real assistance to the family. This did not seem to trouble Mrs. Smith, as her opening up to me seemed to serve the purpose of ventilation rather than to indicate any expectation that I would help. Certainly I experienced Mrs. Smith as being very accessible to forming a helping relationship and in no way would consider her as "reluctant" or "uninvolved" once she engaged with someone who listened to her with empathy.

Initiating Relationships with Child Clients

In beginning work with a child client, the practitioner needs to set the tone for a type of adult–child relationship that is different from others

the child has experienced. The child usually expects the worker to relate to him or her as a teacher or parent usually does, with corresponding expectations about how the child should "behave." Because the nature of the helping relationship is so very different and unfamiliar to most children, it is the worker's responsibility to say something to the child, in language that the child can understand, about the nature of the helping process. A statement about who the worker is ("I'm a [lady, man, doctor] who helps children and parents with their troubles and worries") and about how the worker will help ("Sometimes we talk, and sometimes we play") gives the child the framework for this unique relationship, even though he or she may not comprehend it fully. It is also important to have some preliminary discussion with the child regarding the reason for the child's contact with the worker, as this has usually been a source of conflict and anxiety for the child and the family. Children, like adults, deserve to be treated with honesty and respect as the basis for an effective helping relationship.

Using Toys to Engage and Work with Children

As will be apparent in many examples of intervention with children in this book, the preferred method for engaging and working with children involves the use of toys and play. Most children have limited verbal abilities, but they communicate their worries and anxieties very graphically through play. Therefore, it is essential for social workers to have familiarity with and a degree of comfort in using toys with children in order to interact effectively with their young clients. I have conducted workshops across the United States and abroad for the purpose of helping social workers learn the rudiments of communicating with children through the symbolic language of play. Although mastery of the complexities of play therapy requires specialized knowledge and training, I believe that every social worker can and should have some minimal knowledge about working with children using play techniques. Given the likelihood of having to work with young children in family sessions or in schools, foster care, residential settings, pediatric units of hospitals, mental health agencies, and family service agencies, social workers must be prepared to use both verbal and nonverbal communication in their interactions with child clients.

Figure 3.3 lists the basic play materials that should be available in every office to facilitate appropriate interactions with child clients, and the Appendices list a number of suppliers of these materials. Students who are beginning their careers and expect to work with children should begin to acquire play materials that they can carry with them in a tote bag, so that they will not be dependent on the presence of supplies in the particular offices in which they are doing their internships. In a pre-

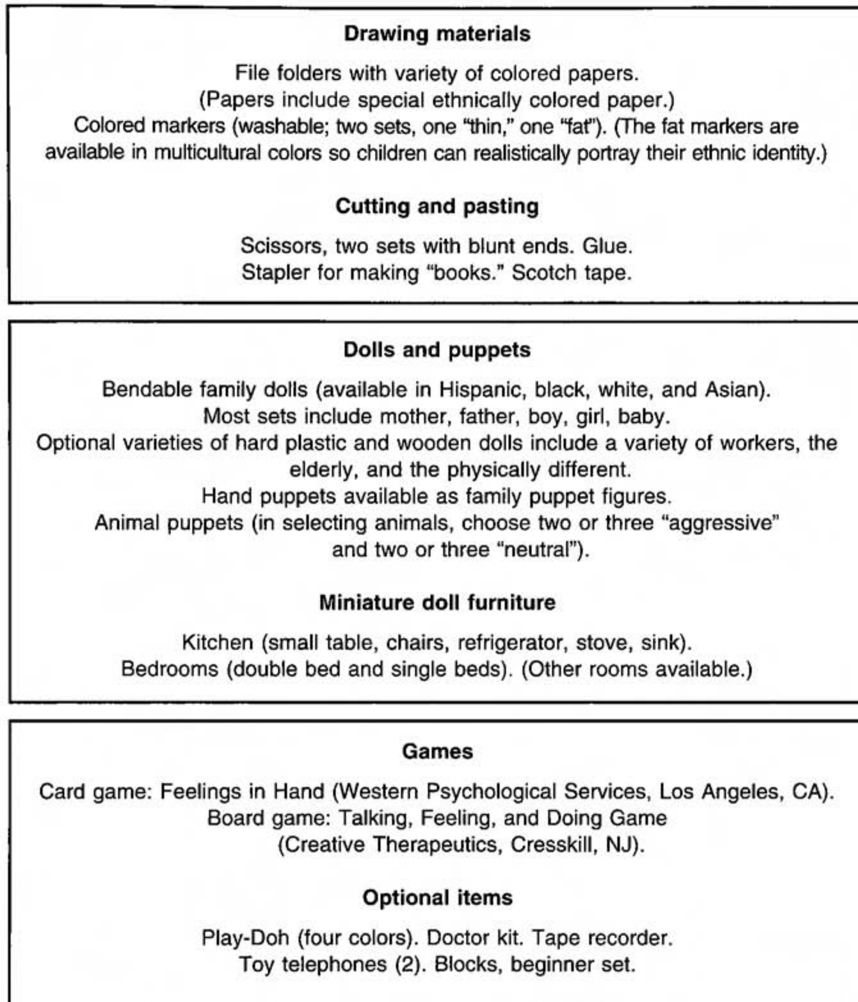

FIGURE 3.3. Equipping the "average" office for work with children.

vious publication (Webb, 1999), I have reviewed various play materials and their use in work with young clients. In this book, examples of the use of drawings can be found in Chapters 4–8 and 10–14, an example of puppet play is given in Chapter 7, and examples of the use of family dolls are provided in Chapters 11, 12, and 15. A videotape demonstrating play techniques is also available (Webb, 1994b).

Trying to engage young children in a helping relationship without the use of toys and play materials would be as unthinkable as trying to

communicate with a deaf person without the use of sign language. A young child may have a rudimentary understanding of verbal communication, and a hearing-impaired person may be able to communicate in writing or may have some knowledge of lip reading, but neither situation respects the basic principle of "starting where the client is." Children (and the physically challenged) have too often been overlooked and treated like inferior beings. The concept of "adultcentrism" (Petyr, 1992; Tyson, 1995) calls attention to the fact that many practitioners expect children to respond as if they were adults. It argues that children should be accorded the rights that are due them, beginning with the use of communication methods that are "user-friendly" to child clients.

Relationships with Other Professionals

Any social worker who provides services to children will, of necessity, have reason to interact with other professionals. Depending on the circumstances of the particular case, it may be necessary and appropriate to collaborate with the following range of persons who may have contact with the child:

- The child's teacher
- The school psychologist
- The child's special education teacher
- The child's physician
- The child's caseworker/guardian *ad litem* (i.e., a lawyer or other individual assigned to protect the child's legal interests)

Necessary procedures must be followed prior to any discussion with other professionals. *A social worker must have signed releases from a child's parent(s) prior to engaging in any contact with others involved in the case.* In addition to obtaining these releases, it is a good idea to discuss with the parent(s) just how much information about the family they are comfortable having the worker disclose (Wachtel, 1994). For example, parents may understand the importance of the worker's learning about test results (either medical or educational) in connection with the agreed-upon purpose of helping their child with self-esteem issues. However, they may not see the utility of the worker's sharing information about his or her psychosocial assessment and intervention with school personnel. Wachtel (1994) points out how helpful it can be for the teacher to be able to reinforce certain goals with the child in the classroom, so that the teacher, parents, and worker are all emphasizing the same objectives. When this approach is presented to parents as in their child's best interests, the parents usu-

ally will permit the worker to use his or her professional judgment regarding what to share with others.

As a rule, a worker should exercise restraint about sharing family information that is not directly related to helping the child. Other professionals do not necessarily subscribe to the same code of confidentiality as that of the social work profession, and once personal matters move into the "public" domain, the clients' right to privacy can no longer be guaranteed. A continuing focus on the *purpose* of sharing information will help determine what and how much to share; the best interests of the clients should be the guiding ethical principle in each instance.

CONCLUDING COMMENTS

The quality of relationships between clients and a social worker and among the various helpers in a specific case often determines the success or failure of the helping contact. Positive relationships can inspire motivation and hope for change, whereas negative relationships can reinforce feelings of futility and even hostility. Because of the *purposive* focus of the helping relationship, a client can begin to believe that something different can happen and that he or she will receive assistance in planning and creating a life change. Listening carefully to the client's vision of what he or she wants is the key to the worker's understanding and empathy. Weick and Pope (1988) point out that the client's views may be different from what the worker envisions and that true client self-determination flows from the worker's appreciation and respect for the inner meaning of the client's reality.

This principle of respect for the client applies to work with children in the necessity for adults to communicate with children in *their* language of play rather than expecting children to use words exclusively. A relationship between a social worker and a child client therefore makes special demands on the worker, who must join with the child on his or her developmental level, while simultaneously attempting to comprehend the meaning of the child's play so that the worker can respond helpfully within the play metaphor.

Similarly, the need to convey respect applies when working collaboratively with other professionals. There may be differences in language and viewpoints between a social worker and other professionals, such as teachers or physicians. The very attempt on the worker's part to understand how another professional views the client's situation conveys an attitude of appreciation for the contribution of the other individual. If terminology or language differences interfere with understanding, it is appropriate for the worker to ask for clarification.

Workers who use family and small-group modalities are familiar with the need to maintain a neutral stance and to listen and observe each member without forming alliances with any one person. The same principle applies in work with the various individuals involved in many helping situations. The goal of objectivity does not imply coldness but rather the ability to relate to different people according to their own specific needs and to keep the purpose of all relationships clearly in mind.

DISCUSSION QUESTIONS AND ROLE-PLAY EXERCISES

1. Imagine that you are the school social worker assigned to work with the Smith family. Consider where, how, and with which family member(s) you would structure the *first* meeting. Give reasons for your decision.
2. Role play several alternative scenarios of the initial meeting with the Smith family, such as the following:
   a. With Mrs. Smith and the worker, at the school.
   b. With Mrs. Smith, Barbie, and the worker, at the school.
   c. With Barbie and the worker, at the school.
   d. With the entire family, at the shelter.

   After the completion of all of these, discuss the different types of information obtained in each format and the relative degree of pressure on the worker in each interview situation.
3. Again, imagine that you are the school social worker. What other professionals would you want to contact in connection with your work with Barbie and Mrs. Smith? How would you approach Mrs. Smith to gain her approval of these contacts? Role play this exchange.

❖ CHAPTER 4 ❖

The Biopsychosocial Assessment of the Child

Most social workers rely on assessments and treatment plans to guide them in their work. The process of helping a child depends on understanding as fully as possible *all* the factors that have contributed to and that maintain a problematic situation, so that a practitioner can formulate, propose, and implement an appropriate remedy. Because "the problem" as presented by the parents, by the school, or by others often represents only the tip of the iceberg, leaving a great deal more material beneath the surface, the social worker must look up, down, and all around while trying to analyze the totality of the problem situation. For example, parents may refer a child because of his or her troublesome behavior, but the "real" problem may be their disturbed marriage, to which the child is reacting. In Barbie's situation (Chapter 3), Mrs. Smith identified Barbie's educational needs but not the family's lack of stability and multiple problems.

Before recommending a course of action for a child and family, a social worker must have a clear sense of the strengths and weaknesses of the vessel in which all parties are traveling, as well as of the possible detours and obstacles that may be encountered in trying to reach the destination. It is also essential to know about the possible rescue resources available in the event of an emergency. The biopsychosocial assessment functions like a compass and a nautical chart: It assists the worker in helping the child and family navigate toward their goals.

WHAT IS AN ASSESSMENT?

The assessment has been described as "the thinking process that seeks out the meaning of case situations, puts the particulars of the case in some order, and leads to appropriate interventions" (Meyer, 1993, p. 3). An-

other definition refers to assessment as "the worker's professional opinion about the facts and their meaning" (Northen, 1987, p. 179). Although the assessment process is time-consuming and often difficult because of its complexity, it may reveal exciting discoveries. The worker, like an explorer or a detective, uncovers as much as possible about the presenting problem in order to determine its history, magnitude, and ramifications. This *appraisal* component of assessment requires that the worker analyze the interrelationship among biological, psychological, and sociocultural factors as these pertain to a client's life situation. Traditionally, social workers have emphasized the *psychosocial* components of the presenting problem (psychological factors and environmental/cultural influences). In recent years there has been more recognition of the potential importance of biological factors such as temperament and prenatal influences, especially as these affect children's development.

The reason for conducting an assessment is to try to understand why a problem exists so that some kind of remedy can be recommended. Sometimes an assessment leads a social worker to identify the need for specialized medical, psychological, or educational evaluations and to make appropriate referrals. For example, in assessing the factors contributing to Barbie Smith's poor school performance (Chapter 3), the school social worker might have considered the possibility that her academic delays were perhaps related to fetal alcohol/addiction syndrome, assuming that her mother had used substances during her pregnancy with Barbie. The fact that Barbie changed schools so frequently may have been only partially responsible for her academic difficulties. Had timely testing been completed and specific disabilities revealed, Barbie's educational planning could have targeted remediation of her specific learning deficits.

Important Points about Assessment

1. Collecting data during the initial phase of work does not mean that the client's pressing needs for immediate help are put on hold while the worker systematically and single-mindedly goes about formulating the biopsychosocial assessment. *Assessment and intervention typically occur simultaneously.*

2. The assessment process is not over when the biopsychosocial summary is written. *Assessment is an ongoing process* and therefore subject to elaboration and revision throughout the contact with the clients.

3. Assessment of children is always tentative, because children's development is in flux. *Child evaluations, therefore, should be repeated periodically to allow for normal developmental changes.*

THE ASSESSMENT PROCESS

The purpose of conducting an assessment is to understand the multiplicity of factors that are contributing to the presenting problem, so that an agreement can be made about how to alleviate it. The following basic questions must be considered in planning the steps of the assessment:

1. Who/what is to be assessed? (Child? Parents? Entire family or subsets of the family? Peers? Neighborhood?)
2. In what order should the assessment be conducted? (Should parents, child, or whole family be seen first?) And what general guidelines should be followed in contacts with each party?
3. What collateral information should be obtained? (School, medical, psychological, legal reports?)
4. What assessment tools should be employed? (A few of the options for selection: Developmental history and family background; tripartite assessment forms; genograms, eco-maps, etc.; DSM-IV-TR; psychological and educational testing)
5. How should the relevant data be summarized?
6. How should the assessment be reviewed with parents and others?

I devote the remainder of this chapter to discussing these questions.

DETERMINING WHO/WHAT IS TO BE ASSESSED

Determining the "unit of attention" is a basic task in beginning work with any case situation. Most individuals live in families, and these families, in turn, are subject to both the favorable and the harmful influences of their surrounding environment. A systems viewpoint recognizes that every part is influenced by the whole to which it belongs, just as the whole, in turn, is affected by its individual members. Chapter 1 has discussed and diagrammed an ecological perspective on etiology, upon which this chapter expands. In several previous books (Webb, 1991, 1999, 1993, 2002a), I have presented different versions of a tripartite conceptionalization of assessment, taking account of three groups of factors that interact in any assessment:

- Factors related to the individual.
- Factors related to the problem situation.
- Factors related to the support system.

When a child comes to the attention of a social worker, it is imperative that the worker keep these three general categories of factors in mind

as he or she tries to understand the complex dimensions of the problem situation. Like a juggler tossing balls into the air sequentially and keeping them aloft, the worker must possess the ability to divide his or her attention among the numerous people and events related to the particular case. Figure 4.1 diagrams the interactive components of a tripartite assessment.

I have developed three different forms to guide the worker in obtaining, organizing, and recording information preparatory to formulating a biopsychosocial assessment. These are presented and discussed in the section on assessment tools later in this chapter. The amount of information to be collected can seem overwhelming, especially to the beginning social worker, who may not immediately comprehend its relevance. It is important to stress that the purpose of data collection is to

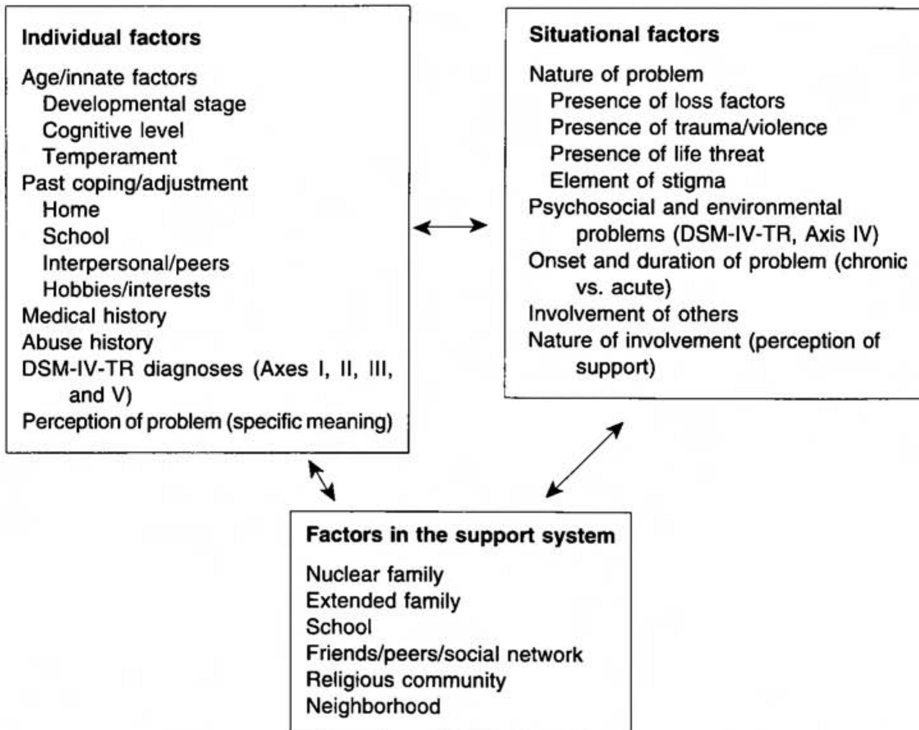

FIGURE 4.1. Interactive components of a tripartite assessment. From *Social Work Practice with Children* (2nd ed.) by Nancy Boyd Webb. Copyright 2003 by The Guilford Press. Permission to photocopy this figure is granted to purchasers of this book for personal use only (see copyright page for details).

guide the worker in setting goals and planning intervention strategies. Therefore, although my assessment model is comprehensive in order to apply to a wide range of problem situations, each separate assessment need not include information on *all* the items listed on the forms. *The worker's judgment about the relevant factors in each case situation guides the assessment process accordingly.*

OBTAINING COLLATERAL INFORMATION

Information about a child and family usually comes from a number of sources, in addition to the personal observations and interviews of the social worker. These other sources of data include reports of the clients' past contacts with other agencies, as well as summaries of past and current school, medical, and legal contacts. *Releases must be signed by the client (or the client's parents) before the worker can request collateral information.* Sometimes a client arranges to have reports sent directly to a worker, after signing necessary releases for the reporting agency. However, more typically, in the first meeting with a client or parent the intake worker determines the collateral information that is relevant, discusses this with the client or parent, and obtains his or her signature prior to requesting the information.

In cases involving children, some agencies routinely ask parent(s) to sign releases to obtain the child's school and medical records. Occasionally a parent objects to having the school know that a child is receiving counseling, and if the problem is not school-related, there is no necessity to obtain school records. For example, a child with a sibling/family conflict may be doing well in the academic sphere, and thus school and medical records would be superfluous. However, in cases in which the worker believes that school records are essential for completing the assessment, he or she may need to discuss this necessity with the parents and encourage them to reconsider.

Sometimes a worker wants to speak with a child's teacher and make a school visit. Sometimes a home visit is appropriate in order to observe a child's interaction with a babysitter or to assess the atmosphere in the home. Often a telephone conference with the child's pediatrician is helpful, especially if the child has somatic complaints. When the child's troublesome behavior is the focus of concern, the worker may ask the parents and the teacher to fill out a behavior checklist (see "Assessment Tools" later in the chapter). Again, the decision about what information to obtain depends on the circumstances in each case and the worker's judgment about what information will lead to improved understanding.

ORDER AND GENERAL GUIDELINES FOR ASSESSMENT

The Usual Order of Assessment for a Child Client

It is a truism that first impressions may be lasting. Therefore, a social worker must consider carefully the impact of seeing one family member before another. The worker's observations and impressions weigh heavily in the assessment process, and when the worker interviews one family member prior to another, that individual enjoys the possible advantage of having his or her point of view heard *first*. Sometimes the worker inadvertently forms an alliance with the family member seen first, thereby putting members who are seen later at a disadvantage. Ideally, the worker remains neutral and objective, regardless of the order in which clients are seen.

The usual order of assessment, when the presenting client is a child, is as follows:

1. The worker meets with the parent(s). In situations of separation or divorce, contact with the noncustodial parent may involve a separate interview or a telephone conference.
2. The worker conducts two or three play evaluation sessions with the child.
3. The worker sees the entire family when the problem situation seems to have reverberations for other family members. (This step may be postponed until later or, in some cases, may never occur.)
4. (Optional) The worker contacts the child's teacher by telephone, and, depending on circumstances, makes a school visit and/or requests school records. (See the previous section, "Obtaining Collateral Information.")
5. The worker refers the child for psychological or educational testing, if appropriate.
6. The worker obtains a report from the child's pediatrician. (See the previous section, "Obtaining Collateral Information.")

General Guidelines for Contacts with the Parent(s)

There are several important reasons to see the parent(s) first when the child is under 10 years of age:

- To form an alliance with the parents (essential for ongoing work with the child).
- To obtain a developmental history of the child, including matters the parent(s) may not wish to discuss in the child's presence.

- To prepare the parent(s) to prepare the child for the assessment sessions.
- To obtain signed releases for all collateral contacts.

General guidelines for pursuing the first three of these goals follow.

Forming an Alliance with the Parent(s)

Working with children requires that the worker include parents as essential partners in helping their children. When parents are not included, the worker walks the dangerous ground of ignoring the very roots of children's identity and being. Insofar as a child's identity consists of his or her dual inheritance from a male and a female parent, the child instinctively attributes the basis of his or her identity to those two people. Even when a parent is unknown, the child has fantasies about that parent, which may reflect the child's expectations about his or her own future life.

Most parents are imperfect, insofar as they are human, and some are so disabled by their own upbringing that they do not know how to parent effectively. Work with children is complicated by the fact that the counselor has to deal not only with appealing youngsters who may be "victimized" but also with parents who, out of ignorance or desperation, may have substantially contributed to their children's problems. Blaming a parent, however, is *never* productive and may ultimately result in a worker's inability to help a child. Even in the most compellingly incriminating situations of parent neglect, abuse, criminality, and/or abandonment, we must not minimize parents' ongoing influence on their children. A child who was unwanted, resented, and abused by a parent must constantly cope with the meaning of this rejection. Eventually the child must come to some understanding about the abuse related to the parent's own deficiencies, but this realization usually does not occur until adulthood. Parents are major influences in their children's lives, both in reality and as symbols. Workers, therefore, must put all judgments aside and find ways to include parents in the process of assessing and helping.

Obtaining the Child's Developmental History

The assessment of a child is difficult because of the many factors that may contribute to the child's presenting problem. Obtaining the developmental history serves two purposes: (1) It provides a template against which to measure the course of the child's emotional and physical growth; and (2) it gives a sense of the family environment into which the child was born and in which he or she has developed. The developmental history

form presented later in this chapter is one of several assessment tools. The history should be obtained either from a parent or from someone else who has been intimately involved in the child's upbringing.

In addition to the specifics of the child's development, the worker learns a great deal from the *manner* in which the parent or other caretaker conveys the information. Does he or she seem to take pride in the child's development, or is the child pictured as troublesome and annoying? Sometimes a parent can remember very little about the child's early life, which suggests that the parent was or is not very tuned in to the child. Possibly a mother's difficulty recalling details results from her past postpartum depression or drug/alcohol abuse, and the worker may appropriately inquire about these factors.

For example, in the process of obtaining information from Mrs. Smith about Barbie's language and social development, a sensitive school social worker would have empathized with Mrs. Smith's life circumstances during Barbie's early childhood. The worker's caring attitude might have encouraged this mother of three children and victim of spousal abuse to openly acknowledge her use of drugs and alcohol as a means of dealing with her depression and frustration at this time. Had Barbie been present during the intake, Mrs. Smith might not have felt comfortable disclosing her own addictive behavior. Barbie was 10 years old at the time of the referral to the special school program for homeless children, and Mrs. Smith brought her daughter with her when she visited the school to enroll her. Under these circumstances, it is usually possible for the school social worker to arrange a private meeting with the mother to obtain the history and release forms while the child visits the classroom.

Preparing the Parent to Prepare the Child for the Assessment

Although this was not what happened in Barbie's case, a parent often applies for services for a child and meets with an intake worker without the child's being present. An example is the case of Tammy, age 4 (Chapter 7), whose serious separation problem in nursery school prompted her teacher to suggest that the mother obtain some counseling to alleviate the child's unhappy, withdrawn behavior.

In situations such as this, when a parent meets with the worker first, the worker then has the opportunity to help the parent think about how to prepare the child for subsequent meetings with the worker. Parents often want to avoid telling their child anything ahead of time, possibly because they themselves feel uncomfortable about "the problem" and because they do not know what to say to the child. I have found that parents are very relieved when I give them explicit suggestions. First, I propose that they tell their child that, because they have been concerned

about the fact that they can't seem to help him or her, they have found and spoken with somebody who "helps children and families with their troubles and worries." I further suggest that the parents tell the child that they will be bringing the child to see this person, who has toys and who helps children "sometimes by talking and sometimes by playing with them." I assure parents that, if necessary, they may remain with their child during part or all of the session, depending on the child's level of comfort. I also convey my experience that most children greatly *enjoy* the assessment sessions, so that the parents will approach their child with an optimistic spirit.

General Guidelines for Assessment Sessions with the Child

It is usually advisable to see children for two or three play evaluation sessions. The child's behavior with a stranger during the first session may not be typical, and, in any case, the worker will need to see repeated examples of the child's behavior before coming to any conclusions.

The First Session

The most important task of the worker in the first session is to establish a relationship with the child in which the child feels understood, listened to, and respected as a person. Initially the child will expect the worker to be like other adults, such as parents or teachers, so the worker must make a point during the first session of clarifying the helping role. The worker may ask the child something like this: "Did your mother explain to you who I am, and why she brought you here?" (Most children do not answer this question clearly.) As suggested in Chapter 3, the worker can then say something like the following: "I am a [doctor, lady, man] who helps children and their parents with their troubles and their worries. Do you know what 'worries' are? [Pause for child's response.] Sometimes we'll be talking, and sometimes we'll play."

Preparing the Office for Child Evaluation Sessions. Evaluation sessions differ from the less structured play therapy or helping sessions that may follow the assessment. Just as the social worker beginning with an adult client usually follows an interview guide in obtaining specific information during the intake, the play therapist or social worker who is meeting a child client for the first time needs to prepare in advance and have planned activities and appropriate materials on hand. The worker selects these to serve the dual purpose of (1) making the child client feel com-

fortable (by offering age-appropriate play material) and (2) providing the worker with information that will assist in understanding the nature and scope of the child's difficulties. Therefore, the office setup for an evaluation session with a 9-year-old differs from that for a 4-year-old because of the types of play materials that the worker makes available to each child.

In evaluation/assessment sessions I have a limited number of toys in view, in order to avoid overstimulating the child and causing scattered play. Table 4.1 outlines suggested play materials for assessment sessions with children of different ages. This table is only a general guide and should not be used rigidly. Work with children requires spontaneity, flexibility, and a tolerance for surprise; the overriding obligation is to respond to the uniqueness of each child.

Suggested Activities for the First Session. I provide drawing materials to children of all ages and routinely ask them in the first session to make two specific drawings: (1) the Draw-A-Person and (2) the Draw-A-Family. When a child spends a long time on the first drawing and appears to have expended a great deal of effort on this task, I do not ask him or her to complete another drawing during that session. On the other hand, some children can readily complete both a Draw-A-Person and a Draw-A-Family, with energy and enthusiasm. I then invite these children to do a third drawing that can be anything they wish (optional drawing). My videotape *Techniques of Play Therapy* (Webb, 1994b) illustrates different responses of three children in initial sessions to my re-

TABLE 4.1. Suggested Play Materials for Assessment Sessions with Children of Different Ages

Materials	Ages 3–5	Ages 6–7	Ages 8–10
Colored paper	×	×	×
Colored markers	×	×	×
Scissors	×	×	×
Glue, Scotch tape	×	×	×
Play-Doh	×	×	
Clay		×	×
Small, bendable family dolls	×	×	
Dollhouse furniture (especially kitchen and bedroom)	×	×	
Blocks	×	×	
Animal puppets	×	×	×
Feelings in Hand card game (see Figure 3.3)		×	×
Talking, Feeling, and Doing Game (see Figure 3.3)		×	×

quest that each child make some drawings. The youngest child, Trey, age 3½, refused to draw anything; 5-year-old Willie spent more than 10 minutes completing his Draw-A-Person (Figure 4.2); and the third child, Natalie, age 4½, completed a Draw-A-Person, a Draw-A-Family, and an optional drawing within a 5-minute interval (Figures 4.3–4.5).

The worker must be attuned to the child's ability, level of energy, and degree of anxiety. Requests for specific drawings should be tailored to the child's responsiveness. Future sessions will provide additional opportunities to obtain further drawings from the child. *The worker should keep in mind that establishing a relationship with the child is the primary goal in the first session and that the toys and activities are means to that important end.*

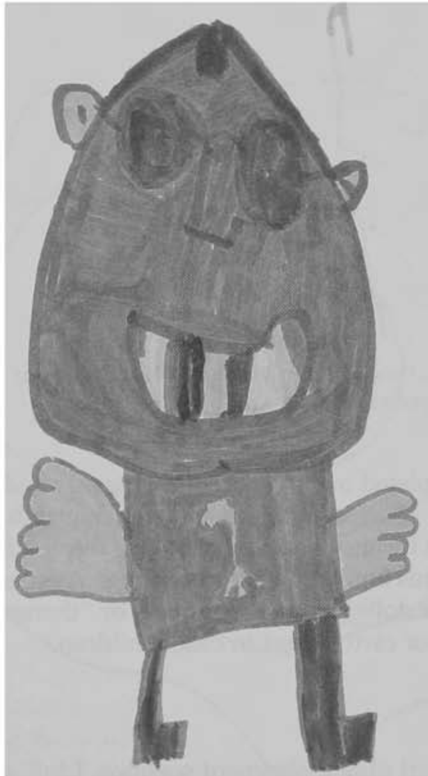

FIGURE 4.2. Willie's Draw-A-Person. From Webb (1994b). Copyright 1994 by The Guilford Press. Reprinted by permission.

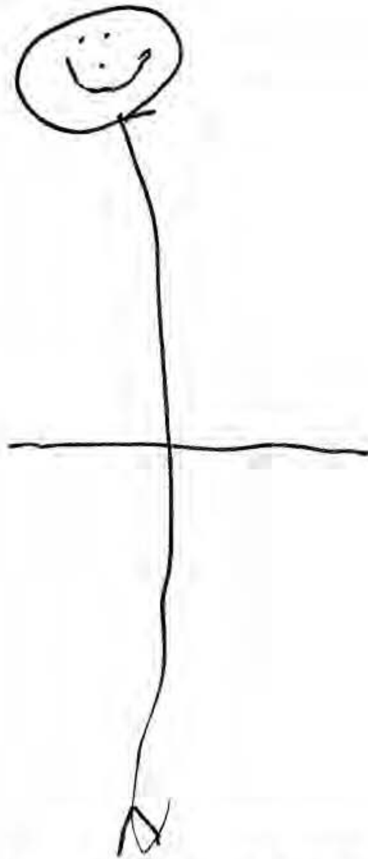

FIGURE 4.3. Natalie's Draw-A-Person. From Webb (1994b). Copyright 1994 by The Guilford Press. Reprinted by permission.

After a child has completed one or more drawings, I usually suggest a change of activity. If the child is age 7 or younger, I introduce a set of small family dolls and doll furniture and suggest that the child might like to make up a story about this family. Children over age 7, especially boys, may not want to play with dolls, so I offer puppets or "therapeutic" (i.e., special/structured) board or card games to older children.

Subsequent Sessions

During the second and third play assessment sessions, I follow a pattern similar to that of the first session. That is, I usually begin by asking the child whether he or she would like to draw and then introduce other toys

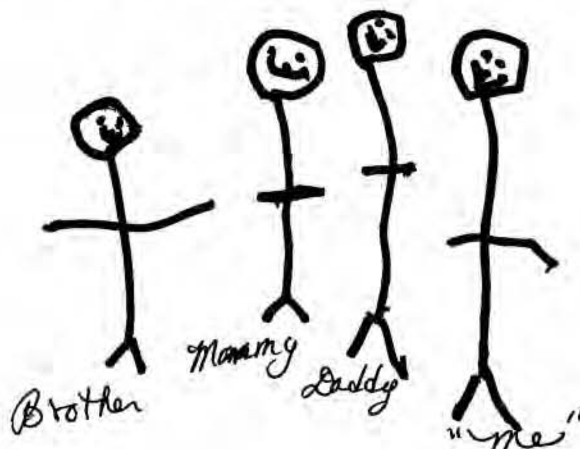

FIGURE 4.4. Natalie's Draw-A-Family. From Webb (1994b). Copyright 1994 by The Guilford Press. Reprinted by permission.

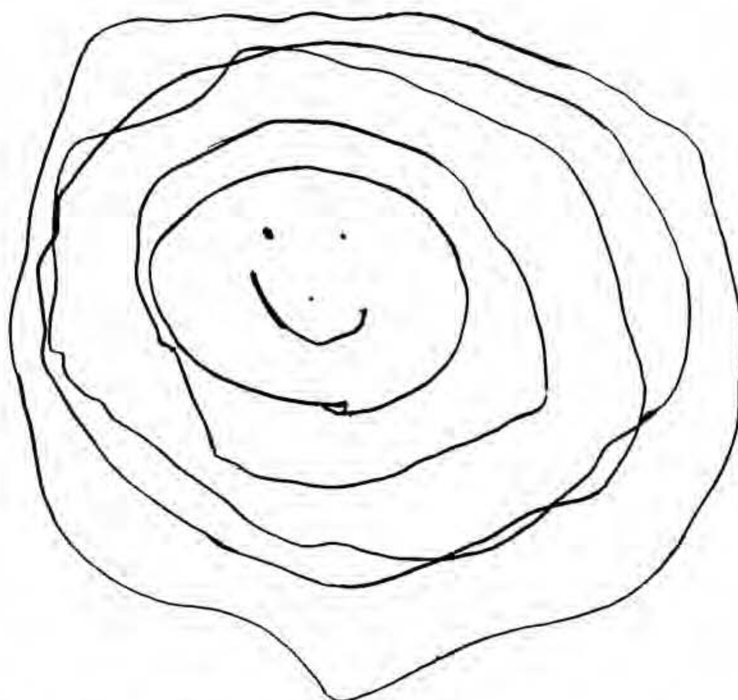

FIGURE 4.5. Natalie's optional drawing. From Webb (1994b). Copyright 1994 by The Guilford Press. Reprinted by permission.

and activities. Of course, the child remembers the first session and often comes to subsequent meetings eager to resume a play activity he or she enjoyed in the first session. The worker should take special note of such requests, as they may have particular significance in understanding the child's circumstances.

What to Look For in Child Evaluation Sessions

During the evaluation, the social worker is trying to learn as much as possible about the child by observing the child's play and the manner in which he or she relates. After each play session, the worker should take some notes about the following aspects of the child's behavior:

1. *Developmental factors: Age-appropriateness of child's play*. What developmental tasks/issues and concerns are typical of the "average" child of the age under consideration? The worker should evaluate the child's play (including drawings) in terms of age-appropriateness.

2. *Mood/quality of child's play*. How can this child's play be characterized with regard to the dimension of creativity–constrictiveness? Happy or sad? Aggressive or passive? Has the mood varied over the course of the session(s)? In instances in which constriction is noted in the child's play, does this appear to be evidence of anxiety or of the child's temperament?

3. *Themes in child's play and possible areas of conflict*. What significant themes can be noted in the child's play? How often do those themes occur? And what factors in the child's life might they stem from? (This last question is merely speculative; however, *numerous* occurrences of aggressive or abandonment play themes, for example, should be noted for further exploration, as should other themes, such as nurturance.) Are there similarities or differences between the types of conflicts or problem situations presented by the child in play and those noted in the parent's or caretaker's earlier reports?

4. *Separation anxiety/ability to relate to worker*. What indications of separation anxiety are noted in the child's actual separation from parent or caretaker in the first session? Do themes in the child's play or interruptions in the play reflect separation concerns? How does the child relate to the social worker? Consider behavior at different points in time, especially variations in the child's responses within a particular session and among successive sessions.

5. *Ability to concentrate in session*. How distractible is the child? Can he or she focus on a task until completion? Does the child seem to be attending to noises outside the room?

Table 4.2 provides a form for reviewing and recording the child's play.

TABLE 4.2. Assessment of the Child's Behavior in Play Sessions

Date _______ Which session _______ Child's age _______ (years) _______ (months)

1. Age-appropriateness of child's play (check one)
   Regressed _______ Average _______ Advanced

Notes:

2. Mood/quality of child's play (check all that apply)
   Happy _______ Sad _______ Anxious _______ Scattered _______
   Creative _______ Aggressive _______ Passive _______ Other (describe)

Notes:

3. Themes in child's play (check all that apply)
   Abandonment _______ Nurturance _______ Anger _______
   Fear _______ Loneliness _______ Danger _______ Other _____________

Notes:

4. Ability to separate from parent/caretaker
   Appropriate for age _______ Inappropriate _______

Notes:

5. Ability to relate to worker: At beginning of session _______ In middle _______
   At end _______
   In second session _______ In third session _______

Notes:

6. Ability to concentrate in session
   Good _______ Moderate _______ Distractible _______

Notes:

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When the worker has completed the evaluation sessions with the child and obtained all other necessary reports (see the section "Obtaining Collateral Information"), he or she meets again with the parents to give them a verbal summary of the assessment and recommendations and to involve the parents in setting goals and formulating a treatment plan.

ASSESSMENT TOOLS

Many different tools are available to assist the worker in forming an assessment of a child and family. Few workers (if any) will use all the tools described here in any one case. The nature of the agency often dictates the use of particular assessment methods, such as the DSM in a mental health clinic or a genogram in a child welfare or family services agency. Although we may all agree that "the more information we have, the better" about an individual child, time constraints often prevent the completion of a comprehensive assessment. Reality dictates that the worker choose the assessment tools that promise to produce the most useful information for the purpose of a specific evaluation within a reasonable time frame.

Among the possible choices of assessment tools are the following:

- Developmental history form (Webb, described below)
- Tripartite assessment forms (Webb, see Tables 4.3, 4.4, and 4.5)
- Assessment of risk and protective factors (Davies, 1999)
- Genogram (McGoldrick & Gerson, 1985)
- Eco-map (Hartman, 1978)
- Culturagram (Congress, 1994)
- Educational and psychological testing
- Specific drawing exercises (Malchiodi, 1998; di Leo, 1973)
- Projective questions

Developmental History Form

The developmental history form I have created for my practice and teaching (Table 4.3) includes a sweeping view of the child's life from birth to the present, concluding with an appraisal of the child's ego strengths and weaknesses. The developmental history constitutes the core of the assessment, pointing to areas of developmental delay, difficulties in separation/individuation, the child's school history, and affective social development. Appraisal of the child's development depends on the worker's solid knowledge of typical developmental norms. As discussed in Chapter 2, this knowledge base is essential in work with children.

The experience of relating information about the child's life sometimes makes a parent very contemplative. The review can, in itself, help a parent understand significant pieces of the child's life in a manner that is meaningful to him or her. This occurred, for example, in the intake with Tammy's mother (see Chapter 7), who began to realize as I questioned her about Tammy's friends and babysitters that she had never permitted

Tammy to be cared for by anyone other than herself or her own mother. The fact that Tammy's mother was currently having difficulty getting pregnant a second time seemed to cause the mother to cling to the child, even as the child was clinging to the mother.

In contrast to Tammy's insightful mother, who was able to make meaningful connections between her child's behavior and her own anxieties, other parents may have difficulty remaining focused on their child during the intake. This appeared to be the case in my lengthy telephone call with Mrs. Smith, when I asked her to tell me about Barbie's life before she started school. Mrs. Smith began crying and talking about how unsupportive her family was and how she eventually had decided to "pay back to others what they had done" to her, even though she knew now that it was wrong. I am still not sure about the meaning of this statement other than as a possible explanation for her drug-dealing activities, which had led to her imprisonment. I sensed during that phone conversation how very needy Mrs. Smith was. Had I been attempting to obtain a developmental history of Barbie, it might have been necessary to focus first on Mrs. Smith because of her own numerous problems. Once such a parent has felt validated and respected, he or she may be more able to focus on the related experiences of his or her child.

Tripartite Assessment Forms

During and following the collection of data for the developmental history, the worker begins to weigh the significance of the numerous events and experiences in the child's life. I have developed three forms to help the worker in completing a tripartite assessment (Tables 4.4–4.6). These forms organize the data into distinctive categories that further assist in identifying pivotal influences on the child's life.

Applying Developmental History/Tripartite Assessment Principles: The Case of Barbie

Before I continue with the description of various assessment tools, it may be instructive to consider how the tasks of obtaining a developmental history and conducting a tripartite assessment were carried out, and might have been carried out, in the case of Barbie Smith. First, I want to emphasize that, in the case of a child as disadvantaged as Barbie, the most useful way of beginning an assessment may be to consider the child's strengths. On the *No Place Like Home* videotape (Hunt, 1992), Barbie presented as an appeal-

TABLE 4.3. Developmental History Outline

I. *Identification and description of child and family* (outline). Give ages, birthdates, genders, and occupations of all family members. These may be separated into (1) relatives in the home, (2) relatives outside the home, and (3) nonrelated persons living in the home.

II. *Presenting problem* (one or two sentences, in the parents' own words). State the problem that brings the child to the agency, the referring source, and the source's statement of the problem.

III. *History of problem*. Include how problem got started (onset, duration, intensity) and circumstances under which the problem manifests itself.

IV. *Family background* (including three-generation genogram). Indicate ethnicity, religion, socioeconomic status, educational and occupational data, and some conceptualization of patterns of interaction within the family, especially with regard to the child.

V. *Specific developmental history*
  - A. Family atmosphere into which the child was born
    1. Marital situation
    2. Financial situation
    3. Was pregnancy planned or unplanned?
    4. Parental attitudes toward children; maturity for parenting
    5. Physical living situation—space?
    6. What kind of community environment?
  - B. Delivery
    1. Abnormalities, difficulties, unusual procedures
    2. Gender of child (parental/sibling reactions)
    3. Birth weight
  - C. Infancy
    1. Physical development (feeding, toileting, activity level, motor development)
    2. Emotional responsiveness and sensitivity
    3. Quality of mothering (maternal availability for positive, fulfilling relationship); who was the primary caretaker?
    4. Parental perception of child's temperament (easy–difficult)
  - D. Early childhood
    1. Language development
    2. Separation/individuation (18–36 months)
       - a. Physical separation (any delays in development?)
       - b. Maternal reactions to toddler's greater independence
       - c. Outside factors affecting mother and child (medical, psychological, social)
    3. Other factors affecting child's early emotional development
       - a. Sibling births
       - b. Separations from parents
       - c. Medical problems/health-related difficulties
       - d. Unavailable or severely deprived parents
    4. Reactions to nursery school or other separation
    5. Discovery of anatomical sexual differences (reactions)
    6. Exposure to sexual activity or materials
    7. Exposure to traumatic events
    8. Affective/social development
    9. Fantasy life and play

(*continued*)

TABLE 4.3. (continued)

VI. *School history*
1. Separation reactions
2. Ability to learn, concentration, cognitive development
3. Superego formation (clear sense of "right" and "wrong")
4. Any noted difficulties in behavior or learning
5. External factors (teachers, moving, etc.)

VII. *Ego strengths and weaknesses*
1. Friends
2. Hobbies/special interests
3. Frustration tolerance, ability to delay gratification
4. Previous symptoms or difficulties

VIII. *Current functioning* (one or two sentences describing child's present adaptation).

ing youngster who had not yet been destroyed by the cruel circumstances of her life. She was open about her feelings, conveying resignation about her homeless circumstances and past beatings. Yet she demonstrated the ability to be playful and enjoy herself when she went roller skating and when the filmmaker allowed her to experiment with a camcorder. Barbie had not only "survived" her difficult childhood; she had matured into a preadolescent with an appeal that caught the interest of a filmmaker and myself. She had learned to take basic care of herself; in the videotape she is shown washing her own hair, cooking a simple meal, and even serving it to her mother. In many respects, she seemed old for her years, especially when she applied eye makeup prior to going skating, as if she were preparing for a "date"—behavior that probably imitated her mother and sister.

Any social workers or other professional helpers entering Barbie's life needed to question whether and how this youngster could have a more fulfilling life than that of her mother and how to insure that this child would not be swept along in the relentless current of poverty, dependence, and constricted beliefs about her future options as a woman.

Information Actually Obtained about Barbie at Time of Referral

The intake interview at the time of Barbie's entry to the special school program for homeless children required (or involved) numerous forms and releases. In addition to factual information about the family's current living situation, details were obtained about Barbie's health and educational history. The forms did not include information about the child's developmental history, but the social worker nonetheless obtained some information about Barbie's history of foster care while her mother

TABLE 4.4. Individual Factors in the Assessment of the Child

1. Age _____ years _____ months   Date of birth_________
   Date of assessment_________
   a. Developmental stage:
      Freud_____
      Erikson_____
   b. Cognitive level:
      Piaget_____
   c. Temperament:
      Thomas and Chess_____
2. Past coping/adjustment
   a. Home (as reported by parents): Good___Fair___Poor___
   b. School (as reported by teachers and parents): Good___Fair___Poor___
   c. Interpersonal/peers (as reported by parents and self): Good___Fair___Poor___
   d. Hobbies/interests (list) ______________________________
3. Medical history (as reported by parents and pediatrician)—describe serious illnesses, operations, and injuries since birth, with dates and outcome ____________________
   ____
   ____
4. Abuse history
   a. Physical: No___ Yes___ Reported (Y or N)___ Child's age___
      Single episode___ Repeated___ Perpetrator_______________
      Outcome (give details)______________________________
      ____
   b. Sexual: No___ Yes___ Reported (Y or N)___ Child's age___
      Single episode___ Repeated___ Perpetrator_____
      Outcome (give details)______________________________
      ____
      ____
5. Exposure to traumatic events (give details with dates and outcome)_______________
   ____
6. DSM-IV-TR diagnosis: Axis I_____Axis II_____Axis III_____
7. Child's personal perception of problem: What is the specific *meaning* of this difficulty to the child at this time?______________________________

Note. This form is one part of a three-part assessment of the child, which also includes an assessment of situational factors (Table 4.5) and an assessment of the child's support system (Table 4.6).

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was in prison for possession of firearms and possession and manufacture of methamphetamines.

According to the information given by Mrs. Smith at intake, she began using drugs when Barbie was about 3 years old, and she was imprisoned for 20 months when Barbie was between 5 and 6 years old. At that time all three children were placed in foster homes in which, according to Mrs. Smith, the girls were molested and beaten. These charges were

TABLE 4.5. Situational Factors in the Assessment of the Child

1. Nature of problem
   a. Presence of loss factors
      Separation from family members (list relationship and length of separation)______
      ____
      Death of family members (list relationship and cause of death)______________
      ____
      Loss of familiar environment (describe)______________________________
      ____
      Loss of familiar role/status (describe; temporary or permanent?)______________
      ____
      Loss of body part or function (describe, with prognosis) __________________
      ____
   b. Presence of trauma/violence
      Witnessed: Verbal___ Physical___
      Experienced: Verbal___ Physical___
   c. Presence of life threat
      Personal (describe)__________________________________
      ____
      To family members (describe, identifying relationship) _______________
      ____
      To others (describe)__________________________________
      ____
   d. Presence of physical injury or pain (describe)_______________________
      ____
   e. Element of stigma/shame associated with problem (describe)______________
      ____
2. Psychosocial and environmental problems: DSM-IV-TR, Axis IV (list problems) ________
   ____
3. Onset and duration of problem
   a. Chronic (give details, including child's age at onset and frequency of occurrence)
      ____
      ____
   b. Acute (give child's age and duration of problem)_______________________
      ____
4. Involvement of others
   a. Nature of involvement (describe)_______________________
   b. Perception of support: Sufficient___ Insufficient___

Note. This form is one part of a three-part assessment of the child, which also includes an assessment of individual factors (Table 4.4) and an assessment of the child's support system (Table 4.6).

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TABLE 4.6. Assessment of the Child's Support System

1. Nuclear family members
   a. How responsive are they to the child's needs? Not at all ___ Somewhat ___ Very ___
   b. To what extent is the child included in discussions about "the problem situation"? Frequently ___ Never ___ Sometimes ___
   c. Do parents tend to show a judgmental attitude toward the child's behavior? Yes ___ No ___
2. Extended family members
   a. How frequently are they in contact with the child? Rarely ___ Monthly ___ Weekly ___ Daily ___
   b. Describe nature of the relationships, indicating who is the most supportive relative to the child ___
   c. To what extent do the views of the extended family differ or agree with those of the nuclear family on matters pertaining to the child? (give details) ___
3. School/peers/social network
   a. Child's grade in school ___
   b. Child's friendship network: How many friends does child have? Many ___ "A few" ___ None ___
   c. Would child like to have more friends than he or she has? Yes ___ No ___
   d. How many days after school, on the average, does the child play with another child? Most days ___ Once or twice ___ Never ___
4. Religious affiliation
   a. Does the child/family participate in religious services? Yes ___ (If yes, give name of religious group:) No ___
   b. If yes, indicate how frequently the child/family participates: Weekly ___ Major holiday observances ___ Rarely ___
5. Neighborhood/school activities
   a. Is the family involved with neighborhood/school activities? No___ Yes___
   b. If yes, describe ___

Note. This form is one part of a three-part assessment of the child, which also includes an assessment of individual factors (Table 4.4) and an assessment of situational factors (Table 4.5).

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investigated and later dropped by the district attorney. The girls received counseling for about 2 years, and Mrs. Smith stated that she herself had also been in treatment several times. She claimed during the intake that she had been drug-free since she was released from prison, when Barbie was about age 7; she was employed as a bartender for a while following her release.

The intake also revealed information about Barbie's father. Barbie's parents were married when she was 4 years old, having lived together

for 2 years prior to her birth. They separated a year later and were divorced when Barbie was 9. According to Mrs. Smith, her former husband had physically abused her and the children, and she had taken out many court orders of protection against him. He later moved out of state, and Barbie had not seen him since she was 9, although he maintained occasional telephone contact with his daughter.

Reconstruction of Significant Factors in Barbie's Developmental History

In this case, as in many presented to social workers, comprehensive information was (and still is) lacking, and a social worker would have had to make professional judgments despite many missing pieces. Because homeless children require prompt emergency services, it is understandable that the school did not get *detailed* facts about the child's history beyond the preceding 2 years. Actually, the information obtained by the intake worker exceeded the minimum required on the form.

In order to reconstruct the important events in Barbie's development, I devised a time line, listing pivotal events of each year of the child's life from her birth to the time of the Hunt videotape. There was virtually *no* information about the period from Barbie's infancy until she was 3 years old, when her mother stated that she began using drugs. We can speculate that this period may have been characterized by Mrs. Smith's alternating states of feeling overwhelmed by the care of three young children and trying to medicate herself with drugs or alcohol. If Mrs. Smith used amphetamines, these would have had a stimulating affect on her mood, and, typically, according to Straussner (1993, p. 311), alcohol serves a sedating function for users of amphetamines. We do not have any information about Mrs. Smith's *alcohol* use, but a colleague of mine—a professor who teaches courses on alcohol and other substances—commented about the similarity between Barbie's facial features (as depicted in the publicity photo for *No Place Like Home*) and those of children with fetal alcohol syndrome (U.S. Department of Health and Human Services, 1993, p. 203).

Whether or not Barbie's mother was using alcohol prior to her admitted substance abuse when Barbie was 3 years old, we can reasonably question the quality and consistency of Barbie's early parenting experiences. The marriage of Barbie's mother and father lasted only a year, and Mrs. Smith's incarceration soon after, when Barbie was 5, suggests that the family circumstances were tumultuous and not conducive to a child's need for emotional calm and stability.

Pivotal elements in the assessment of individual factors in Barbie's development (see Table 4.4) included the following:

1. *Abuse history* (item 4 in Table 4.4). Details are lacking, but Mrs. Smith referred to *multiple* instances in which Barbie's father physically abused both her and the children. On the videotape, Barbie asked pointedly, "Just because he hit us, that doesn't mean he doesn't love us, does it?" In addition to physical abuse by her father, Mrs. Smith stated that Barbie was physically and emotionally abused in foster care. Details about this are unknown.

2. *Exposure to traumatic events* (item 5 in Table 4.4). Barbie's early life was characterized by the "loss" of both parents, as well as the loss of her familiar intact family. We do not know what Barbie was told at age 5 when she "lost" her mother to the prison system. She also "lost" her sister, brother, and father at the same time, and her father never returned to live with the family after her mother was released.

The assessment of the child's support system (see Table 4.6) was also revealing. There appeared to be very few supports available to the Smith family in the usual form of extended family members or religious or community affiliations. Mrs. Smith spoke on the tape about her poor relationships with her own family, and she conveyed an attitude of anger and resentment toward them. She had a friendly manner, however, and she appeared to have some male friends, who were shown on the tape helping the family move. In view of the frequency of the family's moves (seven times during a 6-month period), it was remarkable that this mother had the stamina to persevere in her determination to keep her family together. She verbalized this goal frequently, and this may have reassured Barbie about her own personal worth and value. Barbie admired her mother and wanted to be like her. The child seemed unaware of her mother's deficiencies and failures, choosing instead to identify with her strengths. The mother's strong love for Barbie had helped the child endure repeated experiences of abuse and loss. Given the severity of Barbie's early life experiences, it was truly remarkable that she related as well as she did to adults. No information was available about her relationships with peers, however, which certainly would have been compromised by the family's frequent moves. Homeless children typically demonstrate lowered self-esteem and difficulty in making friends (Timberlake & Sabatino, 1994).

Risk and Protective Factors

Davies (1999, p. 45) points out that the identification of risk and protective factors is a critical part of any assessment. Although the presence of

protective factors may balance and offset risks, if more than three risk factors exist, "the child and parents are more likely to become overwhelmed, resulting in a developmental or psychiatric disorder in the child" (Davies, 1999, p. 49).

Risk Factors

This terms refers to influences in the individual and the surrounding social environment that increase the probability of negative future outcomes for children (Kirby & Fraser, 1997). Davies (1999, p. 49) identifies the following three types of risk factors:

- Vulnerabilities in the child, such as mental retardation or chronic illness.
- Impaired parenting.
- Socioeconomic and institutional factors, such as lack of access to medical care or chronic exposure of the family to poverty and social disadvantage.

We note that in Barbie's case two of the three risk factors were present, namely impaired parenting and chronic poverty.

Protective Factors

The quality of parenting is probably the most important mediator of risk for children, but positive relationships with other adults also can serve a protective function. Barbie appeared to have a secure attachment relationship with her mother, despite her mother's shortcomings, and, in addition, she seemed to benefit from the ongoing attention of the filmmaker. Other protective factors for this girl included her general good health and an easy temperament.

Resilience

Davies (1999) wisely emphasizes that risk factors do not determine a child's fate. Studies have shown that only about one-third of any population of at-risk children actually experiences a negative outcome (Wolin & Wolin, 1995) and that the remainder seem to survive without major developmental disruptions (Kirby & Fraser, 1997). These "survivors" were referred to as "invulnerable children" by Anthony and Cohler (1987); authors now tend to use the label "resilient" (Garmezy, 1985; Rutter, 1987; Gitterman, 2001; Norman, 2000).

TABLE 4.7. Common Risk and Protective Factors for Serious Childhood Social Problems: An Ecological and Multisystems Perspective

System level	Risk factors	Protective factors
Broad environmental conditions	Few opportunities for education and employment Racial discrimination and injustice Poverty/low socioeconomic status	Many opportunities for education, employment, growth, and achievement
Family, school, and neighborhood conditions	Child maltreatment Interparental conflict Parental psychopathology Poor parenting	Social support Presence of caring/supportive adult Positive parent–child relationship Effective parenting
Individual psychosocial and biological characteristics	Gender Biomedical problems	"Easy" temperament as an infant Self-esteem and self-efficacy Competence in normative roles High intelligence

Note. Adapted from Kirby and Fraser (1997, p. 20). Copyright 1997 by the National Association of Social Workers, Inc. Adapted by permission.

Although risk and protective factors appear to be oppositional, Fox (2001) maintains that resiliency actually develops from the interaction between the two sets of factors. He states, "The key in the development of resiliency is not in avoiding risk, but rather in accommodating to it successfully" (p. 140). Table 4.7 specifies common risk and protective factors.

Although Barbie's mother had made negative choices for herself and her family in the past, when she was involved in producing and taking drugs, at the time of the video she appeared to be making repeated efforts to survive and to keep her family together. She was demonstrating good coping and resilience in the face of severe adversity. During the period of the video, Barbie admitted to being discouraged by the many moves, yet she continued to function and to be open to new relationships.

Genogram

The genogram, probably one of the most useful of assessment tools, enables the worker to diagram on one page all the members of both the nuclear and the extended family, together with identifying information about them (e.g., ages, occupations, marital status, dates and manner of

deaths, and the quality of relationships among various family members). Readers wanting instruction in the construction of genograms can consult McGoldrick and Gerson (1985) and Hartman (1978).

"Reading" a genogram can reveal the following helpful information about a child and family:

- The similarity or difference between the position of the child in his or her nuclear family and the corresponding position of a parent in his or her family of origin.
- Relative(s) the child was named for.
- Repetition of problems across the generations (e.g., learning disabilities and alcohol dependence).
- Patterns of "cutoffs" when family conflict is not resolved.
- Patterns of closeness, dependence, and lack of separation linking family members, regardless of age or marital status.

The worker usually constructs the genogram together with the parent(s). If the child is present, this process can provide important information regarding how much the child knows about extended family members. If the child is *not* present, it may be helpful to involve the child in constructing a separate genogram later; however, the worker should keep in mind that developmental considerations probably prevent a child under 6 years of age from being able to conceptualize family relationships on paper.

The school for homeless children in which Barbie Smith was enrolled did not routinely construct genograms with the families of students. My attempt to produce a genogram of the Smith family is based on the scant information presented on the videotape and the intake forms. Because no information was available about members of Mrs. Smith's family of origin, the genogram consists of only two generations. Some of the data may be inaccurate; these would have had to be confirmed or corrected by Mrs. Smith during the process of working with her.

Because the genogram of the Smith family is so sketchy, I have combined it with an eco-map to illustrate the various helping agencies with which the family was involved (see Chapter 3, Figure 3.2). In many homeless urban families like the Smiths, the helping system serves as an essential substitute for the extended family, whose members may be unable or unwilling to offer financial or other support.

Eco-Map

Together with the genogram, the eco-map (Hartman, 1978) offers a visual representation of the persons and potential resources and depicts the

family's connections with their environment. As shown with regard to the Smith family, the genogram diagrams family relationships, whereas the eco-map illustrates contacts with social agencies and other community resources. The eco-map also usually contains an abbreviated genogram in its center, showing the members of the household in which the clients reside.

Culturagram

As a family assessment tool, the culturagram (Congress, 1994) offers social workers an important method for recognizing and individualizing the impact of ethnicity on culturally diverse families. The families with which social workers interact usually come from many different cultural backgrounds, and a tool such as the culturagram can assist in understanding each family's unique heritage and belief system. Chapters in this book that deal with children from minority, immigrant, or mixed cultures include the cases of Jacob and Damien (Chapter 1), José (Chapter 2), Eli (Chapter 9), Maria (Chapter 10), Vanessa and Vernon (Chapter 13), and Alexa (Chapter 15). Each of these children lived in a home in which language, beliefs, values, and connections with the community were influenced to varying degrees by the cultural history of his or her particular family. Sometimes the children of immigrants serve as interpreters for their parents, thus reversing usual parent–child roles. At other times, the parents' expectations about acceptable child behavior differ from the prevailing norms; this puts undue pressure on the children, who are caught between two worlds (see Webb, 2001, for a further discussion of cultural factors in parent–child relationships).

The culturagram provides a structured method for recording a family's cultural history and beliefs, and as such it is an essential resource in assessment and intervention with culturally diverse families.

In the case of the Smith family, information about the ethnicity of the family was incomplete. The school program Barbie attended obtains data about languages spoken in the home and about the ethnicity of various family members. Barbie's school record identified her as a native-born English speaker, with only English spoken in her home. With respect to ethnicity, the Lapp, Lettish (Latvia), and Jamaican categories were checked as applying to "spouse partner," but we do not know whether these applied to Barbie's father or to other men in the home. No categories were checked as applying to Mrs. Smith's ethnicity. Barbie's light blonde hair, blue eyes, and pale skin were similar to her mother's and sister's coloring

and seem characteristic of persons with northern European origins. We have no information about the family's religious or cultural practices.

DSM-IV-TR

The DSM-IV-TR, the latest edition of an assessment tool produced by the American Psychiatric Association (2000), is a system of classifying observable symptoms and behaviors into discrete diagnostic categories. Many practitioners (Johnson, 1993a; Rapoport & Ismond, 1990) are concerned about affixing diagnostic labels to children, whose development is in flux and whose "disorders" may be reactive to family and environmental stress rather than indicative of intrinsic pathology. Furthermore, scientific validation is lacking for many of the DSM categories used in practice with children, and some concepts applicable to adults have been extended to children without adequate recognition of the essential biological and psychosocial differences between children and adults (Johnson, 1994; Garmezy, 1985).

These reservations notwithstanding, DSM classifications are widely used in clinical practice and probably will become even more so in the current environment of managed care, in which DSM diagnoses are required for reimbursement. Johnson (1993a) points out that "neither social work nor any other discipline, so far, has produced [an alternative to the DSM] that has gained wide acceptance" (p. 144). Therefore, we must use it "by default" until a more satisfactory system emerges.

My own view is that the DSM is a very useful assessment tool for identifying and understanding certain psychological disorders and other conditions. I would never employ *only* the DSM, however, in formulating an assessment, because the genogram and eco-map provide essential information that is not included in the DSM.

A DSM-IV-TR assessment involves the following five "axes" (American Psychiatric Association, 2000, p. 27), each of which covers a different domain of information that may assist the practitioner in specifying the nature and scope of the difficulty under examination so that appropriate interventions may be planned:

Axis I	Clinical Disorders Other Conditions That May Be a Focus of Clinical Attention
Axis II	Personality Disorders Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning (GAF)

Had Barbie Smith's school social worker used the DSM at the time of Barbie's entry into the school, the following multiaxial diagnosis could have assisted in formulating an appropriate treatment plan:

Axis I	315.00	Reading Disorder (pending formal tests)
	315.2	Disorder of Written Expression (pending formal tests)
Axis II	V71.09	No diagnosis
Axis III		Deferred, pending medical exam
Axis IV		Problems with primary support group (parental divorce, past physical abuse by father, erratic contact with father)
		Problems related to the social environment (inadequate social support)
		Educational problems (academic problems)
		Occupational problems (mother's unemployment)
		Housing problems (homelessness, unsafe neighborhood)
		Economic problems (poverty, inadequate welfare support)
		Problems related to interaction with the legal system/crime (mother on probation)
Axis V	GAF = 50	(current and past year)

It is my belief that pulling together the information obtained at intake within a DSM framework would have alerted the school staff as to specific problem areas that might have been contributing to Barbie's learning difficulties. Although the main function of school is to educate, a special program targeted to homeless children must, of necessity, attend to the basic needs of the students and their families before the children's education can proceed. Barbie's special needs would have been listed explicitly on DSM Axes I and IV. Axis V would have indicated that Barbie's general level of functioning was fairly low, both currently and during the past year (estimated at 50, with the range from 0 to 100). Because this child's problem situation had not changed during the past year, the important question about the chronicity of her difficulties would have been highlighted. Barbie's mother stated at intake that Barbie had received special education services within the previous 3 years, so these records would have had to be obtained in order to compare Barbie's present academic functioning with her former level and to maintain some continuity with regard to the educational focus.

Educational and Psychological Testing

The following types of tests commonly used with children (Barker, 1995) may be recommended either by the intake worker or by the child study team in order to obtain more detailed information about the child:

Tests of academic attainment
Intelligence tests
Personality tests
Behavior checklists
Tests assessing specific psychological conditions, such as anxiety, depression, self-esteem, and sustained attention

The social worker does not test the child but must understand when to make a referral and how to explain the need for specialized testing to the child and the parent(s). We do not know which, if any, of these types of tests were completed with Barbie at the time of referral.

Tests of academic achievement are usually part of children's regular school records, as they are often performed on an annual basis in order to determine the children's appropriate class placement. Intelligence tests are not performed routinely in most schools, and they have been criticized in the past decade as being culturally biased. Nonetheless, they give a rough estimate of a child's native ability, and they are especially useful in suggesting the need for additional specialized testing for possible learning disabilities when a sizable discrepancy exists between the verbal and performance subsections.

Personality tests such as the Children's Apperception Test (CAT) attempt to elicit responses that reflect the child's inner world and mental state. This is a projective test, adapted from the adult Thematic Apperception Test (TAT). Both present the client with a series of ambiguous pictures onto which the client "projects" his or her personal meaning.

Another assessment measure sometimes employed as part of the assessment process is the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983; Achenbach, 1991), on which a parent or teacher responds to questions about his or her perceptions of a child's behavior. This measure results in several different opinions, which may be useful in pinpointing a particular setting or person with which the child's behavior is considered most troublesome. The Achenbach and Edelbrock CBCL (1983) is widely used in the child welfare field to track outcomes of services. A 2-day roundtable attended by 30 researchers was held in 1997 to share experiences in using this tool and to summarize and publish this knowl-

edge for the benefit of others in the field (LeProhn, Wetherbee, Lamont, Achenbach, & Pecora, 2002.

Another behavior checklist with separate forms for parents and teachers has been developed by Conners (1969, 1970).

An intake worker who is concerned about a child's depressed mood may ask the child to fill out a questionnaire about the level of his or her depressed feelings (the Children's Depression Inventory; Kovacs, 1978). Of course, this presumes that the child can read or that the child is willing to respond to questions read by the worker. Pfeffer (1986) lists a series of questions to ask in evaluating a child's risk of suicide. In situations in which I have serious questions about a child's depression and possible suicide risk, I communicate this to the parent and strongly suggest an immediate psychiatric consultation. Another self-report checklist, the State–Trait Anxiety Inventory for Children (Spielberger, 1973), assesses children's anxiety, and other scales exist for assessing the preschool child's home environment (Caldwell & Bradley, 1979).

In my own practice, I rarely use these various checklists. I prefer to base my assessment on my observations of the interactions among the child, the parent(s), and myself, as well as on the actual statements of the child and the family and on the various reports from collateral sources. When social workers begin their work with a child and a family, the workers must focus on getting to know them as people; requests to fill out forms can feel rather impersonal and cold. However, because these checklists and tests may be used by school psychologists, it is important for workers to know about their contents and purpose. A manual of typical tests used in child assessment (e.g., Goldman, Stein, & Guerry, 1983) can serve as a useful resource.

Children's Drawings

As previously discussed, I routinely invite children to complete several drawings during their assessment sessions. Because I am a social worker and not a psychologist, I do not "score" these drawings, as would a psychologist analyzing a Draw-A-Person test or a Kinetic Family Drawing. Whereas the psychologist examines the child's drawings and evaluates them with respect to the child's personality and developmental level, I follow the guidelines used by art therapists in using drawings in assessment and therapy (DiLeo, 1973; Oster & Gould, 1987, pp. 21–28, 41–43, 47–48; Malchiodi, 1998). Some of the elements to be noted in the child's drawings include the size and position of the figures, the absence or exaggeration of body parts, the use of color and shading, the nature of fa-

cial expressions, and the general mood of the drawing. In addition, the child's attitude in producing it (e.g., labored, rushed, perfectionistic, or self-critical) should be noted.

Family drawings can reveal a child's feelings about different family members. We can note who is drawn largest and which family members are closest to one another. Sometimes a child will tell a story about the drawing that can reveal significant family dynamics. It is important, however, *never* to make any assumptions about the family from only one drawing. The child's pictures are only a part of the overall assessment, and other corroborating information will always be necessary before making any conclusions.

Projective Questions

Commonly used by social workers and others in initial sessions with children, projective questions seek to elicit a child's feelings about his or her family and life. Examples of typical projective questions are as follows:

1. "If you had three wishes, what would you wish for?" (When a savvy child responds that he or she would want a thousand more wishes, the worker needs to specify that this will not be possible, and that the child must specify what he or she wants.)
2. "If a baby bird fell out of the nest, what might happen?" (The child is expected to complete the story.)
3. "If you were going on a rocket trip to the moon, and you could take only one person with you, who would you want to go?" (The child's response is expected to reveal the most important person in his or her life, but it may also reflect the child's judgment about who would be most helpful in this special situation.)

The child's responses to these and other projective questions should be explored by the worker in an unhurried, interested way. The child should be given the explicit message that there is no one "right" answer and that the worker is asking the questions in order to get to know the child better.

SUMMARIZING THE RELEVANT DATA

During the process of gathering information about a child and family, the worker continually weighs the significance of his or her findings and im-

mediately starts to generate hypotheses about what is wrong and how to help. This analysis, synthesis, and speculation constitute an ongoing process that continues *throughout the life of the case*. However, during the early evaluation of a case, most agencies expect the worker to formulate a biopsychosocial assessment summary in writing. According to Kadushin (1995), "Gathering data does not in itself yield an assessment. Data must be organized, interpreted, integrated with theory, and made meaningful to derive an assessment" (p. 63). The three tripartite assessment forms (Tables 4.4–4.6) will help the worker organize the data preparatory to formulating a summary statement regarding the significant features of the case.

Hepworth, Rooney, and Larsen (2002, pp. 198–216) recommend a multidimensional assessment to deal with the client's identified problems and concerns. I have prepared a retrospective assessment summary for Barbie Smith during the period of her enrollment in the First Place School program, with special attention to factors relevant to a *child* assessment. The categories of the assessment are as follows:

- The nature of the client's problems.
- The coping capacities of the client and significant others; assessing strengths and obstacles, risks and protective factors.
- The other persons or systems involved in the client's problems.
- The available or needed resources.
- The client's motivation to work on the problems.

A SAMPLE BIOPSYCHOSOCIAL ASSESSMENT SUMMARY: BARBIE SMITH

Date of birth: 6-6-82
Date of evaluation: 2-10-93 (hypothetical)
Age at time of evaluation: 10 years, 8 months

Reason for Referral

The family was referred to the First Place School, a special education program for children in transition, by the shelter in which they were currently residing. The mother was seeking schooling for Barbie, then in third grade. The family had moved seven times in 6 months and had been befriended and videotaped by a filmmaker, Kathryn Hunt, during this period. Ms. Hunt had also recommended this school program to Mrs. Smith.

Family Description

This female-headed household consists of a mother and three children, all born of different fathers. The mother has a history of imprisonment for the possession of firearms and methamphetamines, but she claims to have been "clean" since her release 3 years ago. She is estranged from her family of origin and has no contact with the children's fathers, one of whom is deceased and another of whom lives out of state (Barbie's father). The family receives public assistance and has been living in various shelters and welfare motels. They move because of inability to pay the rent and dissatisfaction with the neighborhood, which the mother describes as populated by addicts and pimps.

Family Composition

Lori (mother)	Age 34, unemployed (former bartender)
Donna (daughter)	Age 18, school dropout, in and out of home (living with boyfriend when away)
David (son)	Age 16, school dropout
Barbie (daughter)	Age 10, third grade

The Nature of the Client's and Family's Problems

This homeless family seems beset by one crisis after another. The mother, a former addict, appears to be highly motivated to help her younger daughter obtain schooling, but her ability to organize her life in a way that will achieve this goal is questionable. Although the mother is not seeking help for herself, she clearly plays a pivotal role in this child's ability to pursue a normal developmental course. Therefore, it is essential to engage and help the mother with her numerous problems. The mother's energies are totally absorbed in searching out places for the family to reside.

Mrs. Smith alludes (on the Hunt videotape) to serious problems with her family of origin. She herself has been abused, and although we know no details about this, she appears to have suffered emotional damage that requires attention. This mother is trying to the best of her ability to hold her family together, but she seems to be under great stress and may be at risk for depression and/or resumption of drug abuse.

Mrs. Smith, while professing "distrust of the system," nonetheless maintains an open attitude toward persons on the periphery, such as the

filmmaker and myself (by telephone). This suggests that despite her feelings of anger and hurt, she has not closed herself off completely and may be still reachable.

Barbie's problems are secondary to the situation of her family. Her delay in academic performance is understandable in view of her extremely erratic school attendance. If Barbie spends a consistent period of time in one school, we can better evaluate her true ability. With regard to the housing situation, Barbie's mother states that the girl sleeps with her lights on because of roaches and that she is beginning to have nightmares.

Coping Capacities of Client and Family: Assessing Strengths and Obstacles and Risks and Protective Factors

Both Barbie and her mother demonstrate an unusual ability to deal with the uncertainties of their lives. We lack in-depth information about how they deal with stress, but the video portrayal suggests both resignation and determination on Mrs. Smith's part. At one point, she questions whether she may have brought her difficulties upon herself—a statement that demonstrates some capacity for self-reflection, despite its exaggeration.

Neither Barbie nor her mother likes the uncertain quality of their life. Persons who live in a continual state of crisis are sometimes described as "borderline," but we have insufficient information on which to base this or any other diagnosis. However, the possibility of a mental disorder, in addition to a diagnosis of drug addiction, will need to be considered in evaluating Mrs. Smith's coping methods. She has a lot of strength, but she also seems to be under great stress.

Barbie's coping capacities are more difficult to determine. She is about 2 years behind her expected grade level, which probably has a negative impact on her self-esteem. After Barbie's first 2 months at First Place, her teacher wrote as follows:

> Barbie seems very defensive about her low skill level. She often seems angry and wants to control others. She may need counseling. *She really is a sweet little girl. She needs a lot of nurturing and patience.* (emphasis added)

Everything in the teacher's comments is understandable, in view of this child's life experience. Her lack of academic skills makes her anxious and defensive, and she responds with anger and an attempt to control others. So much of her own life has been beyond her control that she tries to exert whatever influence she can on others.

Despite Barbie's harsh past and present life, she still elicits positive feelings in adults, indicating a probability that she will be able to respond to a helping relationship.

Other Persons or Systems Involved in Client's and Family's Situation

A number of different agencies are involved with this family, but there is no evidence that they are in contact with one another to coordinate the case planning. The housing authority was instrumental in making Barbie's referral to the school. Mrs. Smith has ongoing contact with the public assistance agency and also with the corrections department, as she is on probation. Both of Barbie's siblings also have had special school affiliations, and her sister reports monthly to a medical clinic for chronic kidney and heart problems.

Barbie's school records have not yet been obtained. She has changed schools so often that the records have not kept up with her. This situation presents serious problems in terms of academic planning targeted to Barbie's specific needs.

Available or Needed Resources

1. The family's most pressing need at this time is for decent housing in a safe neighborhood. The housing should afford a quiet place for Barbie to do her homework and read.

2. Case management/coordination is essential to bring the various helping agencies into contact with one another. The school could appropriately assume this role, as Barbie's academic success will depend on various family circumstances, including her mother's ability to remain drug-free and supportive to her children.

3. Academic tutoring is needed for Barbie. This should follow a review of previous tests and completion of current tests to target Barbie's special needs.

4. Counseling is also indicated for Barbie. Ideally, this should occur on both an individual and a group basis. Barbie should benefit from individual counseling to deal with her feelings about her past traumatic experiences, such as being in foster care, the abuse she suffered from her father and while in foster care, and her father's apparent abandonment of her. Group therapy with other homeless children will serve the function of mutual support and self-esteem building. The group members can identify themselves as "survivors" and reinforce one another's positive coping strategies.

5. Job counseling and training are needed for Mrs. Smith. [Note: Suggestions about approaching Mrs. Smith on this matter were discussed in Chapter 3.]

6. Individual counseling is also indicated for Mrs. Smith. (The success of this will depend on the worker's establishing a positive relationship pertaining to a concrete service, such as putting Mrs. Smith in contact with a resource for housing or job training.) Mrs. Smith has many issues to work out, including her conflicted relationship with her family of origin, her problematic relationships with men, and her history of addiction and homelessness. It is important to highlight how hard Mrs. Smith is trying to keep her family together, as this is her strength and the key to motivating her. Basic trust in the helping relationship will build slowly.

7. Mrs. Smith should be encouraged to attend Narcotics Anonymous or other group counseling focused on addiction. In order to maintain her sobriety, Mrs. Smith needs to establish new friends and activities that are not drug-related.

8. Educational and/or occupational counseling may well be needed for Barbie's older siblings. We do not know enough about either one to suggest specifics, but as they appear on the Hunt videotape, neither seems to be headed toward a productive work career.

Client's and Family's Motivation to Work on Their Problems

Motivation is unknown at present. The problems as listed here are not recognized as such by Mrs. Smith or Barbie. The key to progress with the members of this family will be to engage them in a trusting relationship, based on Mrs. Smith's interest in providing schooling for Barbie and on keeping her family together. Barbie, as a 10-year-old girl, requires education and social opportunities with her peers. Acknowledgement of Barbie's needs and of how these are connected to the family's problems must occur within the context of a trusting helping relationship. Then contracting about how to work on the recognized needs can occur naturally. This will be discussed in the next chapter.

Note. This assessment is based on observations from the videotape (Hunt, 1992) and on reports of various individuals who had contact with the Smith family. It is *not* based on any play sessions with Barbie nor on firsthand contact with her or her family.

FEEDBACK/REVIEW WITH PARENTS AND OTHER PROFESSIONALS

Engaging the Parent(s) in the Feedback/Review Process

It is the responsibility of the person formulating the assessment to share it with a child's parent(s) and with other professionals involved in the case. In the case of Barbie Smith, I am assuming that the school social worker might have taken the initiative in engaging Mrs. Smith and in convening a case conference in order to involve all the concerned professionals in establishing mutually agreed-upon goals and a plan for collaboration.

Maintaining contact with Mrs. Smith would have been essential to engaging her, both for Barbie's education and for the potential overall benefits for the Smith family. The worker would have had to stress that "the educational *team*" planned to pay special attention to Barbie's situation because she was a new student and that the team would convene a meeting to make specific recommendations for Barbie. The worker would also have had to emphasize that the *parent's* input into this meeting would be very important and that he or she would thus need Mrs. Smith's help to prepare for the meeting.

Often parents are intimidated by child study meetings in which "professionals" use unfamiliar terminology in talking about *their* children. The worker would have had to emphasize that he or she would need to meet with Mrs. Smith several times to prepare for this meeting and might have suggested that Mrs. Smith ride the school bus to come to these special individual planning meetings. The purposes of the individual meetings with Barbie's mother would have been to establish a relationship with her, to learn more about Barbie's history, and to give Mrs. Smith a private review of the recommendations about her daughter prior to the case review meeting. The worker could have offered to record and summarize the various recommendations for Mrs. Smith after the meeting.

Releases for sharing of information among the numerous agencies involved with a family are routinely signed when a child enrolls in a special school program such as First Place. During the one or two individual meetings with a child's parent(s) prior to the case conference, the social worker emphasizes how important it is for all these separate people to cooperate on behalf of both the child and the family.

In the event that a parent does not keep the agreed-upon appointment with a social worker, a note should be sent home with the child

stating the worker's concern and repeating the necessity of the parent's input with respect to the upcoming meeting. The note should offer the prospect of a home visit if the parent is unable to come to the next scheduled meeting. Actually, a home visit is often very helpful because of the opportunity it affords the worker to see the environment in which the child is living.

The Case Conference

The case conference provides the opportunity for professionals involved in separate aspects of a case to meet in person to discuss the multidimensional elements of a given family's situation. In the case of the Smith family, had such a conference taken place, the probation officer and the housing authority worker might have put their heads together to resolve the prejudice Mrs. Smith faced in obtaining housing because of her history as a felon. Furthermore, the probation officer and the school social worker might have explored Mrs. Smith's employment prospects, with the possibility of recommending testing for her to ascertain her interests and abilities.

Once such a meeting has taken place, it is much easier to coordinate the case through ongoing telephone contact. The impact on Mrs. Smith if such a meeting had taken place can only be guessed, but it would, of necessity, have been self-affirming with regard to the time and care these numerous professional helpers would have devoted to helping her and her family.

CONCLUDING COMMENTS

Assessment is a complex and systematic process, requiring discipline, patience, the ability to apply a body of professional knowledge, and sensitivity to clients' strengths and their unique individual and cultural profiles. Depending on each situation, varying attention must be given to biological, psychological, and social factors that interact and merge into a particular situation of human need. The case of Barbie Smith emphasizes the social factors of homelessness and poverty, as these contributed to the psychological distress associated with family dysfunction, abuse, addiction, imprisonment, and school failure.

The purpose of assessment is to point to needs that require intervention. The next chapter deals with establishing goals that flow from the needs identified in the assessment. One aspect of Barbie's case about which more information was needed was the possibility that a learning

disability (biological factor) was interfering with her educational progress. Special testing could have provided details about this. I have noted that Barbie seemed to possess a resilient temperament, which had helped her cope with a non-nurturing environment. This strength, similar to her mother's, would have provided a basis for optimism about the prospects of moving beyond the assessment to a series of helping interventions that would have a positive impact on this family's future.

DISCUSSION QUESTIONS AND ROLE-PLAY EXERCISE

1. How can the worker deal with his or her negative feelings about parents who are overwhelmed with multiple problems and who seem oblivious to their children's needs?
2. Discuss the advantages and the disadvantages of using the DSM in assessing children. Consider the impact on Barbie Smith's family of employing this classification. How would you proceed in prioritizing the problem situations noted on Axis IV of Barbie's DSM diagnosis?
3. Examine the four drawings in this chapter (Figures 4.2–4.5). What elements in the children's drawings do you find of interest in terms of possibly conveying information about the children? After obtaining these drawings, what other play materials would you introduce?
4. Role-play a session with Mrs. Smith in which a worker attempts to engage her and prepare her for the case conference about Barbie.

❖ CHAPTER 5 ❖

Contracting, Planning Interventions, and Tracking Progress

Every case situation is different, yet human needs are very similar despite these individual differences. Maslow's hierarchy of needs remains as pertinent today as it was over 30 years ago, when he first maintained that we all have certain basic needs that must be met in order for us to reach our full potential as humans (Maslow, 1970). The first level of needs includes the fundamental necessities of life, such as food, water, and shelter, which assure our physiological survival. The second level of needs consists of safety considerations; the third is to feel loved and to belong; the fourth is the need for self-esteem. The culminating achievement of "self-actualization" occurs after the lower-level needs have been met and the individual realizes the fulfillment of his or her potential as a person.

CONTRACTING: ENGAGING CLIENTS AND IDENTIFYING THEIR NEEDS

According to Maslow's schema, Barbie Smith's life (see Chapters 3 and 4) was characterized by unmet needs on every level. Any helpers involved with the Smith family, however, would have had to consider carefully where to start and how to involve Mrs. Smith in the decision-making process. It certainly would have been contraindicated for other people, no matter how good their intentions, to "take over" and disempower Mrs. Smith in regard to decisions about her own family. In fact, any school social worker must understand that a pupil's mother is not a *client* but the parent of a student who may or may not welcome assistance with various family difficulties. For this reason I used the term "unintentional client" in Chapter 3 to refer to Mrs. Smith's uncertain status. The engage-

ment process of a mother like Mrs. Smith involves making an offer to help with matters other than her child's education. *A person becomes a client only after an offer to help has been made and accepted.*

Chapter 3 emphasized the importance of focusing on the client's perception of his or her needs, in order to suggest some strategies that could have been used to engage Mrs. Smith in job-related counseling for herself. The rationale for this relates to the mother's important role as an identification model for her daughter, Barbie. A commitment to help the family locate decent housing would have been equally important, and this would ideally have coincided with the effort to upgrade Mrs. Smith's employment prospects. Like the job training offer, the housing issue would have had to be couched in terms of *Barbie's* needs in order to capture Mrs. Smith's attention successfully. This mother's willingness to discuss her family problems and needs would have depended on repeated emphasis on the interconnection between the family circumstances and Barbie's learning situation. For example, if the school social worker had mentioned to Mrs. Smith the importance of Barbie's having a quiet place to do her homework, this topic would inevitably have brought up the issue of the family's poor housing and lack of privacy. Discussing the family's housing needs in the context of *Barbie's* academic requirements might have been more acceptable to Mrs. Smith than a direct offer of assistance, which she might have perceived as the worker's prejudgment that she was incompetent to take care of this matter herself.

It is not unusual for parents who live in ghetto or substandard environments, such as that in which the Smith family resided, to feel misunderstood by and alienated from middle-class helpers whose life experience differs drastically from theirs. Combrinck-Graham (1989, p. 235) points out that

> poverty is more than just a low income. Rather, it is an encompassing lifestyle of opportunism and survival . . . and a dangerous life. Poor families, when they ask for help, need acceptance of their situation, recognition of their efforts to make life livable, and assistance in identifying and connecting with any additional resources the sociopolitical system may have to offer them.

When the gap between worker and client appears too great, the client reacts to the perceived lack of empathy by missing appointments, which the worker may subsequently label "client resistance."

Engaging poor families in treatment makes special demands on the worker to understand the problem *from the clients' point of view*. This task

> requires that the clinician understand the *context* in which the problem is embedded . . . [and pay] attention to the concrete needs of the family,

> lest the reality of its world be invalidated and the therapist lose all credibility. Immediate intervention in this area is possibly the most powerful and most connecting engagement skill, regardless of the discipline of the clinician. (Parnell & Vanderkloot, 1989, p. 447; emphasis added)

It seems probable that Mrs. Smith would have responded positively to an offer to help Barbie through assisting her family to find better housing if the worker making such an offer had indicated respect for her and an understanding of how repeatedly frustrated she had been in her own efforts to accomplish this. Her criminal history as a felon made it difficult for this mother to obtain housing in the absence of a sponsor who would vouch for her dependability in paying the rent regularly. The help of Mrs. Smith's public assistance worker and probation officer (with Mrs. Smith's permission) could have been very valuable in working out some form of guaranteed direct-deposit rental system.

In this multiproblem family, as in others, environmental interventions such as seeking new housing are generally implemented in concert with other interventions. Hepworth, Rooney, and Larsen (2002, p. 219) point out that "problems, strengths, and resources encountered in direct social work practice result from interaction of intrapersonal, interpersonal, and environmental systems. Difficulties are rarely confined to one of these systems, for functional imbalance in one system typically contributes to imbalance in others."

Mrs. Smith's psychological status was not assessed, despite the many stresses to which she alluded on the video. We do not know whether individual counseling was recommended to her. As reported in Chapter 3, Mrs. Smith chose not to become involved in the various opportunities at the school, which might have addressed some of her own needs in a group format (such as a parenting support group).

Even more troubling was the fact that Mrs. Smith did not make it possible for Barbie to attend school on a consistent basis. Despite the availability of transportation, Barbie missed 15 out of the 31 school days during the 2 months she was enrolled in the First Place program. The family then obtained Section 8 housing, and Barbie transferred to a neighborhood school briefly before leaving for an extended stay with her father out of state.

Choi and Snyder (1999) mention that homelessness can exacerbate existing disorders and contribute to depression and anxiety, thereby making it more difficult for individuals to carry out normal daily functions. A consultant with many years of experience in the addictions field expressed great skepticism that Mrs. Smith would have remained drug-free during the time shown on the video, which was the period during which Barbie missed so many days of school. Many former addicts find

it formidable to get up in the morning and organize their lives. The consultant also commented that Mrs. Smith actually may have *needed* Barbie and her brother to help her with various daily living tasks. The tape showed Barbie and David preparing and serving their mother a simple meal and also assisting with the laundry. Of course, many children perform routine chores to help their parents, and we do not know for certain whether or not Mrs. Smith had returned to using drugs at this time. However, it is unfortunate that she was not sufficiently engaged by the school to avail herself of any of its potentially useful services for homeless families or to obtain a referral for counseling services outside the school.

I would like to consider, in retrospect, how the school personnel might have successfully engaged Mrs. Smith at the time of Barbie's first contact with them. I do not intend this to be critical of what was done or not done at the time but rather to use hindsight as a way to learn from experience, in order to highlight engagement methods that may be effective with other homeless and disenfranchised populations.

Mrs. Smith's request at the time of the school's initial contact with her was for schooling for Barbie. A wide-angle, ecological view of the child's situation would have challenged the helpers to broaden the mother's view of her daughter's needs to include the notion that helping Barbie would require that she simultaneously help *herself* and the rest of her family.

Successful contracting with Mrs. Smith, therefore, would have involved (1) starting with the mother's request for schooling (i.e., starting where the client was) and then (2) expanding this request to include housing, job training, and supportive counseling to help *all* family members cope with their past and current stresses. All of this would have had to be presented in a manner that recognized and validated Mrs. Smith's strong wish to be a good mother and to keep her family together. Thus, *successful contracting helps clients to want what they need*. It culminates in an oral agreement, which then becomes operationalized through putting specific goals in writing.

PLANNING INTERVENTIONS

The Unit of Attention

What would have been the appropriate focus of the Smith case? The people or their environment? The child (Barbie) or her family? A "person-in-environment" ecosystems perspective (Germain, 1973; Meyer, 1983; Davies, 1999; Hepworth, Rooney, & Larsen, 2002) encourages the worker

to consider all relevant dimensions of the case, including the degree of fit (or lack of fit) between the people and their environments.

Whenever a child is the reason for referral, involvement with the family is mandatory. However, the unique circumstances of each case determine the degree to which either the child or the family becomes the primary "unit of attention." In some situations, such as helping a child process and accept his or her placement or traumatic experience (see Chapters 10 and 14), work with the child is primary, and family counseling is secondary to helping the child. In other situations, work with the family is pivotal to understanding and helping the child. This is true, for example, in families in which divorce (Chapter 11) or a substance use disorder (Chapter 13) is a major factor. Still another method of work involves conjoint sessions with the child and family members. Many variations may also be appropriate, including alternating among individual child sessions, parent–child sessions, and full family sessions. The circumstances of each case determine who is seen and in which combinations, and these circumstances may vary over the lifespan of the case. The preferred model, presented frequently in this book, is one that integrates child and family therapy.

The worker must keep a wide-angle focus on both environmental considerations *and* the persons involved. In Chapter 1, a multisystems diagram of problem situations (Figure 1.1) depicts the interplay of reciprocal influences between the child and his or her physical and social environment. Specific factors, such as the child's temperament and coping style, can mediate and counteract detrimental conditions in an unsafe, nonsupportive environment; conversely, a fragile child with a very reactive temperament may respond poorly even in supportive environmental conditions. Therefore, we must always consider interactive factors—those pertaining to the "fit" between persons and their environment—in assessing problem situations and planning interventions.

Setting Goals and a Time Frame

The establishment of goals follows directly from the client's recognition that help is needed and from his or her agreement to focus with the worker on amelioration of the particular difficulties.

The goals may be outlined for individual family members and/or for the family as a unit, depending on the situation. Establishing a time frame for completion of certain goals or tasks increases motivation. Goals may be listed as "long term," requiring a protracted period of time (possibly 9–12 months) for their completion, or as "short term," with a designated target date for completion (possibly in 1 month). *It is essential for*

the client to participate in the setting of the goals and the time frame, and it is usually advisable to put these in writing.

Keeping Goals Manageable: A Sample Dialogue

A cardinal rule in setting goals is to draft them in a manner that promises achievable results. The worker wants the client to have an experience of success, no matter how small this may be. Furthermore, it is important not to overwhelm the client; therefore, it is essential to begin with a limited number of manageable goals, with the understanding that once success has been achieved with the initial list, others may be added.

The sample biopsychosocial assessment summary for Barbie, given in Chapter 4, lists eight "needed resources" for helping the Smith family. This comprehensive list could have been converted into specific goals during a planning session with Mrs. Smith and Barbie. It would have been important to begin with goals for Barbie that centered around her educational needs and to specify family or personal goals for Mrs. Smith that would also have an impact on Barbie. A dialogue for this hypothetical meeting follows.

WORKER: I know that you are both very eager to have Barbie get a good start and do as well as possible in her new school. We want to do whatever we can also, so the purpose of this meeting is to decide *together* how to help Barbie achieve up to her fullest potential.

MRS. SMITH: Unfortunately, Barbie is behind where she should be for her age. We've moved so much, and she's been in so many different schools. It's not her fault.

WORKER: Of course it isn't her fault. (*To Barbie*) There are other children in this school who don't have permanent homes and who have changed schools a lot. In fact, this school was designed exactly for kids like you, and we have some special ways to try to help.

BARBIE: Like what?

WORKER: Several different programs and activities that you will find out about as you go along. The first way is to try to find out just what you do know, so we can help you catch up, wherever you may need to. So I'm going to start a list of what the school will do, and what each of you can do. (*The worker divides a sheet of paper into three columns and heads the first column "The School," the second section "Barbie,"*

and the third section "Mrs. Smith.") Under "The School," I'm going to write "1. Academic tests" and "2. Special tutoring." Barbie will be given a special teacher, who will work individually with her to help her in whatever areas the tests show she needs help. How does that sound? [See Figure 5.1.]

BARBIE: Will I have a lot of homework?

WORKER: We don't expect you to get caught up the first week, or the first month! Yes, you will have homework, but it probably won't be more than an hour or, at most, two a day. (*To Mrs. Smith*) Would you be able to help Barbie figure out a quiet place and a time to do her homework?

MRS. SMITH: That's not so easy. We're in a one-bedroom motel, and the only table is where we all eat.

WORKER: Lots of kids do their homework on the kitchen table. The trick is to cut down on the distracting noise level, like from a TV. Do you think you could set aside a regular time each afternoon that would be "quiet time" for Barbie, and for you also, when there would be no TV and no distractions?

MRS. SMITH: That would be a miracle. But I'll try. Sometimes Barbie doesn't want to go to school when she doesn't do her homework or if she doesn't get it right.

Goal: To improve Barbie's school/academic performance

The School	Barbie	Mrs. Smith
1. Academic tests	1. Do homework at least 1 hour every day	1. Arrange 1 hour of quiet time every school afternoon
2. Special tutoring	2. Come to school every day	2. Be sure Barbie attends school every day
Signature: [Worker]	Signature: [Barbie]	Signature: [Mrs. Smith]
Date:	Date:	Date:

FIGURE 5.1. Goals contract. From *Social Work Practice with Children* (2nd ed.) by Nancy Boyd Webb. Copyright 2003 by The Guilford Press. Permission to photocopy this figure is granted to purchasers of this book for personal use only (see copyright page for details).

WORKER: In this school you don't always have to get it right, but you do have to try. So, Mrs. Smith, I'm writing this in your section: "1. Make a family rule for 1 hour of quiet time every afternoon, when there will be no TV and no noisy talk." The other thing is that you must be sure Barbie comes to school every day. She can't learn or catch up if she isn't here. So I'll write "2. Be sure Barbie comes to school every day."

Now we have to think about what to put in Barbie's section of this agreement. What do you think, Barbie?

BARBIE: I have to do my homework.

WORKER: Yes. You have to try. And your special teacher will help you. So I'll write this for you: "1. Do homework at least 1 hour each day." I also think you have to promise to come to school every day unless you are sick. I'm going to write that down as number 2. Actually, I think you'll like it here and *want* to come. We have some special groups for kids to get to know each other, and I'll see you tomorrow and tell you about those.

Sometimes the three of us will meet together, like today, and other times I'll meet alone with each of you. Let's make an appointment when we can all meet together again, so we can see how things are going with everybody's goals. I'd also like to set a separate appointment for Mrs. Smith to give me some background about Barbie.

Obviously, this would have been only the beginning of the contracting process. The next conjoint meeting (which ideally would have been scheduled within a week) would have provided an opportunity for reports of success in implementing the two goals of Barbie's regular school attendance and the homework routine. Later, separate individual meetings with Barbie and Mrs. Smith could have been used to introduce the offer of individual counseling, as well as support groups for each. Possible future long-range goals and short-term tasks for achieving these are outlined for Barbie and Mrs. Smith.

Barbie

Long-range: To improve school performance

Short-term tasks:

- Attend school regularly
- Complete 1 hour of homework daily
- Participate in academic tutoring

Long-range: To deal with her feelings about her family and their homelessness
Short-term tasks:

- Participate in group therapy with other homeless children
- Participate in weekly individual therapy to deal with past losses

Mrs. Smith
Long-range: To maintain sobriety
Short-term tasks

- Attend Narcotics Anonymous
- Establish new friendships and activities that are not drug-related

Long-range: To obtain job counseling and training
Short-term tasks

- Participate in vocational testing/counseling
- Select two or three possible career choices
- Examine newspapers regularly to check job availability

Long-range: To deal with her feelings about her past history of abuse
Short-term tasks

- To make a commitment to individual counseling
- To participate in group therapy with women who also have abuse histories

These goals are merely suggested and would need the agreement of the individuals involved to enhance their motivation to work on them. Both the process of participation in formulating goals and the experience of achieving success are very ego-enhancing and increase self-esteem. Success in achieving goals, in turn, enhances clients' motivation to work on additional, more challenging tasks.

Various Intervention Options

Let us consider the range of intervention options that might have been pursued with the Smith family, both within and outside the First Place program. Within the school setting, support groups exist both for children and for parents. In addition, individual counseling is available for children, and case management for families. The latter includes networking and coordination with shelter providers, as well as referrals and follow-up to other services (housing, mental health, etc.). A flyer describing the range

of services is given to each parent upon the child's admission, so this could have served as a nonthreatening way to review the available services with Mrs. Smith in a follow-up meeting. During this and subsequent sessions, the matter of the family's housing needs and Mrs. Smith's employment counseling or training could have been discussed, as could possible referrals for school or employment counseling for Barbie's siblings.

Individual counseling (therapy) for parents is *not* available through the school's professional staff, and therefore this very important referral for Mrs. Smith would have had to be made to an outside agency. Because this family was already involved with so many other outside agencies, it would have been understandable if Mrs. Smith were resistant to engaging with yet another person and place. Nonetheless, because help for Mrs. Smith would translate into potential help for her entire family, the matter of finding a counseling program for her that she could accept would have had to be pursued with utmost care and determination. It probably would have been best to make this referral after the relationship with Mrs. Smith was firmly established through provision of other needed services.

Individual counseling for children is available through the school and would have been a vital resource for Barbie. Her issues of past abuse and loss were probably continuing to create anxiety for her, and her family's ongoing lack of stability may well have made her vulnerable to loneliness, depression, and low self-esteem (Bassuk & Rubin, 1986; Choi & Snyder, 1999).

In addition to a relationship with a counselor or therapist, Barbie might have benefited from a mentoring relationship. The literature reports the important role of such relationships in contributing to resilience in high-risk youths (Rhodes, 1994). Barbie's life was lacking in role models other than her mother. She had no known female relatives (other than her sister) and had never been involved in the type of extracurricular activities, such as Girl Scouts or team sports, that would provide her with other models of adult females she might choose to emulate. Studies in Great Britain (Rutter, 1979, 1987) and Hawaii (Werner & Smith, 1982) found that children living in developmentally hazardous settings who sought support from nonparental adults had a lower risk of psychiatric disorders and were more resilient than children living in similar settings who did not seek such support. Anthony's work on "the invulnerable child" also confirms the significance of one positive relationship in the lives of children growing up in very hostile home and/or community environments (Anthony & Cohler, 1987).

Finally, because of her family's frequent moves, Barbie had never had the opportunity to establish friendships with peers. She may have lacked socialization skills and would probably have benefited from being in a

group with other children in similar circumstances. Issues discussed in these school-based groups include friendships, conflicts with classmates, loss of former friends and schools, and domestic violence. It is very supportive for children to learn through being in such a group that they are not the only ones who have difficulties such as these.

Teamwork within and between Agencies

Professional collaboration would have been the key to success in the Smith case, as the clients' motivation and ability to work on their own behalf might have been limited. This would probably have been a "labor-intensive" case, requiring a major input from staff members to maintain the clients' motivation. Within the school, it would have been essential for the special education teacher working with Barbie to be aware of the physical limitations of the child's home environment and to know about the agreed-upon contract for protected homework time. In addition, the regular classroom teacher would have needed to know about Barbie's history of extensive school changes, which may have interfered with the girl's ability to make friends and participate in social exchanges appropriate for a 10-year-old.

Regular pupil review conferences could also have alerted all staff members to significant developments in the family that might affect Barbie's ability to concentrate and learn. Examples of such developments might include Mrs. Smith's becoming involved with a new man or Mrs. Smith's arguing with Barbie's sister, Donna, over Donna's choice of boyfriend.

Parnell and Vanderkloot (1989) state that they cannot work with poor, multiproblem families without a team of professionals:

> For members of the team, the involvement of the other members spells relief from the recurrent crises, the chronic problems, and the many occasions when it is necessary to devote whole days to individual clients. Furthermore, the team members function as a support group to one another, and as the nucleus of a resource network. (p. 452)

This kind of collaboration is also necessary among staff members in different agencies who are working with a multiproblem family. Certainly it would have been within the purview of Mrs. Smith's probation worker to help arrange adequate housing. It would *not* seem appropriate for someone with a history of addiction and possession of drugs to be living in an environment populated by substance users. Similarly, it would seem inappropriate for someone like Mrs. Smith to obtain employment in a bar, where she would probably be thrown into contact with many alcohol-

addicted individuals. We do not know how much (if anything) Mrs. Smith's probation officer knew about her life at this time, but a case conference, coordinated by the school, would have provided the opportunity for *all* the professionals involved to meet with Mrs. Smith to share information and to coordinate planning on her behalf.

TRACKING PROGRESS AND TERMINATING

Tracking Progress

Once relationships have been established among the various professionals involved in a case, the process of keeping abreast of developments becomes easier. Ideally, the case conference establishes clear areas of responsibility, so that each member of the "team" knows his or her focus of duty, and no one person feels overburdened by attempting to work alone with *all* the various facets of the case. In the case of the Smiths, the school social worker might have become the case manager, with the understanding that new developments and the concerns of other agencies could be funneled through him or her. This might appear to be a major responsibility in and of itself, but if others shared the tasks of helping Mrs. Smith find permanent housing, job training, addiction counseling, and mental health counseling, then the school social worker would have been freed from becoming involved personally in each of these tasks. The school, after all, was the primary contact point for the child, and the other agencies (probation, social services, housing, mental health, etc.) could share the responsibility of trying to rehabilitate the Smiths and help point them toward a more productive life.

Of course, the danger of having so many different people involved with the Smiths would have been that the family could have become scattered and frustrated because of having too many people to relate to. They also might confuse the appropriate functions of each unless they were given direct guidance. Each professional could be clear in communicating his or her specific helping role to the family.

Case review conferences should be held periodically to track the progress of each case. The timing of such reviews should be determined during the original conference. Because of the rapidly changing elements in the Smith case, a plan for a review in 6 months might have been impractical, although in other case situations this is a reasonable period of time. Probably a once-a-month review would have been appropriate for this family.

The Smith family found Section 8 housing after Barbie had been at First Place School only 2 months. They moved, her records were trans-

ferred to a regular public school, and the case management role of the special school ceased to exist. In retrospect, a fallback plan to prevent the family's becoming "lost" would have helped keep both the helpers and this family on track.

Termination

The concept of "termination" is not applicable in dealing with young children whose development is in flux or with families that have serious and ongoing problems. What happens is that some families drop out of sight for a period of time and later come to the attention of other agencies, which may be unaware of previous efforts to help the family.

The word "termination" assumes that the difficulties presented at intake have been resolved and that there will be no further contacts. It certainly cannot guarantee that similar or different problems will not resurface at a later time. It is quite likely that a child who shows sufficient difficulties to come to the attention of a school social worker in third grade will again present problems in middle school, when physiological development creates stresses that make the individual less able to cope. The fact that a child has a confidential record related to the earlier difficulties may assist the counselor or social worker who meets this child for the first time at age 12. In my opinion, the availability of records offers great aid to professionals who enter a case after much work has already been done but about which the parent(s) may give an incomplete report.

UPDATE ON THE SMITH FAMILY: 1995

The following summary of what happened to the Smiths after the end of the *No Place Like Home* videotape (Hunt, 1992) is based on information from the filmmaker, Kathryn Hunt; on my telephone conversation with Mrs. Smith; and on various conversations with the First Place School personnel, who had signed releases from Mrs. Smith to share this information.

The end of the video announced that Barbie had been sent a one-way ticket and that she had gone to visit her father. Her mother told me that Barbie remained with her father for an extended time (almost a full school year), although the original plan had been for a summer visit only. When Barbie eventually returned to her mother, she told the filmmaker

that she had not gone to school during the previous year. However, the school records do indicate an out-of-state registration. The facts about this remain unclear.

During the summer following Barbie's stay with her father, I attempted to contact the family in order to obtain releases for the first edition of this book. The filmmaker had prepared Mrs. Smith for my call, and Mrs. Smith had indicated her willingness to give me her permission. I spoke to Barbie and David before finally reaching Mrs. Smith. My conversation with her took place the night before they were to be evicted from the apartment in which they had lived for more than a year following Barbie's transfer out of the special school program. Mrs. Smith gave me permission over the phone and indicated her willingness to sign releases, which I said I would send to Kathryn Hunt.

Following their eviction, it took 4 months for the personnel at the school and Ms. Hunt to locate the family. During this time, Mrs. Smith evidently had some trouble with the law and was imprisoned again briefly (I do not know any details). Because I continued to press the school to locate the family, they eventually did so, through the department of social services. I had assumed that if the Smiths were still in the same state, they would be receiving public assistance. The fact that Barbie was *not* enrolled in school (which had been verified) constituted grounds to report Mrs. Smith for neglect, and this information was conveyed to her through a note to her public assistance worker.

Mrs. Smith soon after reappeared at the special school program to enroll Barbie. Barbie remained there for a full 6-month period, during which time Mrs. Smith accepted a referral and involved herself in counseling provided by the mental health system. Barbie made considerable academic gains during this period, was tested, and was found *not* to have a learning disability. In other words, her considerable academic delays were attributable to her irregular school attendance. At this time Barbie was eligible to continue at that school program for 1 more year, after which she would be too old. However, the availability of this special school program for Barbie was contingent upon her family's continuing homeless status. Were she to transfer to a "regular" public middle school, it would be unlikely that there would be any special services to accommodate her special needs.

Barbie's sister, Donna, was once again living apart from Mrs. Smith and Barbie. She had had a baby and was living alone with her child, because the baby's father was in prison. Barbie's brother had also moved out, and his whereabouts were unknown. At the time of the 1995 update, Barbie had her own room in the motel where she resided with her mother.

UPDATE ON BARBIE: 2002

In connection with preparing the second edition of this book, I again contacted Kathryn Hunt to see if she had remained in touch with the Smith family during the past 6 years. She said that she had and that these contacts were reciprocal: Sometimes they would contact her, and other times she would telephone them. She gave me a brief overview and offered to call Mrs. Smith to see if she and Barbie would agree to talk with me. After Ms. Hunt notified me that the family would welcome my call, I telephoned and learned that Barbie had recently moved out of state with her boyfriend. Her mother expected to hear from her, and she said that she would pass along my message and ask Barbie if she could give me her telephone number.

At this writing I have spoken with Barbie twice, once soon after her move, when she was living temporarily with her boyfriend's cousins, and several months later, after the couple had moved to live with the boyfriend's parents. During this time the couple had married and were looking forward to the birth of a baby in a few months. The summary below has been reviewed and approved by Barbie and her husband, whom I will call Mike. Barbie told me that Mike was not comfortable with giving details about his baby for this book, and therefore I mainly focus on summarizing Barbie's life during the years of her adolescence.

After the previous update, when Barbie had returned to live with her mother and was attending First Place School again, the pattern of family instability and frequent changes of residence continued because of her mother's ongoing drug involvement and other periods of imprisonment. Barbie lived for a while with her sister in California, then for another period with her father in the Southwest. Some of this time was relatively stable for Barbie; she attended school and reconciled with her father. He had remarried, had a baby, and was not involved with drugs for about 6 years. In telling me about her father and this period of time, Barbie said, "Dad gave me rules about what I could and couldn't do. I realized that he loved me. I got to know him and I forgave him. He was kind to me and even let me call my mom from his house." Unfortunately, his ability to remain drug-free did not last, and he is now back in prison.

Barbie admitted that she also had been involved with drugs for about 9 years but stated that she has been clean for the last 2 and a half years. I thought that this could not be an accurate memory, because if she had been drug-free since she was 16, that would mean that she began experimenting when she was 7! I asked for clarification, and Barbie said that it

was, in fact, true. She credits her husband with helping her get off drugs. Now her only addiction is cigarette smoking.

I asked Barbie whether she remembered her experiences in foster care when she was little, and she said that she did, mentioning the names of her foster parents. When I questioned her about the counseling that her mother had mentioned to the school social worker, Barbie reported that the counselor had told her that everything she said would be confidential but that the counselor then repeated what Barbie had said to her mother and her mother's boyfriend. Barbie felt very betrayed by this, and I explained that counselors are obligated to report it if they believe that a child is being abused. I'm not sure if this was the case in this situation. Barbie felt that it was wrong for the counselor to tell her that she could trust her, then later betrayed this trust.

I also asked if Barbie remembered the First Place School, and she referred to the school social worker there by name. When I inquired whether she had been there long enough to make any friends, she recalled a Chinese boy and walking to the park to go swimming with her school class once a week.

Barbie was one credit short of being able to graduate with her class in Arizona, but she later obtained her GED. When she returned to live with her mother, she held different jobs in fast-food restaurants and in stores. She met her future husband when she was 16, and she said, "He's the best thing that ever happened to me." At another point in the conversation, she said that she is happier now than she has ever been in her life.

Currently Barbie maintains weekly telephone contact with both her sister and her mother. She confirmed that she never had any contact with grandparents or other relatives. However, she appears to be making a new life for herself in a new part of the country where she is involved with her husband's family. She is looking forward to the baby's birth.

CONCLUDING COMMENTS

Contracting assumes that a client has the motivation and ability to follow through with an agreed-upon plan. Sometimes a plan that seems logical and feasible on one day can become invalid when the client's circumstances change and the plan becomes unworkable. Therefore, the time frame of contracts with multiproblem clients and families should be short, and there should be frequent monitoring.

The case of Barbie Smith graphically illustrates the impact of homelessness on school attendance and child development. This population of children clearly requires special services such as those described here. However, the lack of follow-up after a family obtains housing and a child

leaves the program can have serious consequences if the child goes for protracted periods of time without schooling. This state of affairs needs more careful monitoring by public assistance programs that provide financial support to families. Computerization should permit tracking of homeless children's school attendance in order to insure that such children do not fall between the cracks.

DISCUSSION QUESTIONS

1. Discuss the ethical issue involved in trying to broaden a client's views of what he or she needs, as described in the beginning of this chapter. To what extent should the contract reflect the worker's vision about the client's potential for growth and change, and how does this conform to the principle of client self-determination?
2. What intervention(s) do you think would have been appropriate to encourage Barbie's more regular school attendance? If the school social worker suspected that Mrs. Smith had resumed drug use, how might this have been handled?
3. Consider the concepts of "risk" and "resilience" as they apply to Barbie Smith. Suggest some factors that may have contributed to her resilience. What do you predict for her future, and on what do you base your prediction?
4. Discuss the pros and cons of providing a *separate* school program for homeless children. How would you address the important issue of integrating children who have been in a separate program into a regular school program at a later date?

❖ PART III ❖

Different Methods of Helping Children

❖ CHAPTER 6 ❖

Working with the Family

Children and their families are interdependent. Therefore, when one member of a family system experiences difficulties, the stress reverberates to all members of the family. Although a child may be singled out as having a "problem," the practitioner must look beyond the individual and think about the meaning and significance of that problem to *all* the family members, in order to understand the problem's source and to determine how best to focus helping efforts.

TWO DISTINCT HELPING APPROACHES: CHILD-CENTERED AND FAMILY THERAPY

Practitioners with different theoretical orientations define problems differently. If the child's "problem" is viewed as inherent in the *child*, individual play therapy is usually recommended as the treatment of choice, with adjunctive counseling for the parents or family. Alternatively, if the child's problem is considered as reactive to dysfunctional *family* interactions, then the assumption follows that the child's difficulty will resolve itself when the family's communication improves. These two polar views mirror the distinctive historical roots and different philosophical underpinnings of practice in the fields of child and family therapy. The manners in which practitioners with different theoretical orientations define the problem lead to very different helping methods.

Systems Thinking and the Exclusion of Children from Family Therapy

Believing that the *real* problem is a troubled marriage and/or dysfunctional family communication, many family therapists work diligently in the first few sessions "to redefine the problem as systemic, rather than

that of the individual child" (Wachtel, 1994, p. 2). The family is regarded *as* the patient rather than as the family *of* the patient (Bloch & LaPerriere, 1973). This focus on the family unit has resulted in a neglect of children within many approaches to family therapy. Indeed, in their zeal to remove children from the position of "symptom bearers," many family therapists have gone to the extreme of eliminating young, nonverbal children altogether from their therapy sessions (Chasin & White, 1989). Of course, sometimes a child's dysfunction *is* in fact reactive to parental conflict, and then the focus should properly be on the marriage and not on the child. At other times, however, when children have bona fide troubles (e.g., their own identity issues, peer and school problems, or intrinsic conditions such as physical or learning disabilities), they need and deserve one-to-one work to help them. The danger in the family systems approach is that it may ignore children's needs as individuals. Treating the child *only* as a "pawn in the game-playing between adults" (McDermott & Char, 1974, p. 425) is not only adult-oriented but also simplistic and neglectful of children's rights.

The Exclusion of Parents from Child Therapy

In contrast, some therapists who espouse the "child-centered" approach exclude parents from the playroom and do not believe that work with parents is essential for successful child therapy (Axline, 1947; Landreth, 1991). Because of a different perspective about how to help, many of these therapists consider the relationship between the child and the therapist to be so growth-enhancing and healing that the present, here-and-now therapeutic relationship supersedes the impact of the child's past history and other relationships. Similar to the traditional child psychiatry model, child-centered therapy focuses on treatment of the identified child patient, with minimal contact with the parents.

A famous child-centered therapy case that excluded the parents is described by Virginia Axline (1964) in her book *Dibs: In Search of Self.* Every time I use this case for teaching purposes, I am in awe of Axline's work: She managed to develop a trusting relationship with a mute, oppositional 5-year-old child, whom parents and teachers were beginning to consider mentally retarded. Axline helped Dibs reveal his exceptional potential as a person in weekly sessions over an 18-month period, without any regular involvement of the child's parents.

Nevertheless, despite the remarkably successful outcome of this case, I am troubled by any approach that appears to elevate the *practitioner's* relationship with the child to a more important position than the parent–child relationship. It is true that the outcome for Dibs was very positive

and that his mother became more responsive to him and to the therapist once the boy's behavior began to change. But his therapy took a fairly long time to achieve and would probably have been infeasible within a modern-day managed care system. Even more troubling, from a theoretical standpoint, was Axline's willingness to permit Dibs's mother to distance herself from her child, whereas Axline as the "expert" made him "better." The therapist thus inadvertently reinforced the mother's feelings of incompetence, as well as of contempt for her child's problems. A family therapist working with this case would have tried to validate the mother's essential role in her child's future life and thereby helped to make an inadequate mother take some credit for her son's spectacular change from a mute, oppositional 5-year-old to a responsive, charming 7-year-old.

AN INTEGRATED CHILD AND FAMILY MODEL

Not all practitioners who work with children subscribe exclusively to either a child-centered or a family-centered approach. As far back as the 1960s, Guerney (1964) developed a form of parent–child therapy called "filial therapy," which has since been renamed "child relationship enhancement therapy." It is based on teaching parents to become empathic and accepting of their child in a manner similar to the role of a play therapist (Guerney, 1964; Guerney & Guerney, 1994).

During the 1990s, other practitioners began to blend individual and family approaches. For example, Wachtel (1994) employed an integrated "child-in-family approach," and O'Connor (1991) proposed an ecosystemic model. Other books on the topic of family play therapy (Gil, 1994; Schaefer & Carey, 1994) provided many useful examples of successful integration of child and family therapy. Gil stated (1994, p. 33) that "the integration of play with family therapy strengthens both therapeutic approaches."

In my own work, and in the various examples presented in this book, I try to employ whatever helping method seems to make sense for a particular child and family, rather than rigidly following either a child-centered or a family-centered approach because of allegiance to a particular method of working. A quote from an article that was first published almost 40 years ago expresses my own ideal of practice:

> It is true that treatment of only the parents (McNamara, 1963), the entire family (Bell, 1961), or only the child (Blanchard, 1946) may produce beneficial results. There is no good theoretical reason why one particular approach should be used on all problems. . . . *Effective treatment should*

> *be designed for whatever problems are recognized and should involve family members in ways that will ameliorate those problems.* (Straughan, 1964/1994, p. 99; emphasis added)

DIFFERENT LEVELS OF FAMILY INVOLVEMENT

As I emphasize in this book and demonstrate in various examples, work with children *always* includes some sort of work with their parents when they are living and available. Whether siblings are seen depends on the nature of the presenting problem and on conflicts in relationships that become evident in the course of the work. For example, in a previous publication (Webb, 1993, 2002a), I have included several cases involving sibling and family work following deaths and parental separation.

Sometimes it is appropriate for a babysitter or a member of the extended family (e.g., a grandmother) to be included in sessions with the child. Often I see the entire family together for one or more sessions in order to assess the nature of the family members' interactions and to involve them in thinking about how they might get along better. I refer to myself as a "child and family social worker," thereby indicating to the family my ability to work flexibly with the various family members in different combinations, as well as in a unit.

Parent Counseling/Guidance

When a child is being seen on a weekly basis, I like to confer with the parents in "counseling/guidance sessions" on a monthly basis. The main purpose of these parent meetings is to give and receive feedback about the child's progress. The meetings also offer the worker the opportunity to ask questions about matters the child may have raised, to reinforce a parent's positive efforts with the child, and to support the parent in his or her continuing frustrations.

The issue of confidentiality always comes up in family work. Because of my belief that it is important to foster parent–child communication and to convey the sense that the parent(s), child, and practitioner are all working *together* to try to alleviate the problem situation, I do not want to overvalue the importance of a child's relationship with me and leave a parent feeling like an outsider. Therefore, I share my impressions about the child openly with the parent, and, without quoting the child verbatim, I give the parent a sense of the nature of the child's participation in his or her sessions with me. Because this is a two-way street, I also share with the child, discreetly and appropriately, concerns that the parent may

have brought to my attention. Sometimes the parent meeting indicates the need for a family session, which I then schedule, after clarifying with the child the potential positive outcome from such a meeting.

Practitioners in agency practice sometimes encounter parents who are reluctant to come to parent or family meetings. These parents may not be aware that their child has a problem, or they may prefer to let the school or someone else handle it. Often, such parents may be burdened by work and home responsibilities and worries; they may view their child's difficulty with anger and may resent that yet another demand is now being placed on their time. Practitioners, in turn, sometimes become resentful when parents are unwilling to put the necessary effort into trying to help their own children. *It is the professional's responsibility to reach out and make the extra effort to connect with parents who are resistant to becoming involved.* Often, doing this requires stretching one's empathic sensitivity, to try to understand and feel what a particular mother's or father's life must be like. Offering to make a home visit may have a positive effect, as may trying to schedule an appointment in a restaurant near a parent's workplace during his or her lunch hour. A practitioner who sincerely believes in the importance of parents' involvement and backs up this conviction with both words and action has a better chance of engaging parents.

Parent–Child Sessions

It is appropriate to see a child together with a parent under certain circumstances. First, there may be no choice if the child has separation problems of such severity that he or she cannot tolerate being separated from the parent (usually the mother). Second, it is essential to have the parent present during at least part of the session when a behavior modification program has been set up; the therapist will need to encourage the parent to praise the child for gains or to discuss with both the child and parent certain alterations in the program if the child is not achieving success with it. The use of parent–child sessions in connection with a behavior modification program is described in greater detail later in this chapter (see the case of Tim).

When a child is experiencing separation anxiety, as in the case of Tammy (Chapter 7), the issue becomes one of helping mother and child learn to separate from each other. The session itself serves as a training opportunity. It is advisable for the practitioner to have a separate session or a telephone conference with the mother before the joint session to coach her in an overall plan for gradual separation and increase her willingness to carry out the plan. Depending on the child's tolerance level and

other possible contributing factors (such as the mother's own need to keep the child close), a plan can be established for the mother to sit in the doorway of the playroom, watching but not playing actively with the child. When the child appears to have established an adequate level of comfort with the practitioner, the practitioner will suggest to the mother that she take a look at an interesting article in a magazine in the waiting room. The mother should then leave without a big goodbye scene, which might raise the child's anxiety again. This planned leavetaking may need to be repeated several times before the child can eventually begin the session in the playroom without the mother. This protocol for gradual separation can also be applied to a day care or nursery school situation in which the child cannot tolerate separation from the mother and, with modification, to bedtime separation problems.

Sessions with Siblings

Sessions with siblings may be appropriate in cases in which the nature of the presenting problem constitutes a shared family experience—for example, the death of a relative or an upcoming parental divorce (Webb, 1993, 2002a). Such sessions may also be useful when the practitioner becomes aware of intensive sibling conflict in the course of working with one child in the family.

Other children in a family *always* have some reaction to the fact that one of their siblings is in therapy. When the family considers the necessity for treatment as a weakness on the treated child's part, the sibling who is not in treatment may feel superior to the brother or sister who needs individual help. However, sometimes certain privileges accompany therapy, such as additional attention from the parents or a dinosaur sticker or a food treat from the therapist at the end of a session. This can make the treated child appear to be the recipient of special "goodies" that are not accorded to other siblings in the family.

I try to alert parents to this possible source of strain and suggest that they use the situation to emphasize that each brother and sister is different and that the siblings will all have different positive and negative experiences in their lives. This discussion can prove to be a window into how each child is perceived in the family, as well as how the child in treatment views himself or herself in comparison with the other children.

When siblings are seen together, it is important to model this respect for individual difference as a principle of interaction. Certain guidelines and rules need to be made explicit, just as in group or family sessions (see Table 6.1, later in this chapter). I have found it especially important with siblings to establish the ground rule that differences or arguments that emerge dur-

ing the session must not continue when the siblings leave the office. They may repeat positive things about one another, but not negatives.

It is sometimes necessary to separate siblings when they are arguing and unable to take turns speaking and listening to one another. This happened in the case of the Martini sisters, ages 8 and 10 (Webb, 1993, 2002a), whose anger toward each other became excessive and out of control following the closely timed proximity of their parents' separation and their uncle/godfather's death. Unable to express their rage at their grieving parents, they took it out on each other. When I attempted to see them together, the sessions were dominated by arguments, name-calling, destructive putdowns, and some tears of frustration.

Realizing that the joint work was becoming counterproductive, I began splitting the sessions and seeing each girl individually. Prior to doing so, I told the girls that I could see how angry they both were and that they had a right to feel angry, but that I could not let them take their feelings out on each other. I also advised each parent to echo this principle and to separate the girls physically when they fought at home. In individual sessions, one girl drew a frightening werewolf with his teeth bared, and the other pounded, poked, and aggressively rolled out various lumps of clay. After several months of these split sessions, during which each girl was permitted to express her angry feelings symbolically through play, the parents reported noticeably reduced fighting at home, and I was able to resume some conjoint sessions with them.

Sessions with the Entire Family

The purpose of seeing the entire family together is twofold: (1) to see firsthand how family members relate to one another and (2) to help the family find and use more positive and gratifying ways of relating.

Seeing the Parents First

Whole-family sessions provide wonderful opportunities to observe family members' interactions, but they also can seem very intimidating to the practitioner, who may feel outnumbered and quite uncomfortable in the role of outsider. Hepworth and Larsen (1993) recognize that work with the entire family requires advanced skills; they suggest that students and practitioners with little experience in family work begin by seeing the parents without the children. This permits the practitioner to become familiar with the overall problem situation and to begin establishing an alliance with the parents prior to introducing the children into sessions at a later date.

In Chapter 4, I described three reasons for seeing parents alone before seeing children: (1) establishing the alliance, (2) obtaining the developmental history, and (3) preparing a parent to prepare a child for the first session. Wachtel (1994) notes another interesting and important advantage of seeing the parents alone first. Wachtel points out that many parents who come for help in regard to their children's problems have developed some feelings of resentment toward the children, because, in essence, their problems appear to expose the parents as "failures." Parents need to "unload" these negative feelings, including their fears that there is something drastically *wrong* with their children. Obviously, it would be contraindicated for them to do this in the child's presence. Therefore, the cathartic value of having the practitioner listen and respond appropriately to the *parents'* concerns helps strengthen the alliance with them and also permits the practitioner to offer hope and therapeutic optimism that the situation can improve in time.

The "Joining" Process

When the practitioner meets the entire family together for the first time, it is essential that he or she find ways to "join" (Minuchin, 1974) with the family. "Joining" refers to efforts on the practitioner's part to become accepted and "to establish an alliance with the family as a whole, with the key subsystems, and with each individual" (Chasin & White, 1989, p. 17). It is the process through which the practitioner moves from being an outsider to being an insider. This process relies on the practitioner's individual personality and style, as well as on his or her ability to establish enough of a feeling of comfort and connection with various family members that they will be able to tolerate having a stranger know about aspects of their lives not usually revealed to public scrutiny. Different authors suggest different techniques for joining, including small talk, mimicking the family's affect and style (Hepworth & Larsen, 1993), and commenting on a child's clothing, jewelry, or hairstyle (Chasin & White, 1989).

Setting Ground Rules for Family Sessions

Regardless of the particular subject of a "joining" conversation, the family session usually soon moves toward dealing with the important matters that are causing concern. Because the family has its own characteristic method of communicating (which may well include members' interrupting, shouting, and insulting one another), it is incumbent upon the practitioner to set ground rules early in the first session, in order to establish this meeting as different from interactions that occur in the family living

room or kitchen. Sometimes, in the middle of a shouting match, I have found it effective to stand up and offer to leave the room, stating that the family members obviously do not need me to carry on their battles. I point out that if they continue to fight in my office the same way they do at home, then they are wasting their money and all of our time. This statement can be a prelude to establishing a rule that only one person speaks at a time and that family members may disagree with one another but may not insult other persons or put them down because they have different opinions. Setting such ground rules as these in the first session establishes a climate of safety that models respect for the rights of different individuals to express themselves without being heckled. Table 6.1 lists some suggested ground rules and guidelines for family sessions.

Some Practical Suggestions for Working with the Entire Family

When the worker has had a preliminary meeting with the parents prior to the first session with the entire family, he or she will have a sense of the parents' personalities, as well as some background information about the various family members. Depending on the nature of the problem and the ages of the children, the practitioner should prepare to have toys or activities that are age-appropriate and that will permit the family to interact nonverbally through play, as well as verbally. During the preliminary meeting with the parents, I tell them that we cannot expect their children to sit and talk during the entire family meeting, so I will have some toys and activities that will make it easier for the children. I also tell the parents that I may ask them to participate in playing with their children. I make it clear that, although I will be responsible for providing some play materials, I expect them, as the parents, to remain in charge of their children's behavior. In other words, if the children start whining and arguing, I want them to handle it as they would at home.

TABLE 6.1. Ground Rules and Guidelines for Family Session

Only *one* person talks at a time.
No insults, cursing, or putdowns.
Disagreements and arguments are not to be continued outside the office.
Children deserve the same respect as do adults.
Everyone has the right to "pass" (i.e., not to answer or speak).
Parents are in charge of setting limits for children.

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Some suggested items for family session activities include paper and markers, puppets, clay, blocks, and selected board and card games. It is important, however, to avoid overstimulating the children through exposure to numerous toys. Because the purpose of the family session is to learn how the family interacts, it is appropriate for the practitioner to take a directive stance—suggesting, for example, that the children draw a picture of their family doing something (i.e., Kinetic Family Drawing; Burns & Kaufman, 1970, 1972). Alternatively, the family may be asked to act out through puppet play something upsetting that happened in the family. The point is that the family session is not a "free-play" period; it is a time for understanding and discovering new ways of family interaction. The toys and play activities are used to facilitate this understanding.

Cultural Considerations

In some cultures, children are expected to be "seen but not heard." This view may present a strain between the practitioner's desire to permit the children to "have a voice" and the more traditional belief that "adults know best." For example, in the videotape *Tres Madres*, the family therapist Harry Aponte (1990) conducted a family session with three generations of family members, including the 7-year-old girl who was the "identified patient." The child was rarely invited to participate in the adult conversation, and the tape showed her yawning and looking bored. Aponte clearly viewed the child's problem of sleepwalking as incidental to the girl's mother's unhappiness and inability to function appropriately as a mother. Although this dynamic may indeed have been crucial to understanding the case, I question the need to have the child present during this discussion when she had no part in it. A play therapist, sensitive to the *child's* needs as well as to the mother's, would have provided paper and markers and suggested that the child draw pictures of her bedroom, of where her mother lived and where she lived, and of how she would like to have her family live. The conclusion that the child's symptom was related to the lack of a strong maternal presence could have also been deduced from a discussion centered on the child's drawings. The difference is that one approach meaningfully includes the child and the other ignores her. When I have presented this example and viewpoint at workshops, however, some participants have responded that both Aponte and this Hispanic family might have been uncomfortable, for cultural reasons, in giving so much attention to a young child (see Zayas, Canino, & Suarez, 2001, for a discussion of parent–child relationships in mainland Puerto Rican families).

In my own practice with families of different ethnic backgrounds, I have learned to explore the parents' views about child involvement be-

fore including children in an entire family session. Some parents accept my offer to help them try a different way of relating to their children through play. However, this may be too difficult for others to attempt; in these cases I try to adapt my work to the reality of the clients' beliefs even when I may disagree with them.

What to Look For in Family Sessions

After a session with the entire family, the practitioner should try to answer the following questions:

1. Who seems to be the dominant parent? Do the children seem to accept parental rules, or do they try to split the parents by encouraging them to disagree?
2. Do parents share in the discipline, or is one or the other targeted for this role?
3. Which parent appears to set the limits for the children? Do the parents seem to agree, or is one more permissive and one more strict?
4. To whom do the children turn for affection and comfort?
5. Are any alliances between the children apparent? How is the symptomatic child treated by the other family members?
6. How does the symptomatic child relate to each parent? Does each of them respond differently to him or her?
7. How would the situation have to change in order for the family to feel better?

In a feedback session later with the parents, the practitioner will solicit the parents' reactions to the family session and also share some of his or her own impressions. This discussion can result in some important decisions about goals. Another family meeting would be scheduled after a period of time during which the parents will have tried to implement changes.

A Note of Clarification

As is evident in the preceding discussion, my view of "working with the family" is not the same as "family therapy" in the sense of seeking to change the family's roles and structure (Minuchin, 1974; Minuchin & Fishman, 1981). Rather, the integrated child and family approach presented in this book focuses on communication patterns and interactions among family members, in order to help them deal with the presenting problem in a manner that puts them in control of their own behavior. This systems view recognizes that when one person in a family has pain (which

may show up in symptoms), all family members feel the pain in some way (Satir, 1983). This integrated child and family approach is similar to Satir's (1983) "growth model" of family therapy in its focus on clear communication among family members, which in turn promotes enhanced self-worth in each individual adult and child family member.

ETHICAL CHALLENGES IN FAMILY WORK

Because of its complexity, work with families places extra demands on practitioners, who must strive to be fair, objective, and self-aware in the midst of very intense emotional interactions. The goal of maintaining professional neutrality may be especially difficult when the lives of young children are at stake and the impulse to "rescue" them is ignited in the worker. Often individuals enter the helping professions because of their sincere, altruistic motivation to help people, such as children, who for various reasons cannot help themselves. What is the danger, then, in wanting to "rescue" children? From whom or what are they being rescued? And what will become of them after the rescue?

There is a significant difference between helping and rescuing, because the implication in "rescue" is that the individual is being removed from a dangerous situation. In my opinion, a "child-rescuing" mentality serves to establish a barrier, rather than a bond, between a practitioner and a parent. When the worker becomes judgmental toward the parent, his or her ability to work effectively with the parent is greatly reduced, and ultimately the child suffers.

Work with children requires the ability to relate to children's parents. This relationship, however, inevitably stimulates memories and overtones from a practitioner's own family of origin. In supervising child therapists, and in my own work, I have often traced a lack of empathy or other therapeutic impasses to experiences in the practitioner's own family of origin or present family (Webb, 1989). "Countertransference can be triggered by identification with one of the clients, the family, the style of communication, and similar events in the therapist's life" (Miller, 1994, p. 16). Therefore, it is incumbent on practitioners working with families to be self-aware and to receive regular supervision or consultation to help them recognize areas of possible identification with the families with which they are working.

Efforts to help children without attention to helping their families are shortsighted and will have limited impact. Admittedly, the work in trying to empower a family to help itself may seem more formidable than that of spending time individually with a child. However, more attention must be focused on this essential larger task if we are truly to integrate child and family helping.

Confidentiality is another thorny issue that frequently comes up in the context of family work. I have noted in Chapter 2 that children really do not have the legal right to confidentiality with respect to their parents, whose status affords them power to demand that a child reveal certain matters or who may require that a child's medical (counseling) records be revealed to them. When these matters come under dispute, the court may appoint a guardian *ad litem* to represent the child's best interests, but even then the child's position may be ambiguous and conflicted if he or she is caught between the demands of two hostile parents in a divorce proceeding. This situation is discussed more fully in Chapter 11.

Consistently in this book, I present the position that confidentiality between parent and child is neither feasible nor in the child's best interests. I argue for open communication between parent and child for the purpose of increasing their understanding of each other's needs and feelings. When the child and parent treat each other with respect, confidentiality will not be a concern. Practitioners must consistently help families work toward this goal.

WORKING WITH CHILDREN WITH ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER AND THEIR PARENTS

A diagnosis of attention-deficit/hyperactivity disorder (ADHD) usually follows some years of the parents' increasing awareness and growing concern because their child is difficult to manage, has a very high energy level, and is very distractible. This disorder is more common in boys than in girls and is found in approximately 2–5% of children (Garfinkel, 2000). The onset of the hyperactive behaviors usually occurs before the age of 3, but many children do not come to professional attention until they start school and cannot meet the additional demands placed on them in that setting.

The Nature of ADHD

ADHD is a biologically or constitutionally based disability of unclear etiology, although there is some evidence that genetic factors contribute to it (Barker, 1995; Bernier & Siegel, 1994). According to the American Psychiatric Association (2000), the characteristics of children with ADHD may include two different groups of behavior. These are (1) *symptoms of inattention* (e.g., easy distractibility, forgetfulness, lack of follow-through, difficulty organizing tasks and activities, and making careless mistakes) and/or (2) *symptoms of hyperactivity–impulsivity* (e.g., fidgeting, excessive

talking, seemingly "motor-driven" activity, interrupting others, blurting out answers, and difficulty taking turns). A formal diagnosis of ADHD requires at least 6 out of 9 possible behavioral characteristics in one of these two subgroups (or 12 out of the total of 18 in both) "that have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level" (American Psychiatric Association, 2000, p. 92).

Social workers who want to recommend a reference for parents can suggest Russell Barkley's *Taking Charge of ADHD: The Complete, Authoritative Guide for Parents* (2000). Barkley also has written several books on this topic that would be helpful for practitioners who want to learn more about this topic (Barkley, 1997, 1998).

Polombo (2002, pp. 143–144) describes the situation as follows:

> the profile of an individual child's neuropsychological strengths and weaknesses is analogous to the topography of a landscape. For some children the terrain is fairly flat; that is, their competencies are evenly distributed. Other children's profiles look like a terrain filled with prominent peaks. These children are gifted in multiple areas. Yet the valleys between the ridges indicate that their gifts are rarely uniformly distributed across the entire terrain. Gifted children may also have learning disorders (Vail, 1989). For children with learning disorders the terrain is highly variable. There are peaks and valleys that are notable for the contrast they present. The valleys between the peaks are much deeper than one would expect, indicating a great disparity between the areas of strength and those of weakness.

Obviously these differences create great uncertainly for parents and for teachers who find it difficult to understand and accept how a child's behavior can vary so greatly.

Interventions

Bernier and Siegel (1994, p. 143) report that a multimodal approach is most effective in helping children with ADHD and their families. Specific interventions include psychostimulant medication, usually methylphenidate (Ritalin); behavior management skills training for the children's parents and teachers; cognitive, supportive, and play therapy to enable the children to develop self-esteem; and supportive counseling for parents. Several of these methods were employed in the case of Tim (see the next section).

Dane (1990) points out that effective work with parents of children with learning disabilities requires that the social worker understand what

such a disability means to a family. "Only by understanding the specific limitations of the individual child and the child's behavior within the context of its fit within the family and cultural group can the social worker begin to design appropriate strategies for intervention" (Dane, 1990, pp. 137–138). Certainly this statement also applies to work with ADHD children and their families. The tripartite assessment (see Chapter 4) assists the social worker in pinpointing the particular meaning of the child's disability in a given family.

Among various interventions recommended by Dane (1990, pp. 139–140) as helpful for families of children with learning disabilities are the following:

- Educating parents about the special developmental needs of their children (e.g., offering more stimulation and attention to areas in which their children may need extra practice).
- Helping parents anticipate the critical stages of their children's maturational process (e.g., advocating to promote their children's special needs with each new teacher or recreational group leader).
- Assisting parents and their children to determine when it is appropriate for parents to intervene and when the children can be encouraged to advocate for themselves (e.g., moderating parental protective behavior toward the children).

Family Considerations

The impact of living with a "hyped-up" child with many distractible and agitated behaviors cannot be minimized. Children with ADHD do not slow down, and even when watching TV they may bounce on the couch, poke or tickle a sibling, and/or laugh raucously and fall on the floor. Bernier and Siegel (1994, p. 146) state that "the child's noncompliant, disruptive behavior contributes to chronic stress in parents, which in turn produces unproductive parenting behaviors that exacerbate the ADHD symptoms." The cycle of negative parent–child interactions that often characterizes a family with a child who has ADHD results in fewer gratifications in the parental role and reduced parental self-esteem. These factors in turn sometimes precipitate or aggravate parental problems, such as depression (Bernier & Siegel, 1994). A focus on the parents and the family system, therefore, is essential when working with a child with ADHD. If the practitioner can effectively support the parents, this may help to prevent a negative cycle of behaviors that could become worse as the child gets older (Hallowell & Ratey, 1994). The case discussion that follows illustrates some behavioral approaches in work with a 7-year-old boy with ADHD and his family.

THE CASE OF TIM, AGE 7

Family Information

Mother	Kathy Marino, age 35, nursery school teacher.
Father	Tony Marino, age 37, music store owner. Plays in band several nights a week and on weekends.
Sister	Chris, age 3, attends nursery school (but not in Mrs. Marino's class).
Child client	Tim, age 7, second grade; plays hockey and soccer. ADHD diagnosed at end of first grade.
Paternal grandparents	In 60s, babysit two or three times per month.
Maternal grandparents	In 60s, live out of state.
Maternal uncle	Age 38, lives out of state; had ADHD.
Son of uncle	Age 10, has ADHD; on Ritalin.

The Marinos are a white family of Italian descent; they are Catholics.

Presenting Problem

The parents sought help in connection with Tim's recent diagnosis of ADHD. The school had wanted to retain Tim at the end of first grade, and the parents, who disagreed, had had Tim tested and put on Ritalin, and they were concerned about how to handle this situation with him. The mother also wanted guidance as to how to manage Tim's difficult behavior at home.

Assessment and Plan for Intervention

I saw the parents for an initial meeting, followed by three play assessment sessions with Tim. I requested and received the report from the psychologist, who stated that Tim's "principal dysfunction appears to be in the inattention component, somewhat less in the impulsive component, and even less in the hyperactive factor." (The hyperactive and impulsive components are now combined into one symptom group in DSM-IV-TR). The psychologist recommended Ritalin, tutorial assistance, parent counseling, and cognitive-behavioral therapy for Tim.

My evaluation, which I shared with the parents in the feedback session, was that I found Tim to be a charming, very likable child who demonstrated in the sessions with me many of the characteristics of ADHD that would probably cause him difficulty in school. Specifically, I was concerned about the rushed, slapdash manner in which Tim made several drawings, without apparent care as to details (see Figures 6.1 and 6.2). The figure of the person (Figure 6.1) was very distorted, with enormous arms, and none of the figures in the family drawing (Figure 6.2) had hands or feet. These drawings were immature for a 7-year-old.

Moreover, in playing some board games with Tim, I noticed that he had a great deal of difficulty waiting for his turn and following rules, and I wondered how this might affect his social interactions. Curiously, when I asked Tim about friends, he was not able to remember any of their names. Tim also seemed to have a very distorted concept of numbers, telling me that his mother was 103 years old and that there were 93 children in his class at school!

The parents, especially Mrs. Marino, were very open about feeling "overwhelmed" by Tim. He was going to begin Ritalin soon, but even if it helped, they wanted some assistance in learning how to manage him. Because of Mr. Marino's long work hours, the mother often felt unsupported and unable to endure Tim's constant talking, night fears, and excessive demands in the evenings. We agreed on a plan for parent counseling, some mother–child sessions, and some work with Tim alone.

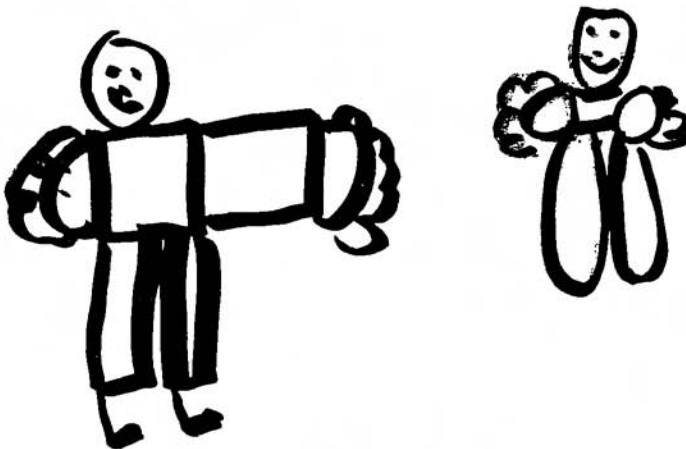

FIGURE 6.1. Tim's Draw-A-Person.

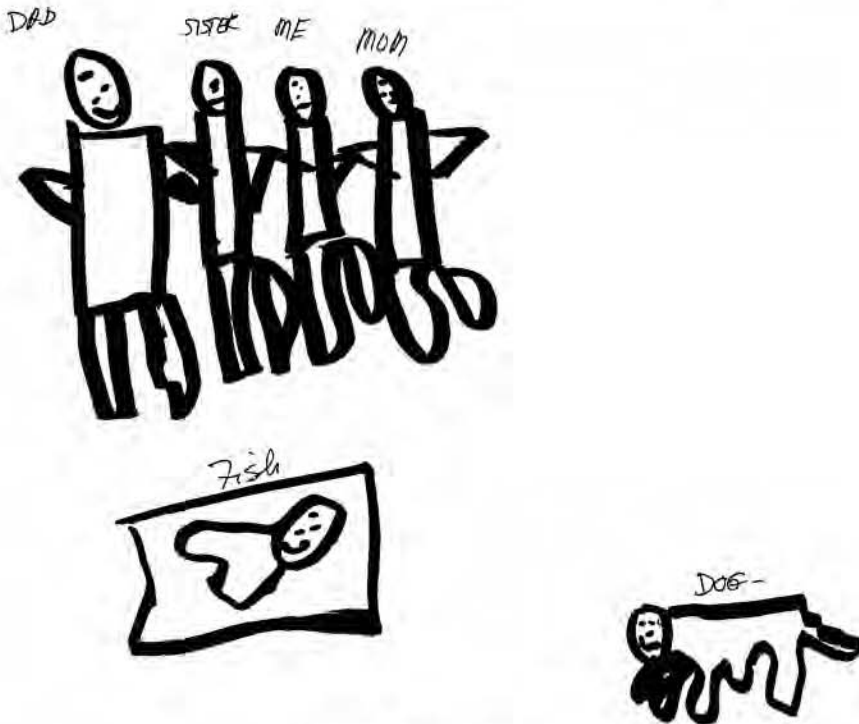

FIGURE 6.2. Tim's Draw-A-Family.

Interventions

Sessions with Tim

My first goal was to establish a positive relationship with this boy, something that had already begun during the assessment phase. I had referred several times to the fact that I helped children and families with their troubles and worries. When Tim could not think of any worries, I let him know that his mother had told me that she lost her temper and yelled at him sometimes. He acknowledged that this happened but seemed incapable of recalling an example of when this happened or of thinking about what might help.

Sessions with Tim and His Mother

I suggested to Tim that we invite his mom into the session, and together the three of us would come up with some techniques to use when they were beginning to lose control, so they wouldn't end up screaming at each other.

I asked them to think of a signal they could give each other that would mean they had to stop talking and separate for a while. They came up with a hand movement across the mouth, which was supposed to signify "Zip your lip." Mrs. Marino was afraid that Tim would try to use this every time she told him to do something he didn't want to do, so I emphasized that this was meant *only* to keep them from screaming at each other. The next week, both Tim and his mother were happy to report that the signal had worked. There had been less negative interaction between them.

Mrs. Marino next wanted to figure out a way for Tim to be able to spend some time alone. She stated that he usually hung around her every minute when she was home and that she needed some quiet time to herself. I asked Tim to think of some things he could do by himself in his room. With Mrs. Marino's help, we made a list. Realizing that Tim would need an incentive to carry out these solitary behaviors, I introduced a graph and suggested a star system for every day Tim succeeded in staying by himself for 10 minutes and, if he got at least four stars, a reward at the end of the week. Tim became very animated as he thought about the rewards he would want, and he finally settled on a particular computer game, which he would be able to "earn" at the end of a month.

The concrete nature of the graph and the stars proved to be an excellent technique for motivating Tim, although there were some disagreements about whether time spent playing with his sister would count and whether he had to check with his mother *before* spending the time alone, as he sometimes would claim that he had completed a 10-minute period when his mother was not home or aware of his behavior. Tim wanted to put more stars on the graph than he had actually earned, but his mother, with my support, was able to set appropriate limits. At the end of the month Tim earned his reward, and immediately *asked* to start a new graph. (See Figure 6.3 for Tim's first graph.)

Another control technique that was useful for Tim was to have him construct a stop sign out of construction paper and hang it up in his room. With his mother, we talked about Tim's need to "slow down." His teacher had written this on his report card, and I thought that a tangible, visible reminder might be useful, as this had been effective with the graph. I also began to use some verbal directives during play sessions, when Tim appeared to be rushing. I would say to him, "You're going too fast. Close your eyes and imagine the stop sign. Count to five; then you can open your eyes and proceed *slowly*."

Parent Counseling

The parents had a good understanding of the biological component of ADHD, so it was not necessary for me to educate them about that. None-

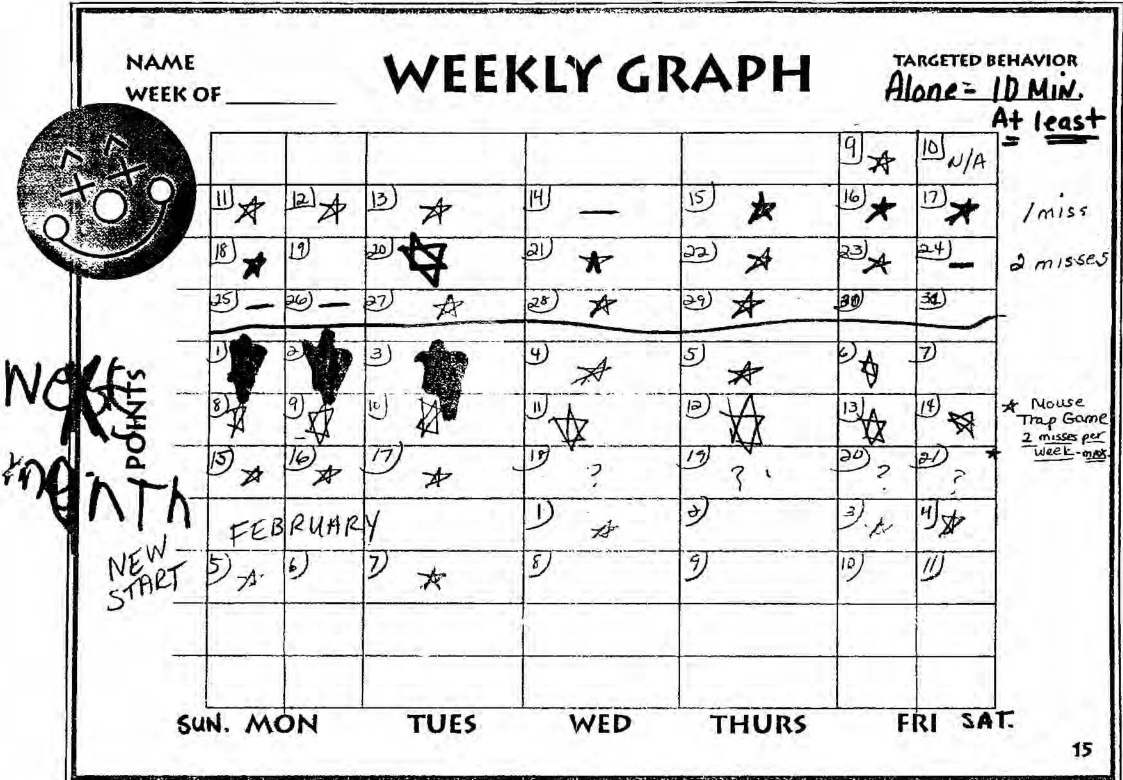

FIGURE 6.3. Tim's weekly graph for the first month of the graph/star system intervention.

theless, Mr. Marino was not entirely happy with the idea of giving Tim a pill to help him concentrate better. He was afraid that this might mean that Tim would stop trying to help himself. I used the example of wearing glasses to help see better; this improves the focus, but it doesn't change the person's basic vision. Similarly, Ritalin does not change the underlying neurological condition, but it gives an immediate benefit for the person's ability to concentrate.

In discussing the graph with Mr. and Mrs. Marino, I emphasized that it motivated Tim because it gave him an immediate reinforcement that he knew would "pay off" at a later time. I emphasized that it was very important for them to give Tim consistent praise whenever he behaved appropriately. I stated that the stars, for now, were an additional reinforcement but that the most important thing was for them to praise Tim when he showed control. Because it was not possible to know exactly how much Tim really *could* control his behavior even when he tried, it was necessary to set small, reasonable goals that he could achieve, so that neither he nor they would become frustrated. I pointed out that this was why I had suggested a 10-minute period of solitary play, rather than 30 minutes. I suggested that after consistent success with one goal, they could extend it in small increments, such as trying a 15-minute period after Tim demonstrated success with the 10-minute period.

Tracking Progress

I followed this child and family on a weekly basis over a school year, with several breaks because of holiday vacation periods. There was steady improvement in the mother–child relationship, to the point at which Tim no longer wanted his mother present during his sessions. His mother also confirmed during the parent sessions that she was feeling much better and that the tension between her and Tim had diminished substantially.

I believe that this improvement was the result of several factors working together for this child's benefit:

1. The medication, which Tim took on school days and which improved his ability to concentrate and complete his schoolwork.
2. The various behavioral methods geared toward helping Tim control his own behavior and the tangible rewards he received when he succeeded.
3. The increase in Tim's self-esteem, which resulted from his having success experiences and receiving positive reinforcement from his parents.
4. The parents' ability to work together and support each other. In the parent meetings, Mr. Marino became more aware of his wife's need

for more support in managing Tim. Mornings were especially difficult for her: She had to get to her job on time, and Tim was often noisy and resistant to getting dressed, which added to her stress. Although Mr. Marino had trouble getting up because he worked late in the evenings, the couple was able to work out a tradeoff of days on which each parent would be responsible for Tim in the mornings, and this relieved Mrs. Marino from feeling that she had to manage him entirely alone.

I planned to follow up with this family periodically, but I did not anticipate that they would need ongoing weekly meetings because they achieved such impressive gains in a relatively short time.

Discussion

This case demonstrates how a child and family under the stress of a recent ADHD diagnosis can be helped effectively. The Marinos seemed to feel out of control and unable to function well, despite their many strengths and areas of achievement. The interventions helped them to assume control of their lives once again and to feel better about one another, which inevitably led to improved parenting.

The specific behavioral interventions demonstrated in this case that are applicable to other children with ADHD and their families are listed in Table 6.2.

The members of this family were remarkable in their ability to help themselves once some limited guidance was offered to them. Many families will require longer and more extensive help. However, the principle

TABLE 6.2. Selected Interventions for Children with ADHD

- Hand signal to stop arguing
- Graph and star system, charting *one* goal
- Solitary time/quiet time for parent and child separation
- List of solitary activities
- Stop sign (construction, display, and discussion)
- Tangible, agreed-upon reward for achieving goal
- Parents' use of praise to reinforce positive behavior
- Play therapy to promote and enhance Tim's self-esteem

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of supporting the parents so that they can be more effective in supporting their own children is the key to working with families of ADHD children.

I did not contact Tim's teacher to collaborate with her, because Mrs. Marino assured me that the school was also employing behavior modification techniques with him, and her descriptions of his teacher's approach seemed appropriate to me.

There probably will not be a true "termination" in this case for many years, as ADHD typically continues at least until adolescence and sometimes later. It is important for the parents to know that they can contact me in the future, according to their perceived need.

UPDATE ON TIM, AGE 14

Tim and his mother came for one follow-up session at my request. He was a good-looking adolescent with close-cropped hair and a friendly manner. He spoke openly about his difficulty with his school work, and he seemed to accept without complaint the fact that he goes to resource room 2 days a week for tutoring. He is passing all his classes in a C range, with an occasional D. He says that he does not like school, but he does like to have fun.

He has taken Ritalin and later Concerta to help him control his distractibility. He takes the medications only for school. He has achieved considerable achievement in hockey; he is on a varsity team and is a high-scoring valuable player. Tim's family supports his interest and attends all his games. Tim is very sociable, and his life centers around ice hockey and his team. When I asked him about his future plans after he graduates from high school, Tim said he might like to be a sports trainer.

In summary, this young man appeared to be doing well, despite his ongoing disability. He has good support from his family and school and appears to have good self-esteem related to his area of strong achievement in hockey.

CONCLUDING COMMENTS

This chapter has reviewed various ways of working with families for the purpose of helping children. Although some practitioners follow a child-centered approach and others focus primarily on the family, I prefer an integrated child and family model because it offers the flexibility to tailor the helping method to the particular needs of each case situation.

It is assumed in this integrated approach that the practitioner will *always* involve the parents to the fullest extent possible. However, different helping approaches may be appropriate, such as parent counseling, working with a parent and child together, sibling sessions, and sessions with the entire family. Within a particular case, different members or subsets of the family may be seen, according to need.

This work places special demands on the practitioner, who must endeavor to remain objective and try to understand the problem situation from the different perspectives of various family members. Ethical considerations arising from expectations of confidentiality and issues of cultural differences between clients and the practitioner require careful self-monitoring and regular supervision and consultation.

The strength of the family becomes the practitioner's ally once the helping relationship has been formed and mutual goals have been established. In work with a family with a child with ADHD, certain guidelines can help the family offer appropriate support to the child once the parents feel that they are supported and respected by the worker.

DISCUSSION QUESTIONS AND ROLE-PLAY EXERCISES

1. How can a practitioner prepare to meet with an entire family for the first time? What information is essential to insure the success of the meeting, and how can the practitioner best obtain this? Role-play the first 5 minutes of a family meeting with the Marino family.
2. If children become silly and out of control during a family session, what kind of response from the worker is appropriate and helpful? If the parents are unable to control the children, what options does the practitioner have?
3. Discuss how the child's therapist can effectively involve resistant parents in the treatment of their children. How can the therapist manage his or her own feelings of resentment toward the parents for their lack of involvement?
4. How should the practitioner respond when a child with ADHD and the family do not experience success in using a hand signal or the graph? If the parents want to punish the child, should the worker suggest another alternative? Discuss both in terms of whether the worker *should* intervene and, if he or she does so, what form the intervention might take. Role-play some different alternatives.
5. Make a list of potential positive reinforcements for a child whose parents cannot afford costly incentives, such as computer games and bicycles. How does the worker respond to the parent who thinks that offering rewards is "just bribery"?

❖ CHAPTER 7 ❖

One-to-One Work with the Child

"Working" with a child usually means that a social worker or other clinician engages the child in play activities for the purpose of helping the child recognize and overcome his or her anxieties. Because children have limited verbal abilities, we cannot expect them to adapt to our adult style of communication. The social worker must "meet the (child) client where he or she is"—namely, on the level of *nonverbal* communication. It has been said that play is the child's work, so the therapist's work is the child's play.

The preferred method of working with children under 12 years old is play therapy. In this approach, the social worker or counselor uses the child's language of play as the primary helping method, with the degree of verbal communication dependent on the child's age and ability to use words. When the child *can* talk, the worker or therapist talks with him or her, but usually in play therapy the child is more comfortable and fluent in the language of play, so the therapist must accept the challenge of "speaking" and responding to the child through the child's symbolic language. Thompson and Rudolph (1992) state that in play therapy "the assumption is that children will translate their imagination into symbolic play action rather than words" (p. 197). Numerous examples in this book illustrate play communication with the child client.

Because this chapter focuses on one-to-one work with the child, it covers some of the basic techniques and approaches used in play therapy, distinguishing between directive and nondirective methods and between open-ended and planned short-term treatment of children. To illustrate the blend of nonverbal and verbal helping methods in work with an older child with verbal ability, a case is presented in which cognitive-behavioral methods combined with parental support helped a 10-year-old girl gain control over her sleep disturbance.

As stated repeatedly in this book, helping a child *always* includes work with the parents or caretakers and other significant family members. It also frequently involves contacts with teachers, the family physician or pediatrician, and other professionals who have had contact with the child and who have relevant information to share. Although this chapter focuses on one-to-one work with the child, this work *never* occurs in isolation and often (as in the cases to be discussed) entails tandem work with the parents. When the clinical social worker or counselor has established a cooperative relationship with the parents and has formulated a plan for individual work with the child as a result of the series of assessment interviews, he or she then proceeds to work with the child in separate sessions. Parental contact then typically occurs on a monthly basis, sometimes with the child included in the parent sessions.

RATIONALE FOR WORKING SEPARATELY WITH THE CHILD

Like adults, children experience anxiety, which can arise from both internal and external sources. Defensive responses (i.e., defense mechanisms) can effectively ward off anxiety (A. Freud, 1937). However, when the defenses are immature or inadequate—as is true for many children—the anxiety may be converted to symptoms that "bind" the anxiety, but at a cost that interferes with day-to-day functioning.

The Case of Anna, Age 5

An example of such anxiety can be seen in the case of Anna, age 5, who developed excessive clinging to her mother during the month following a fire that destroyed the family's apartment in the middle of the night. Although Anna could ride the school bus and attend school as usual, when she was in her new home she could not tolerate having her mother out of her sight. She followed her mother into the bathroom and from room to room in the family's new three-bedroom apartment. Anna's symptoms of clinging were specific to the home situation, indicating that the fire had destroyed her sense of safety and ability to play by herself or with friends in the apartment after school. When she was in her mother's presence, Anna felt secure. However, her need to keep in her mother's proximity interfered with her age-appropriate task of developing increased autonomy and peer relations. Anna's symptoms decreased after several play therapy sessions in which I directed her to draw pictures of the fire and of her favorite stuffed animal that perished in the blaze.

The use of drawings to help "debrief" children following traumatic experiences is discussed more fully in Chapters 12 and 14. The next case illustrates the use of puppets in individual work with a child.

The Case of Tammy, Age 4

Tammy, age 4, was very fearful about having her mother leave her at nursery school. Her mother gave Tammy a picture of the two of them together, which Tammy carried in a little purse attached to her waist. Whenever she missed her mother, she could look at the photo. This "concrete" method of keeping her mother close worked successfully, until the day another child started crying. The teacher took that child on her lap, trying to console her. Tammy began sobbing and crying for her mother and could not be comforted by any of the adults present in the classroom. They had to call her mother to come pick her up. The next morning, when it was time to leave for school, Tammy said she had a stomachache. She began crying and subsequently vomited. This "symptomatic behavior," fueled by anxiety, lasted only until Tammy's mother, thinking that the child might have a virus, permitted Tammy to remain home; the stomachache anxiety disappeared as soon as the separation from the mother was no longer threatened. This behavior was repeated for several days, and although the mother recognized the meaning of Tammy's symptoms, she did not know how to cope with her daughter's separation fears.

During the assessment phase, it became apparent to the social worker that the mother was quite depressed over her inability to become pregnant. Tammy's age-appropriate separation concerns were thus magnified because of the child's worry and confusion about her mother's sadness.

This case was successfully treated through parent counseling and individual play therapy sessions with Tammy. Tammy's fears had escalated to the point at which work with the mother alone was not sufficient to reassure the child that it would be safe for her to spend a few hours each day away from home, playing with peers. In play therapy sessions, Tammy played out her mother's concerns about becoming pregnant through her choice of a spider puppet who laid "thousands and thousands of eggs." It was evident that Tammy understood her mother's wish to get pregnant, even though the mother denied her daughter's knowledge of this. In directed play therapy, I took the role of a honeybee puppet who offered to babysit for the spider's children, so the mother spider could go shopping and buy food for her hungry spider babies. Tammy and I (as the spider and bee) played repeatedly the "goodbye"/ leavetaking of the mother spider and her subsequent return to her chil-

dren. During the mother's absence, I (as the babysitting bee) encouraged the spider children to have a good time playing and enjoying themselves. In effect, I gave both mother and child permission to pursue their own developmental needs. After less than 3 months, Tammy's separation fears at nursery school had totally abated. About a year later, the mother and Tammy came back to show off Tammy's new baby sister!

This example demonstrates the necessary tandem work with *both* the child and the parent in order to relieve the child's symptoms. Individual work with either the mother or the child would have been insufficient. Although counseling the mother to reassure her child that she (the mother) was "all right" was an essential part of treatment, it is unlikely that this reassurance alone would have diminished Tammy's anxiety, which seemed rooted in her conflict about whether to be a "big girl" or whether to remain "Mommy's baby." Individual work with the child moved things along more rapidly than would have occurred if I had intervened only with the mother. Through play communication, Tammy received the message that it was all right to play and have fun with peers in her mother's absence. The work with the mother emphasized my encouragement that she could "let Tammy go," even as the mother spider left her children safely in the care of the babysitting bee.

Situations Calling for One-to-One Work with the Child

When a child has developed symptoms, or when the child's behavior is so extreme as to interfere with his or her ability to interact with others and to proceed with age-appropriate social and cognitive tasks, then individual work is necessary to alleviate the child's anxiety and/or to help the child modify the behavior that is interfering with the normal push toward growth.

Other situations in which individual work with a child is recommended include instances in which the child has been abused, neglected, or abandoned by a parent. Children in these situations will benefit from the opportunity to express their confusion, rage, and neediness with a play therapist or social worker who validates their feelings and gives them the implicit message that what happened was not their fault. These communications often occur through the metaphor of play, with emotions expressed by puppets or doll figures. It is tricky work for the play therapist to confirm such a child's feelings without "blaming" the abusive or neglectful parent. The child needs to feel that the parent

loved him or her, despite the hurtful behavior. The social worker or play therapist working with a child in this type of situation usually benefits from an opportunity to deal with his or her *own* feelings in supervision, as the tendency of the worker to join with the child and "blame" the parent for the child's difficulties must be recognized and held in check.

Sessions with a child alone also serve an important function when the child has low self-esteem because of a physical or cognitive disability. A one-to-one relationship with an adult strongly benefits the disabled child, who comes to feel valued as a person despite the disability. Of course, in such a situation the social worker is simultaneously counseling the parents to insure that they are also attempting to enhance the child's deflated self-esteem. However, children sometimes discount their parents' attempts to praise them, whereas they can more easily accept an expression of genuine positive regard from an unrelated adult.

Yet another circumstance that merits one-to-one intervention with a child is exposure to traumatic events. When children have witnessed or been victims of violence, they require prompt "debriefing" in order to avert later development of symptoms. This debriefing gives them the opportunity to reenact in play what they witnessed or experienced in real life; it thus gives them a sense of control over a situation in which they were helpless. This controlled repetition puts distance between the frightening event and the present circumstances. The role of the social worker supports and emphasizes a child's survival of such a frightening experience.

Thus children in a variety of situations gain from a one-to-one helping relationship with a social worker or other clinician who is dedicated to understanding and spending time to help them. It is not surprising that such therapy almost always is "therapeutic," despite the good intentions of family therapists who wish to remove the child from the role of "identified patient." When the opportunity for individual play sessions is presented in a thoughtful and appealing manner, most children flourish through the experience once they get to know the play therapist and understand the special opportunity for self-expression that the play therapy sessions provide.

However, the fact that something helps does not necessarily argue for its universal application. The realities of economic and time constraints may prevent many families from committing themselves to bringing children for unlimited play therapy appointments, unless the children's symptoms urgently motivate them to seek help. Almost always, the parents will also be expected to attend some counseling or family therapy sessions, so seeking help for children may result in a major commitment

of time and resources that is difficult for many families. Because of these realities, time-limited contracts that are problem-focused are generally better understood and accepted by parents than are treatment goals geared to more general and vague objectives, such as "improved self-esteem." Parents who are from non-European Anglo backgrounds may not understand the concept of mental health services and will require sensitive counseling regarding their child's needs and potential benefit from therapy. My edited book *Culturally Diverse Parent–Child and Family Relationships* (Webb, 2001) provides guidance for practitioners who are working with families from different cultural backgrounds.

In summary, children with the following type of presenting problems will benefit from one-to-one sessions with a play therapist (in addition to whatever intervention may be occurring simultaneously with their parents and/or families):

1. *Children whose anxiety has escalated to the point at which they are not functioning appropriately at home or at school.* They may have developed symptoms, the course of their normal development may have been arrested, and/or they may appear to be "stuck."

2. *Children who have been abused, neglected, and/or abandoned.* As noted, children need to express their confusion, rage, and other feelings about why this happened to them; they also need to understand that it was not their fault. Because their ability to trust adults may be impaired, work with these children may require more time than work with children whose development has not been so seriously compromised.

3. *Children with disabilities that engender feelings of low self-esteem.* Often these children are painfully aware that they are "different" from their peers, and this difference may cause them pain and anger. Work with these children proceeds well when the social worker or counselor can identify some genuinely likable qualities and/or talents in which the youngsters can begin to take some pride. These children's ability to accept themselves as persons with disabilities frequently follows the experience of mourning (through play therapy) for the qualities or abilities they never had.

4. *Children who have been traumatized.* Depending on the circumstances, individual play therapy may be a valuable option, in addition to group and/or family approaches. The more violent the trauma, the more likely it is that victims will require individual intervention. Ideally, this should be offered *before* the emergence of symptoms, as a preventive strategy. Unfortunately, this type of preventive intervention is far from routine. See Chapter 8 for an example of group debriefing following a disaster; see Webb (1991, 1999) for numerous examples of individual work with children after crises of various types.

SELECTED PLAY THERAPY TECHNIQUES

It is ironic that many social work students have contact with young children during their internships and are expected to interact helpfully with them, yet their coursework may not have prepared them in basic play therapy techniques appropriate for work with their child clients. A few years ago I sent a survey to all baccalaureate and master's programs in social work to learn details about curriculum content related to direct intervention with children. Although 48 out of 84 returned responses from B.S.W. programs indicated that their courses contained content related to providing services for *children*, about half (24) of the respondents stated that they did not think there was a need to teach *play therapy* content in their curricula. The reasons given for this were the beliefs that play therapy content is "too specialized" and "not relevant to the work of B.S.W. practitioners." The two negative responses out of a total of 48 from the M.S.W. programs stated that (1) their curriculum was not "therapy-oriented" and (2) that their curriculum was based on a "family systems" model.

Although I do agree that play therapy is a specialized field, I nonetheless argue that social workers at *all* levels can and should be able to use some basic play therapy techniques in their work with children. Generic practitioners need this knowledge and skill just as clinical specialists do, and, clearly, familiarity with play therapy techniques is essential for social workers using a family systems perspective.

Terminology

Let us not be afraid of the word "therapy." I suspect that some of the negative responses in the survey about including play therapy in the social work curriculum reflect a backlash against the medical (clinical treatment) model and a preference to cast social work in a broad context that sees the individual in terms of family and social influences. Although I share a wide view of social workers' professional identity, I do not exclude the concept of therapy as a legitimate helping method *within social work* for individuals (of any age) who are in pain and need of service. My word processor's thesaurus lists "care" as a synonym for "therapy."

What Is Play Therapy?

The term "play therapy" refers to caring and helping interventions with children that employ *play* techniques. Clinicians who refer to themselves as "play therapists" come from many disciplines in addition to social work,

and all have had specialized training and supervision on an advanced level. The list of child-related professional organizations in the Appendices includes the Association for Play Therapy, which regulates post–master's-degree training in this field. Some social workers may wish to obtain this advanced training. However, social workers at all levels can learn to utilize selected play therapy techniques in their work with child clients.

The choice of particular activities will vary according to the child's age and responsiveness to different options; therefore, each social worker's office should contain a range of play materials from which the worker and the child can make selections. (See Figure 3.3 for a list of basic supplies.) The following subsections discuss selected basic play therapy techniques and necessary supplies.

Play Therapy Materials

Figure 3.3 and Table 4.1 of this book list play therapy equipment that I recommend for *every* social worker's office. Even a worker specializing in gerontology may be called upon, for example, to intervene with a school-age grandchild of a terminally ill woman being transferred to hospice care. Providing this child with some drawing paper and markers and suggesting that she draw her happiest memory about "Gramma" will not only occupy the child and permit the worker to speak with the child's mother about necessary plans for convening the family but will also serve an anticipatory grieving function for the child and the mother, who can recognize in the picture a concrete portrayal of the grandmother's significant role in the family. The grandchild can communicate her feelings through concrete images rather than in words, because young children have limited abilities to express emotions in language.

Art/Drawing

In my experience, plain white paper, colored paper, and colored markers are the most useful of all play therapy supplies. Children as young as 3 and as old as 18 can express themselves meaningfully through art and drawings, especially when the play therapist or social worker makes it clear that "drawing here is not like drawing in school; you don't have to be good at it in order to be able to show how you feel." Furthermore, family members can work on drawings or collages together, when given the opportunity to express themselves in this manner.

Chapter 4 has discussed how the Draw-A-Person and the Draw-A-Family can provide useful information in assessing how a child sees him-

self or herself and his or her family. I usually keep these drawings in a special folder with the child's name on it, so the child and I can examine them together at different points in our work. I often ask the child to repeat both these drawings after several months in order to note the changes over the course of time.

When the child refuses to draw or says that he or she can't draw, the "squiggle game" (Winnicott, 1971a, 1971b) almost invariably intrigues the child even as it loosens up his or her inhibitions. In this game, which is essentially a technique of communication through drawings, the child and worker or therapist take turns closing their eyes and then making some kind of "scribble/squiggle" line on the paper, which the other person then has to turn into a figure or object. Each drawing receives a name, and after several have been completed, the child is asked to pick his or her favorite and make up a story about it. An example of the use of this method with a 9-year-old girl whose friend had died tragically can be found in Webb (1993, 2001). This child, who could not bear to talk about her dead friend, made up a "squiggle story" that was replete with danger and threatening death themes. See DiLeo (1973), Oster and Gould (1987), Rubin (1984), and Malchiodi (1998) for guidance in understanding and interpreting children's drawings.

Clay and Play-Doh

Also of compelling appeal across the age span, modeling materials allow a child to create something completely original. Play-Doh is soft and malleable and thus more appropriate for use with the preschool child; modeling clay is stiffer and requires some manual strength to mold into shapes, therefore making it more suitable for school-age children. In a video demonstration of play therapy techniques (Webb, 1994b), a 4-year-old child who was completely uninterested in drawing enthusiastically created dragons and monsters with Play-Doh, thereby suggesting some of his own fears about uncontrolled aggression. On the same video, a 12-year-old girl created a sun with clay as she reflected on how her earlier therapy using clay had helped her gain control over her anger. See Oaklander (1988) for specific suggestions about using clay in group, family, and individual work with children.

Dolls/Puppets

Miniature, bendable family dolls readily lend themselves to reenactment of scenes from a child's family. Preschoolers eagerly engage in this type

of play, which can be facilitated by the use of dollhouse furniture representing the kitchen and bedroom(s). These supplies can be stored in a small container, such as a lunch bag or satchel. I mention this to emphasize that the minimum supplies for play therapy are easily portable and do not require extensive storage space. A fancy dollhouse, for example, is neither necessary nor appropriate, as many children live in small apartments, whereas the typical dollhouse represents a suburban upper-middle-class home. Children are very creative about adapting objects in the office to their play needs (e.g., using tissues for blankets or a turned-over ashtray for a kitchen table). *A worker does not need to offer elaborate play materials to engage a child in play activities.*

Animal and insect puppets appeal to boys and latency-age children, who may believe that dolls are "sissy" and only for girls or younger children. Woltmann (1951/1964) suggests that the selection of puppets should provide the child with the opportunity to express a variety of emotions. For example, an alligator puppet will almost always call forth aggressive, biting play, whereas a rabbit or duck is more "neutral." Assuming that the child and the worker/therapist can each hold two puppets at a time, Woltmann suggests (as a minimum) that the choices available to the child should include two neutral and two aggressive puppets. My own preference is to offer a choice of at least six puppets, so that the child who may not wish to select aggressive puppets will not be forced to do so. Again, I stress that hand puppets are neither heavy nor bulky and can be easily stored in a desk drawer with other play therapy supplies. Often it is possible to find small finger puppets representing insects or animals. When several hand and finger puppets of the same type are used in combination, they often become a "family," and the child may act out some interesting family dynamics using the finger puppets as the children and the larger hand puppets as the parents.

Card and Board Games

Following the publication of *Game Play* (Schaefer & Reid, 1986, 2001), there has been growing awareness of the usefulness of board games with latency-age children in therapy. There has also been a virtual flooding of the market with "therapeutic" board games. Schaefer and Reid (2001) have pointed out the numerous ways in which child therapists can help children while playing board games with them. This understanding is crucial to knowing the difference between just playing with a child and playing *therapeutically* with a child. In numerous workshops on play therapy across the country, I have been asked, "How can playing checkers or Monopoly with a child be therapeutic?" My answer is that unless the

worker or therapist has a purpose in mind and responds consistently to the child during the play according to this purpose, the playing of a game may *not* be therapeutic (apart from the opportunity it provides to build a relationship with the child). For example, it can help the child to point out to the child during the play that he or she seems to have trouble following the rules and that this must cause problems when the child plays with other children. The therapist can then offer to help the child slow down and wait for his or her turn, so that he or she can "be a better player."

Because I am focusing on *basic* play therapy techniques and the necessary supplies for these, I limit my recommendations to two games that I have found especially useful in work with elementary school-age children: the Talking, Feeling, and Doing Game (available from Creative Therapeutics, Cresskill, NJ) and the card game Feelings in Hand (available from Western Psychological Services, Los Angeles, CA). (Full addresses for these and other suppliers of play resources and materials are provided in the Appendices.) These games have certain features that make them attractive to school-age children. In common with commercial board games, they feature the possibility of winning (and losing), and this characteristic enables a worker/therapist to see and talk with a child about how he or she wins or loses in the course of daily activities. In contrast to commercial board games, however, these therapeutic games require a discussion of feelings as an integral part of playing. They give the worker/therapist the opportunity to model "feeling" responses that the child may initially consider inappropriate. For example, when a card in a game asks, "What is the worst thing that someone can say to someone else?" and the therapist responds, "That you are stupid," the child learns that talking about embarrassing issues is all right. Chips are awarded for each response, further motivating the child to respond to each question.

USING THE CHILD'S PLAY THERAPEUTICALLY

Playing therapeutically with a child takes training, experience, and the special ability to relate to the child both playfully and with respect. It is not my intention to suggest that simply by acquiring some play materials, a worker can then, as if by magic, successfully carry out play therapy. In fact, having the necessary supplies is only the beginning of a process that will take hours of persistent relearning of the language of play and struggling to communicate through this symbolic language.

At first, the work feels awkward and confusing. Social workers with many years of experience have said to me, "At least when I speak to adults, I usually know that they understand me; with children, it can be

very puzzling. How do I know that I am playing helpfully or therapeutically with a child?"

This is, of course, the $64,000 question. We do *not* know initially whether our work with children is helpful. We do know that it will not harm children to spend time with adults who are interested in them. Just as in adult therapy, the *relationship* is the key to being helpful, not whether a worker invariably makes the "right" response. And progress takes time, whether with adults or with children.

Letting the Child Direct the Play

As an experienced play therapist, I feel comfortable asking a child what he or she wants me to do (or say). Letting the child direct the play can reveal far more than a response that *I* might guess to be appropriate. I have also found that if the child continues to play (whether or not I immediately understand the underlying meaning of the play), it can serve a purpose for the child. Usually it is only by reflecting about the *themes* of the child's play retrospectively over several sessions that I begin to comprehend its significance.

Ultimately, improvement of the problem or the symptoms suggests that something beneficial has happened. Occasionally, a parent credits the child's play therapy. However, this evaluation (no matter how flattering) cannot be accepted as the exclusive reason for change: The parent or parents have also been interacting with the child in a different way as a result of parent counseling or family therapy, and it is important that the worker or therapist attribute some of the child's improvement to the changes in the *family*. Almost always, progress is multidetermined.

Steps in the Therapeutic Work with the Child

Work with a child can be divided into the following phases:

1. Establishing the relationship with the child
2. Observing and listening to the child
3. Identifying themes in the child's play
4. Formulating a dynamic understanding about the child
5. Responding to the child according to this understanding

These phases of child therapy may overlap. They are listed in order of both occurrence and difficulty, which explains why some workers who are new to working with children may be unable to respond using a

child's play language, despite their ability to relate well to young clients. A *therapeutic* response within a child's play language requires that the worker understand first what the child is communicating and then how this communication reflects interactions and/or feelings from the child's life. Sometimes the connection between the symbolic play and the child's life is obvious, but just as often it is not. The ability to connect the symbol to the child's life requires many hours of supervised practice experience with children. For example, probably most readers instinctively understood the underlying meaning of Tammy's selection of the spider puppet who laid "thousands and thousands of eggs." This could be viewed as the child's wish for her mother to have many babies. My quick response to the child's play scenario followed from the dynamic understanding that Tammy was afraid to leave her mother because her mother was sad and needed her; furthermore, I believed that Tammy needed practice in saying goodbye to her mother and permission to have fun in her mother's absence. This dynamic understanding formed the basis for my assumption in playing the role of the babysitting bee.

When this kind of connection is not readily apparent, it is important for the worker to be able to tolerate ambiguity and to exercise patience while letting the helping process evolve. Not knowing is all right and is well tolerated by children (who often feel baffled themselves in trying to understand their world).

When the child has been given the explanation of who the worker is ("someone who helps children and parents with their troubles and worries") and how the child and worker will interact ("sometimes we talk, and sometimes we play"), then the child is free to begin revealing his or her concerns to the worker/therapist. Incidentally, social workers should avoid using the term "working" in referring to their interactions with children. Talking and playing do not qualify as "work" in a child's *literal* understanding of the word, and if a worker says that he or she is going to be "working" with a child, the child may become confused about what to expect.

DIFFERENT CHILD THERAPY APPROACHES

Brief Historical Synopsis

The practice of child therapy has been in existence since the 1930s and 1940s, when Melanie Klein (1937) and Anna Freud (1946/1968), working separately, adapted methods of adult psychoanalysis to child analysis. Despite disagreements between these two child therapists about certain theoretical and practice issues in work with children, both therapists

agreed about the importance of the therapeutic relationship with the child, and they both relied on play as the primary method of therapeutic communication with children.

In the more than half a century since the beginnings of child therapy, many different helping methods have evolved. Social workers, counselors, psychologists, psychiatrists, and others have developed a wide range of therapeutic interventions. In fact, Kazdin (1988) lists more than 230 "alternative psychosocial treatments" for children and adolescents—a number that seems mind-boggling, even allowing for his inclusion of group and family interventions. Kazdin's list contains some treatments with similar names, suggesting overlap among various approaches; it also includes activities such as yoga and sports groups (not considered therapy in the usual sense), as well as some discrete play therapy *techniques*, such as Winnicott's "squiggle game" and the Talking, Feeling, and Doing Game (which as distinct techniques are always used in combination with other helping methods and cannot therefore be considered as integrated psychosocial treatment methods). Thus Kazdin's list of alternative "treatments" must be viewed with great reservations in regard to the numbers. Even with these reservations, however, it *is* evident that there has been a proliferation of treatment approaches geared to children. No longer are most methods guided primarily by the theoretical underpinnings of psychoanalysis; instead, various behavioral, cognitive, and client-centered therapeutic models have been adapted from adult treatment approaches to serve the purposes of child therapy. Three major approaches utilized by contemporary child therapists are (1) client-centered (child-centered) treatment, (2) psychodynamic child therapy, and (3) cognitive-behavioral treatment.

Client-Centered or Child-Centered Therapy

The basic tenets of the client-centered approach with children, as described by Axline (1947), are as follows:

- Establishment of a warm rapport with the child.
- Empathic understanding and respect for the child's ability to solve his or her own problems.
- A nondirective stance on the part of the therapist, who lets the child lead the way without directing the child in any manner, for as long as the child needs treatment.

In *Dibs: In Search of Self*, Axline (1964) demonstrated the child-centered approach, using play therapy with a 5-year-old boy who was on the verge

of residential placement because of his mutism and his teachers' inability to make contact with him. Dibs flourished in nondirective play therapy with Axline, in which he developed and achieved his exceptional potential, in large measure because of Axline's ability to convey her genuine positive regard for him.

The child-centered approach has changed very little since its inception in the 1940s, with Axline's (1947) text continuing to be "the single best guide for client-centered psychotherapy with children" (Johnson, Rasbury, & Siegel, 1986, p. 130). Other past and current therapists following the child-centered model include Moustakas (1959) and Landreth (2002).

In summary, child-centered therapy is permissive, nondirective, and open-ended. Because it proceeds at the child's pace, it tends to be long term. It focuses on the person of the child, not on the child's problem. Its emphasis on the child's potential for growth is very appealing to social workers and others who wish to focus on clients' strengths, rather than on pathology.

Psychodynamic Child Therapy

Over the years, what began as child psychoanalysis has evolved into a less intensive, more practical approach to working with children—one that still recognizes the existence and power of instincts and conflicts in motivating behavior but that now tends to focus on problems in the child's present life rather than on the child's internal intrapsychic world. Because it is assumed that a child's behaviors and symptoms reflect complex, unconsciously determined meanings, work with the child relies on a thorough assessment to facilitate the therapist's understanding of the child's unconscious motivations, fantasies, impulses, and conflicts as reflected in his or her play. The therapist may utilize aspects of the relationship to make interpretations about the child's wishes and fears with respect to meaningful and significant relationships in the child's past and present life (Chethik, 2000; Johnson et al., 1986; LeVine & Sallee, 1992; Mishne, 1983).

Although therapists differ in the specifics of their approaches, psychodynamic child therapy as a whole is more directive than child-centered therapy. Especially when it is geared toward helping a child who has been traumatized, it may be very focused and of relatively short duration (Terr, 1983, 1989). Using a psychodynamic framework of understanding, the therapist engaged in crisis intervention helps the traumatized child reconstruct the traumatic experience so that the child can gain mastery over the trauma, acknowledge that he or she has survived, and realize that

the trauma belongs in the past. To bring about this transformation requires a high level of direction on the part of the therapist, who may provide particular toys to facilitate the play reenactment. This form of crisis therapy has been helpful for child victims of sexual and cult abuse, in addition to children who have witnessed violence and atrocities and who may be showing symptoms of posttraumatic stress disorder. Bevin (1999), Strand (1999), and James (1989) provide examples of therapy with traumatized children that utilize crisis intervention reconstructive techniques. This work is stressful and demands a high level of skill. *Therapists should not engage in this type of work without special training and supervision.*

In summary, psychodynamic child therapy focuses on helping the child cope with his or her everyday life. It relies on an in-depth understanding of the child's history and present circumstances in order to make connections in play and/or in words that will relieve the child's anxieties and open up new possibilities to the child. When used in crisis intervention, this form of therapy is very directive. Concurrent parent counseling is an essential component of the one-to-one work with the child.

Cognitive-Behavioral Treatment of Children

By contrast with child-centered or psychodynamic therapy, in cognitive-behavioral therapy the child's thoughts (cognitions) and behaviors are the focus of work, not the child's feelings. There are many different forms of cognitive-behavioral therapy, all of which employ learning principles in attempting to alter dysfunctional behavior. After a careful assessment of the presenting problem and of the environmental and/or cognitive antecedents of the problematic behavior, an individual treatment program is tailored to the specific needs and situation of the individual child and family. When the therapist finds that the child's maladaptive thoughts are leading to maladaptive behavior, then the intervention emphasizes helping the child change his or her negative thoughts through self-instructional training, sometimes referred to as "self-talk." When environmental factors appear to be contributing to the persistence of a behavior pattern, then the intervention will target these reinforcing environmental responses through various techniques, such as positive reinforcement of desired behaviors, punishment, and the use of tokens (Johnson et al., 1986; LeVine & Sallee, 1992; Kendall, 2000).

Because children are so dependent on the significant others in their environments, parents and teachers are often enlisted to help with children's behavior modification plans. According to Johnson et al. (1986), "the success of behavioral procedures is often highly dependent on the

direct participation of significant members of the child's environment in the treatment program" (p. 184). The collaboration of a 10-year-old girl and her parents in a cognitive-behavioral treatment approach is described in the case of Linda, later in this chapter.

Synthesis of Approaches

It is possible and useful to combine therapeutic approaches when this seems indicated by the circumstances of the particular case. Wachtel (1994) recommends an integrated treatment approach that employs a combination of systemic, psychodynamic, and behavioral interventions simultaneously. Wachtel (1994, pp. 201–202) states:

> We do not wait until all systematic issues are resolved before attending to the psychodynamic aspect of the problem, nor do we attempt to fully resolve psychodynamic or systemic issues before introducing behavioral interventions. Instead, *psychodynamic and systemic understandings of the problem go hand in hand with behavioral methods targeted at the symptomatic behavior* (emphasis added).

This philosophy recognizes that models of practice often overlap and that the experienced practitioner learns to adapt practice to the client's needs rather than vice versa.

THE CASE OF LINDA, AGE 10

Family Information

Mother	Ann, age 34, buyer for department store.
Father	Jim, age 35, architect in building firm; recovering alcoholic (12 years).
Child client	Linda, age 10, fifth grade; on gymnastics team.
Sister	Amanda, age 8, third grade; very artistic.
Linda's godfather	Robert, age 35, former restaurant manager; recovering alcoholic (14 years).
Linda's godmother	Terry, age 34, secretary.
Robert and Terry's children	Susan, age 6, and Brian, age 4.

Linda was young Brian's godmother, and Linda and Amanda referred to Robert and Terry as "Aunt" and "Uncle." Robert was Jim's Alcoholics Anonymous sponsor; they generally attended meetings together three

times per week. Ann had attended Al-Anon in the past (sometimes with Terry), and the girls had attended a group for children of alcoholics (Unicorn) several years earlier. At the time of intake, Ann was engaged in her own therapy, as was Jim.

This was a Catholic family of European cultural background. The family members observed major milestones, such as First Communion, according to the expected practice in their religion, but they did not attend church regularly.

Presenting Problem

Upon the recommendation of her pediatrician, Ann consulted me because of her concern about Linda's sleep problem of 2 months' duration. Linda was waking every night in the middle of the night because of bad dreams about robbers; she would turn on all the lights in the house and then come into the parents' bedroom and stand by their bed until one of them awoke and returned with her to her bedroom. The parents reported that Linda's sleep difficulty had begun during the family's vacation with Robert and Terry and their children. Linda had awakened in the middle of the night and become panic-stricken when she mistakenly thought a "robber" was kidnapping her godson, Brian. Actually Robert was carrying his son to the bathroom, but in a strange location, Linda was disoriented and terrified. She had to spend that night sleeping in the room with her parents, and she had continued to awaken every night since then. The parents were at first sympathetic, assuming that Linda's problem would subside spontaneously, but they were now becoming tired, annoyed, and concerned about Linda's behavior.

Assessment

I saw the parents once so that I could obtain their view of the problem and learn about Linda's developmental history and the family background. I then saw Linda for two assessment sessions in which we discussed the problem and several possible ways to deal with it.

In the meeting with the parents, I learned that Linda was functioning on a very high level in school and with peers. She was an excellent student and an enthusiastic member of the school gymnastics team. She had slept in her own room since age 2 and had not had separation problems; however, the mother considered Linda somewhat anxious and intense and thought that she put a lot of pressure on herself to succeed. Through the years Linda had expressed some fears at night related to bad

dreams, but she was easily consoled, and the parents had not been concerned until this current nightly problem. The father said he had recently lost patience with Linda, yelled at her, and shaken her when she woke him up in the middle of the night. Both parents were firm in feeling that "this just cannot continue."

In the two assessment sessions with Linda, I tried to understand the reason for the persistence of this problem. Linda said that she woke up because of a dream that a robber was going to "get" her. When this happened, she would get up and put on all the lights in her room, the hall, and the bathroom. Then she would walk into her parents' bedroom and stand by their bed until one of them woke up. She would tell them she had a bad dream, and then either her mother or her father would take her back to her room, reassuring her that it was only a dream and that she was all right.

Because of Linda's age, the work with her combined talking and some play (drawing). During Linda's discussion with me, I asked her to sketch a floor plan of her house and her bedroom so I could get a better picture of her family situation (see Figures 7.1 and 7.2). I also wanted her to draw her dream, and I asked her to draw it in two different ways: the dream she was having now, and the dream she would have later when she was no longer waking up with the bad dream. Figure 7.3 depicts Linda's two dreams, in a "before" (i.e., current) version, with the alarm clock registering 2:00 and a male figure saying, "I'm going to get you"; the "after" dream shows her lying in bed asleep while having a happy dream of going down a slide and saying, "Whee!" I also asked Linda to draw a picture of herself showing how she would look after she had a good night's sleep without waking up. She drew a figure with a smile, saying "Rise and shine," with the alarm clock indicating 7:00 A.M. (Figure 7.4).

In asking for the "after" drawings, I was deliberately conveying the positive suggestion to Linda that her bad dreams would end and that she would feel better as a result. I also made several references to how brave she must be to be able to perform back flips on the balance beam in gymnastics. I wanted to emphasize Linda's strengths in a manner that would help her feel confident and assured that she could successfully master her nighttime fears.

Knowing that it was developmentally unusual for a 10-year-old to be going into her parents' bedroom every night, and also having heard from the father than his patience was wearing thin, I made the decision to begin work immediately on extinguishing this behavior of Linda's. I tried to make this behavior seem inappropriate (ego-dystonic) to Linda by saying to her in a sympathetic tone, "It must be *very* embarrassing for a 10-year-old to have to go to her parents at night! I know that many 4- and 5-year-olds do this, but it certainly is not what most 10-year-olds

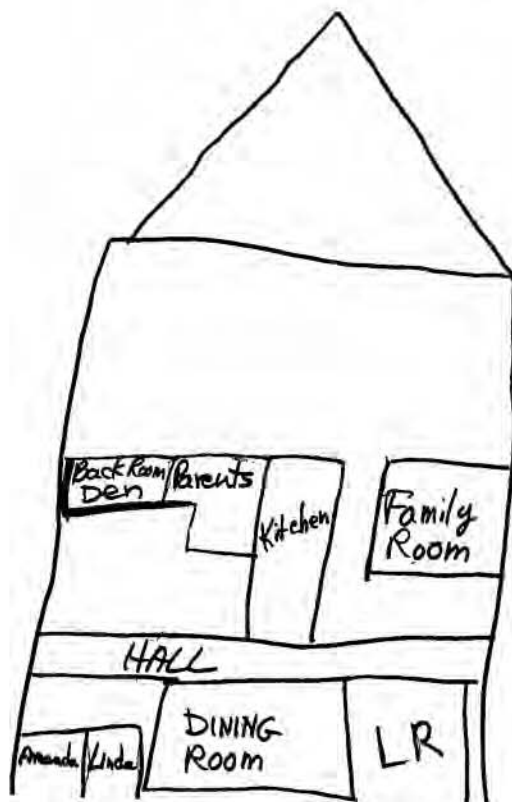


FIGURE 7.1. Floor plan of Linda's house.

want to do. We need to think together about what you can do for *yourself* when you wake up to help you feel better." I then involved Linda in making a list of substitute behaviors, such as listening to her Walkman radio, drawing, writing in her diary, and so forth. A family meeting was planned for the next week to talk about some of the ways Linda's parents could help her, as well as to obtain everyone's input and agreement to a behavior modification plan.

Family Meeting

The meeting was attended by Linda and her parents. I began by stating a common purpose—that of our working together to help Linda get control over her "nighttime problem." Everyone wanted relief in this situation, and each would have a part in helping.

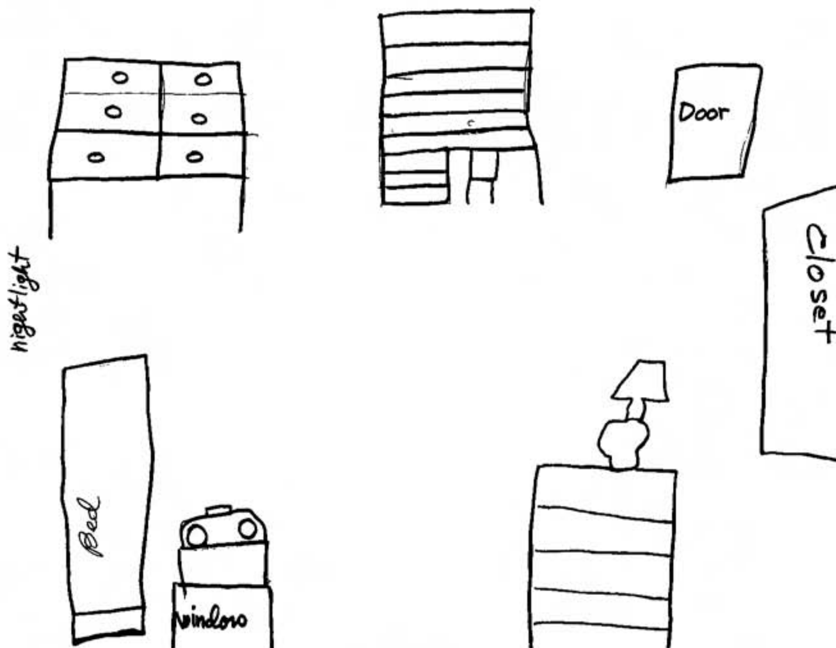


FIGURE 7.2. Floor plan of Linda's bedroom.

First, we agreed that Linda was old enough to take care of herself at night without involving her parents. She couldn't control her dreams or the fact that she woke up, but there was no need for her to go into her parents' room and wake them up. I encouraged Linda to tell her parents that she would not disturb them but that she wanted their permission to put on the lights when she woke up. I suggested that the parents close their door so the lights would not disturb them.

I mentioned that Linda was going to try hard to control her anxiety and that we needed to figure out a way to reward her, because this might take a lot of effort. Together we decided on a time frame for successful completion of the desired behavior (Christmas, which was 6 weeks away) and a reward for succeeding. Linda said she wanted some new bookshelves and some drapes for her room and that she was hoping for a bicycle for Christmas. I suggested that we set up a token system of rewards, with the drapes to come after 2 successful weeks, the bookshelves after 4 weeks, and the bicycle after 6 weeks. I also suggested a gradual tapering of the lights at night: the first week, Linda would be permitted to put on as many lights as she wanted; the second week, all the lights in her *own* room; the third week, only her bedside lamp; and after a month, only a flashlight. The family was enthusiastic about the plan, although

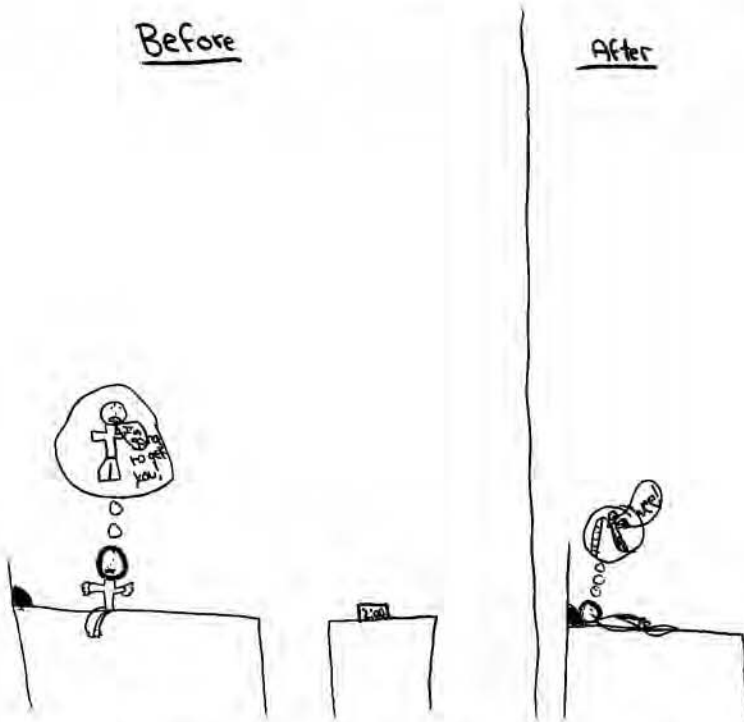


FIGURE 7.3. Linda's drawings of her "before" and "after" dreams.

FIGURE 7.4. Linda's "good night's sleep" drawing.

the father wanted to know how they would handle slipups. I suggested that if the problem returned for more than 2 nights out of 7, the reward system should slow down accordingly. I also planned to see Linda every week and wanted her to report her progress to me.

Treatment Summary

Complete symptom alleviation occurred within 3 weeks, and Linda was sleeping through the night with no more bad dreams. Two weeks after the family session, Linda had to cancel her appointment because she had hurt her foot in a gymnastics injury. The pediatrician was giving her anti-inflammatory medication and wanted her to stay off the foot for 3 days. During our phone conversation, I asked Linda how she was doing at night. She said that she was still waking every night, but she just turned on her bedroom light and then went right back to sleep. I suggested that perhaps the medication would cause her to sleep through the entire night (positive suggestion). The next week Linda reported that she was now sleeping through the night. I kept in contact with the parents to insure that they would carry through with the agreed-upon rewards. During the gradual tapering of sessions on a monthly basis after Christmas, Linda experienced no further nighttime difficulty.

Discussion

The rapid improvement in this case could be attributed to several factors. First, I framed Linda's behavior in a way that was distasteful to her by suggesting that it was typical of younger children; second, her parents removed whatever secondary gratification Linda may have derived from receiving their attention in the middle of the night and instead rewarded her for her strengths (bravery). A third factor may have been the implicit message to Linda that her parents were serious about wanting her to manage her own anxieties. The short-term time frame (6 weeks) was appealing and manageable to all.

It is obvious that this situation required simultaneous involvement of both the child and the parents in a mutually agreed-upon plan. My role as the therapist was that of catalyst and facilitator. In retrospect, the improvement may seem "too good to be true." I took a risk in suggesting that such a rapid change of behavior could occur. I based this on my knowledge of child development (i.e., most 10-year-olds do not have bad dreams that cause them to go into their parents' bedroom for help), as well as the indications from this girl's developmental history that her

development had been proceeding normally until this unusual event. It is fortunate that the parents sought help before the problem escalated and a spiral of negative interaction was set into motion.

CONCLUDING COMMENTS

One-to-one work with the child gives the social worker an opportunity to know the child in a different manner than is possible when the child is seen together with the parents. When the worker encourages the child to play and conveys to the child that he or she will help through *both* playing and talking, the worker relieves the child of the obligation to communicate in the adult's verbal mode. Meeting the child on his or her level respects the child's individuality in a way that is unusual in child–adult relationships.

In one-to-one work, the therapist/worker uses play to interact with the child for the purpose of understanding and helping. This conforms to the commitment of the social work profession to meet clients at the level at which the clients are comfortable. Therefore, *all* social workers must be prepared to use play in their interactions with children.

DISCUSSION QUESTIONS

1. Discuss the dynamics of the separation problem as depicted in the case of Tammy. Why was it necessary to see *both* mother and child in order to resolve this problem? If you were the social worker, what information and advice would you give to Tammy's teacher about managing Tammy's separation difficulties?
2. Why is it important for family therapists to be familiar with play therapy techniques? Give an example of a case in which it might be appropriate to use play techniques in a family session. How can the family therapist go about implementing this?
3. Imagine that you are working with a child who has very low self-esteem because of physical and cognitive disabilities. Discuss how the treatment of this child might differ, depending on whether you were to follow a child-centered, a psychodynamic, or a cognitive-behavioral approach.
4. Discuss the reasons for using play in work with children under 12 years of age. How can social workers become more comfortable in using play techniques?

❖ CHAPTER 8 ❖

Group Work with Children

Many children feel more comfortable interacting with a social worker or counselor in the company of other children than in a one-to-one counseling situation (Rose, 1972; Schiffer, 1984). Whereas the prospect of working with six to eight children at the same time may challenge or even intimidate the counselor or social worker, the group format has the opposite effect on the child group members, who experience mutual support and energy according to the "strength in numbers" principle. The group situation, in comparison with one-to-one counseling, gives a child greater freedom to speak and participate when he or she feels inclined to do so, as other members share the spotlight and can fill an uncomfortable silence. Of course, most children do not *choose* the helping methods through which adults offer them assistance. Even children who feel distressed and worried about some aspects of their lives usually have no idea about either who can help or what means are available for doing so. When such children find themselves in a group with peers who have similar worries, they feel a sense of relief that they are not "the only ones" and hopeful about the prospect of peer understanding and support.

RATIONALE FOR USE OF GROUPS

Children live and must be able to function as social beings. Their initial experience in their family group gradually broadens to include peer relationships when they enter day care or preschool and eventually formal schooling. Some children, in addition, are exposed to group programs in religious settings, and others benefit from participation in recreational groups (e.g., Boy or Girl Scouts and team sports). Indeed, whether or not they are involved in other group activities, school-age children typically and spontaneously form their own neighborhood cliques, "gangs," and clubs (Sarnoff, 1976). Davies (1999) points out that school-age children define themselves in terms of their group membership, not just as individuals.

Children's intrinsic need for belonging and peer acceptance attests to the importance of group experience for their developing sense of personal identity. It is therefore quite logical to employ a group format to help, treat, or counsel children who are experiencing personal, emotional, or behavioral difficulties that interfere with their optimal functioning.

A helping/counseling/therapy group provides children with a social experience in a "safe," nurturing environment that encourages emotional expression and problem solving in the process of demonstrating different individual styles of interacting and coping with common problems. Depending on the type of group and its composition, each member will inevitably be exposed to a variety of responses beyond his or her individual repertoire. Therefore, a counseling group constitutes a learning experience, in addition to providing support and acceptance.

There is general agreement about the rationale for treating children in groups, which Johnson, Rasbury, and Siegel (1986) summarize as follows:

> Groups provide socialization experiences that cannot occur in individual psychotherapy; specifically, the child is exposed to a wider range of relationships. Group treatment is often more appealing to the child than individual treatment because there are more varied activities and experiences, and for some children it is often less emotionally threatening than individual treatment. (p. 266)

The power of the group to promote behavior change can be far greater than generally occurs in individual treatment because of the members' strong motivation for peer acceptance. Peer pressure becomes a strong force in middle childhood because children are afraid of being rejected, excluded, or viewed as inadequate by their peers (Davies, 1999). For children, the peer group can be "either supportive or assaultive" (Papell & Rothman, 1984, p. 1), with corresponding impact on the youngster's sense of self-esteem and identity. A structured group involving both activity and verbal interaction can, through the influence of the peer culture, assist the children with their individual problems and growth needs (Kolodny & Garland, 1984). During the beginning phases of the group, protection may exist for the shy, tentative individual who fears "exposure," but the balance soon shifts in the form of group pressure on individual members to take risks and make changes in their usual ways of relating. Ideally, such a group combines acceptance and confrontation, serving as a behind-the-scenes cheering squad for individual members.

DIFFERENT TYPES OF GROUPS FOR CHILDREN

There is a tendency among some group workers to distinguish between "therapy groups" and "activity groups," with those preferring the latter indicating that they do not want to "pathologize" children's behavior by indicating that they need "therapy" (Malekoff, 2002). On the other hand, professionals with mental health backgrounds consider "therapy" as a positive, not a negative, term. When, for example, children have been sexually abused, group *therapy* is generally considered the treatment of choice (Pelcovitz, 1999; Finkelhor & Berliner, 1995). An antimedical bias, as discussed in Chapter 4, should not lead to rejection of appropriate group therapy treatment when this is indicated by the nature of the child's experiences and behavioral responses.

However, services for children, whether in the form of therapy groups or activity groups, should occur in a format that is developmentally appropriate. This means that with young children the use of activities may be essential to supplement verbal discussions and meet the children's needs for concrete representations of their experiences. Activities provide opportunities for socialization and ego development and therefore contribute to a "therapeutic" outcome. For example, a group of children in foster care were guided over several weeks in a project called "Write Your Own Life Story/Picture Autobiography" (Brandler & Roman, 1991). The structured drawing and personal storytelling actually became "a tool to address the terrible grief these youngsters [felt] about the loss of family" (Brandler & Roman, 1991, p. 128). Hence, an activity can become therapeutic, even as the "therapy" involves an activity; the distinction between "therapy groups" and "activity groups" overlooks the basic interrelationship between the two in work with children.

Historical Overview of Group Work with Children

An excellent review of the development of group psychotherapy with children can be found in Johnson et al. (1986), from which the following discussion is loosely drawn.

In the early 1930s, activity groups were initiated at the Madelyn Borg Child Guidance Institute in New York as an adjunct to individual therapy for children who appeared to require socialization experience. Over a period of 8 years, Samuel Slavson (1943) studied and worked with more than 750 children in 55 separate group treatment programs. He stated that

> in group therapy, we work with children who are directly rejected by parents, family, school, street gangs and community center. . . . They are either excessively aggressive or excessively withdrawn; obsessed with great fears or guilt; they overcompensate . . . by nonsocial or antisocial behavior. . . . What a child needs in such circumstances is a haven of relief, a sanctuary where these distressing, threatening, and hostile pressures can be removed and relief supplied. (Slavson, 1943, pp. 2–3)

The appropriate treatment environment, according to Slavson, is a permissive, noncontrolling setting that provides children the opportunity to express their thoughts and feelings through play and action. The role of the therapist, in Slavson's model, is nondirective or client-centered, although grounded in psychoanalytic theory.

Adaptations of Slavson's "activity group therapy" were developed by Redl (1944), Axline (1947), and Ginott (1961) in approaches stressing ego development through play activities and personal accomplishments. Axline and Ginott employed nondirective methods in which the therapists verbalized and reflected the children's feelings as they emerged in the context of play.

Because the nondirective and noninterpretative format of activity group therapy requires some capacity on the part of the children for self-regulation and emotional control, Slavson later developed a more structured and interpretation-oriented group for disturbed children who needed and benefited from external control and guidance from the therapist. This modified approach, called "activity–interview group psychotherapy," was pilot-tested with latency-age children and subsequently adapted for use with prelatency and early latency-age children in the 1950s by Slavson and Schiffer (1975). For further information about both of Slavson's approaches, see Schiffer (1984).

Behavioral group treatment models emerged in the 1960s as an alternative to psychodynamic and client-centered approaches (Rose, 1967). Focusing on behavior rather than personality as the target of change, behavioral group therapy is highly structured, with specific tasks and goals set for the members. Learning and reinforcement principles, such as behavioral contracting, rehearsal, extinction, modeling, and systematic desensitization techniques, help children to acquire skills in making friends, reducing their aggression and anxiety, and learning about the impact of their behavior on others (Rose, 1972; Bloomquist, 1996).

Current Range of Children's Groups

As we begin the 21st century, we find a veritable plethora of groups for children. These vary according to the nature of the problem situation, the

children's developmental stage, and the philosophy and theoretical stance of the helping personnel regarding the appropriate type of intervention.

Numerous group models target children who have experienced loss, either through parental divorce (Kalter & Schreier, 1994; McGonagle, 1969/1985) or through the death of a family member, teacher, or close friend (Vastola, Nierenberg, & Graham, 1986; Tait & Depta, 1993; Doster & McElroy, 1993; Hickey, 1993). Other reports in the literature include school-based support groups for children of cancer patients (Call, 1990), groups for children in families with HIV/AIDS (Dane, 2002; deRidder, 1999), groups for siblings of handicapped children (Block & Margolis, 1986), groups in a shelter for battered women and their children (Roberts & Roberts, 1990), time-limited groups for children with a variety of problems (Rose, 1985; Gallo-Lopez, 2000), activity groups with children who witnessed violence (Nisivoccia & Lynn, 1999), crisis "debriefing" groups for children in shelters following a natural disaster (Hoffman & Rogers, 1991), and group play therapy (Sweeney & Homeyer, 2000). Most of these groups employ a structured, time-limited format.

Accounts of groups that utilize cognitive and behavioral methods with children include a play group for a 5-year-old boy who had difficulty with peer relationships (Boulanger & Langevin, 1992), a skills training approach in working with depressed children (Stark, Rafaelle, & Reysa, 1994) and with children who have social skills deficits (Schaefer, Jacobsen, & Ghahramanlou, 2000), and cognitive-behavioral group therapy for children with anxiety and phobic disorders (Ginsburg, Silverman, & Kurtines, 1995). With such groups being so ubiquitous, one might ask whether there are any situations in which the referral of a child to a group would be contraindicated. This question is discussed further in the next section.

An Integrated Model for Children's Groups

As previously mentioned, there has been and still is strain in the helping professions between practitioners who provide group *therapy*—focused on helping individuals within a group format (termed the "remedial" model; Papell & Rothman, 1966; Vinter, 1959)—and other practitioners who focus on the group as an entity unto itself, believing that the individuals in such a group benefit both through providing assistance to others and through receiving support from the other group members (the "mutual aid" model; Schwartz, 1977; Gitterman & Shulman, 1986; Shulman, 1984, 1999). For reasons related to children's immature development and special need for adult protection and guidance, neither model in its pure form seems apt for application to children. Rather, I recommend an approach that integrates elements of both models. Children will

not participate in a counseling group (even when they are required to do so) unless they find it enjoyable, interesting, or otherwise appealing. They are social beings, however, and once they begin participating in a group, most benefit greatly from the feeling of acceptance that emerges from the experience of group membership.

Perhaps a new model of social group work merits consideration with regard to children. I suggest that we refer to this model as the "integrated model." With the dual goals of helping each child group member toward greater appreciation of individual *and* group (social) awareness, this approach would meet the children on their level (through providing activities) and at the same time would increase their sense of self-esteem through the experience of group sharing, acceptance, and bonding. The definition of group work formulated by the American Association of Group Work in 1948 seems especially applicable to work with children within the integrated framework just described: "Group Work is a method by which . . . both group interaction and program activities contribute to the growth of the individual, and the achievement of socially desirable goals" (quoted in Sullivan, 1952, p. 420).

A Children's Group Therapy Association, founded by social workers in the greater Boston area in 1977, holds an annual conference in New England in May. Many of the presentations in this conference reflect an integrated approach to group work with children, although none are explicitly labeled as embodying such an approach.

There seems to be a growing recognition of the importance of group work with children. Work with children is different from work with adults, and it does not conform to structures adapted for adults. Group work with children is a promising and rewarding field of practice for social workers. The discussion and case examples in this chapter and elsewhere in this text attest to the viability and versatility of this helping method.

CONSIDERATIONS IN PLANNING A GROUP FOR CHILDREN

Group Composition: Prescreening to Determine Membership

In planning a group for children, the following factors must be evaluated in a screening interview with each child that provides the opportunity to determine the child's suitability for placement in the group:

- The purpose of the group
- The degree of homogeneity–heterogeneity among members

- Ages and gender of members
- Level of maturity and attention span
- Type of problem situation
- Leadership (a single leader vs. coleaders)

Nisivoccia and Lynn (1999) describe a 12-week school-based group of nine girls, between the ages of 9 and 11, each of whom had witnessed violence. The types of violence to which the girls had been exposed included murder, rape, knife fights, stealing, and domestic violence.

Size and Age Considerations

This was a structured group in which programmed activities in each session provided opportunities for the girls to increase their interpersonal skills and to offer mutual aid to one another. If the group had not been structured, a more feasible size would have been four to six children. Children in kindergarten or first grade, who often have difficulty focusing for longer than 20 or 30 minutes at a time, probably would do better in a group limited to three or four children. Thompson and Rudolph (1992) and Johnson et al. (1986) recommend that the age range and/or grade span among child group members not exceed 1–2 years.

Degree of Homogeneity

Because each child deserves the opportunity to participate in the group, the leader(s) must weigh all factors impinging on the comfort level of the members. Usually, the degree of homogeneity with regard to the nature of the problem situation provides a unifying bond, referred to by Schwartz and Zalba (1971) as "the common ground." For example, a child who has HIV may feel tremendous support in a group of peers with the same diagnosis, and the mixing of genders in such a group would not be contraindicated, because the significance of the diagnosis outweighs the possible importance of gender commonality. On the other hand, a mixed-gender group would *not* be appropriate for children who have been sexually abused and whose discussion might be constricted in the presence of members of the opposite sex. In the first group session of the witness-to-violence group, the leader stated that each girl there had "witnessed something terrible and may have some feelings about it" (Nisivoccia & Lynn, 1999, p. 81). This statement helped establish the common ground.

According to the "Noah's Ark" principle (i.e., two by two), each child in a group should share certain identifying characteristics with at least *one* other group member. Thus it is not advisable to put a single boy in a

group with all girls or a single white child in a group with all black children. Children have a need to belong and to fit in, and because they tend to think concretely, they pay close attention to physical characteristics.

Contraindications for Group Membership

The leader(s) must consider the personality attributes of prospective members in order to form a balanced group. Children who present in an extreme way—for example, as excessively self-absorbed, domineering, or unable to give attention to the concerns of peers—probably would be ostracized by a group, with negative consequences for both the individuals and the group as a whole. Yalom (1985) cautions against admitting a potentially "deviant" member into a group because of probable negative responses that will be detrimental to all. In situations in which a leader questions whether or not a prospective group member will "fit," better results may be obtained through arranging a period of individual counseling rather than risking the possible demoralizing experience of rejection by the group. Of course, it might be argued that a "misfit" desperately needs socialization experience. However, a period of individual counseling might help such an individual to reach a point at which group contact would be beneficial.

In addition, group membership may be contraindicated when an individual has been exposed to a stigmatizing or traumatic event that may be difficult for the prospective member to discuss among others and/or that may be too horrific for children in general to hear. In the witness-to-violence group, all members had observed disturbing events, so it was possible for them to support one another. However, it would *not* be appropriate to put a child who had seen a parent murdered in a divorce group with children who had witnessed milder forms of parental conflict. Also, the child who has been bereaved by suicide usually benefits from individual, rather than group, therapy (Eth & Pynoos, 1985; Webb, 1993), as does the child who has been a victim of a traumatic experience (Eth & Pynoos, 1985). When a child has symptoms of posttraumatic stress disorder, the usual treatment protocol includes guided reenactment of the trauma at the child's pace, facilitated on an individual basis with a trained therapist (Bevin, 1999; Doyle & Stoop, 1999). However, when a *group* of children (e.g., a school class or club group) has undergone a traumatic experience (e.g., a natural or human-made disaster), a crisis debriefing group soon after the event is helpful and can serve a preventive intervention purpose. Crisis intervention group debriefing is discussed more fully later in this chapter.

Group Format and Structure

Open-Ended or Time-Limited

A major consideration with regard to the structure of the group is whether it will be open-ended or time-limited. An open-ended group is ongoing and permits members to remain as long as they perceive the need to do so. When old members withdraw from the group, new individuals are added; this permits more seasoned members to orient, and serve as role models for, the newer members. An example of this type of group is a group for children living in substance-abusing families. Some groups targeted for these children follow a structured approach, using a curriculum within an 8- or 12-week format, during the course of which the group membership remains constant. Other programs for children of alcoholics or drug abusers follow the Alcoholics Anonymous model, in which the membership may change from week to week, although some members attend indefinitely as a core group. This model is discussed more fully in Chapter 13.

Either the open-ended or the time-limited group format can be useful, depending on the purpose for which the group is being formed. Because children's sense of time is guided by school semesters, vacations, and holidays, a time-limited framework can conform naturally to their lives. A 12-week group, for example, can be completed between Labor Day and the Christmas vacation. If the group will be repeated during the spring semester, some of the same children may choose to enroll again. In this situation, the leader(s) should evaluate in advance whether to extend a reenrollment offer to previous group members. Sometimes there are more children than can be accommodated in the available groups, and "triage" decisions must be made to insure that all needy children receive service.

Length of Group Meetings

The optimal length of the group meetings also needs to be planned, with practical matters usually dictating these decisions. When a group meets during school, for example, the length of the class period determines the length of the meeting. However, if the group meets after school, the age of the members and the size of the group influence the amount of time needed to assure members full participation. In general, the larger the group and the older the members, the longer the meeting time. For a group of older (11- and 12-year-old) children involved in a structured activity, 1½ hours would be the suggested time period, whereas a

20-minute group meeting may be appropriate for a group of 5- and 6-year-old children.

Frequency of Meetings

The frequency depends on the setting and the purpose of the group. In residential settings and hospitals, group meetings may be convened daily or several times a week. Outpatient settings, such as clinics, community recreational settings, and schools, more typically hold group meetings on a weekly basis.

Leadership Considerations

The question of whether to have a single group leader or coleaders deserves reflection, although in many settings coleadership is not an option because of limited staff availability. There are many advantages to coleadership, especially when one leader is male and the other female, as this arrangement simulates parental roles and provides the opportunity for role modeling. Coleadership also permits the leaders to share impressions about the group, as well as to divide responsibilities for collaborating with other professionals involved with the children, for keeping records, and for maintaining contacts with the parents or guardians, according to the expectations created and agreements made when the group was initiated.

However, coleadership can become a problem if the leaders become competitive with each other, cannot agree about goals, or cannot work comfortably together because of personality or philosophical differences. These possibilities need to be discussed prior to the beginning of the group, so that another leadership plan can be implemented if they cannot be resolved.

When a leader works alone, it is important that he or she receive supervision, because the process of reviewing the group's progress and impasses will assist the leader in maintaining the necessary degree of objectivity. The leader will also benefit from systematic thinking about the nature of his or her leadership role with the group.

Necessary Ground Rules for Children's Groups

In order for a children's group to function effectively, the children must understand the expectations involved in membership. Often part of the first group meeting is devoted to the establishment of rules, which the

children draft for themselves with the leader's assistance. A basic expectation relates to attendance. Children are urged to attend every session, and if they disagree or disapprove of something that happens in the group, they are advised to bring it up at the time. Some group leaders ask children to sign a contract in the first session, agreeing to come for the planned number of group meetings.

Kalter and Schreier (1994) mention these other typical rules in children's groups:

1. Listening (i.e., only one person talks at a time)
2. Right to pass (i.e., members have no obligation to speak or respond)
3. No putdowns (i.e., there is to be no teasing or name-calling)
4. Confidentiality (i.e., members can report outside the group only what they and the leaders have said in the group, *not* what other group members have said)

The Particular Importance of Confidentiality

Probably no issue is more critical than confidentiality. Children may not understand the rationale for keeping what is discussed by others private, and even if they do understand, they may not have the self-control to maintain the promised confidence. Some group leaders use a "confidentiality contract" to emphasize the importance of this issue (Stark et al., 1994). Figure 8.1 illustrates such a contract.

CONFIDENTIALITY CONTRACT

It is important for me to respect the rights of others to confidentiality, just as I want them to respect *my* right to confidentiality.

I hereby promise not to tell ANYONE outside the group what any other group member says during our meetings.

WHAT IS SAID IN THE GROUP MUST ***STAY IN THE GROUP.***

This promise lasts even after the group is over.

Name___________________
Date___________________

FIGURE 8.1. A sample confidentiality contract.

The limits and conditions on the worker's promise of confidentiality should be mentioned in the initial group meeting during the orientation discussion of group members' responsibilities to one another and to the group. Specifically, the worker or counselor states that there are three circumstances in which he or she will be obligated by law to reveal what members say in the group. These are situations in which members discuss their intent to hurt either themselves or others or in which members disclose that someone is hurting them.

In the event that the leader is obliged to break confidence and report a member's disclosure of physical or sexual abuse, serious repercussions can arise for the continuation of the group because members may no longer feel that the group is a safe place. This also tends to be true in family and individual treatment. The matter of confidentiality's continuing even after death has been litigated in court (National Association of Social Workers, 1994).

Banana Splits Groups for Children of Divorce

Banana Splits groups are school-based peer support groups created for school personnel for children of divorce (McGonagle, 1989). The manual states: "BANANA SPLITS is a group for any kid whose family structure has changed. Living with a single parent, a step-parent, a grandparent, all are valid prerequisites for membership" (1989, p. 3:1). It is a comprehensive program that originated in a single school and that has, over the course of a decade, spread to many states. The manual includes curriculum guidance for conducting groups in elementary schools and secondary schools and for parent groups and staff development. The program philosophy is based on the triad of the home, school, and child, recognizing that children in divorcing families respond to multiple stresses related to the changes in their lives and that these stresses can affect their school performance over a number of years. Therefore, students are urged to attend the group during a 3-year time frame, and they are welcome to return at any time in the future when a change, such as a parent's remarriage, threatens their stability.

The groups provide peer support for students who are all confronting similar problems, such as divided loyalties, visitation, and future or current parental remarriage and adjustment to a stepparent and stepsiblings. Permission is obtained from the custodial parents for their children to participate in this group, and parents are encouraged to contact the group leader with any related concerns and to attend periodic parent educational/discussion groups.

The recommended frequency and time of group meetings in the elementary school is biweekly during the students' 30-minute lunch period. The maximum number of children in the group should be no more than 10. The meetings consist of a combination of activities and discussion.

Initially, each child draws and colors a banana, which then he or she then attaches to a paper palm tree after writing his or her name on it. The name "Banana Split" was chosen because of the positive associations to ice cream and to the reality that divorce involves a "split" in the family.

Selected activities for the elementary group include the following, selected at the leader's discretion:

Graffiti Paper. The leader invites the students to write, on a paper-covered wall, their thoughts about the split or some problems that need to be solved, and/or to write answers to problems written by others. No names are ever used, and the paper is displayed for about 6 weeks. (See Figure 8.2 for an example of a Graffiti Wall.)

Pizza Pie. Students are given two drawings with large circles, representing a pizza. One page states, "The Pieces in My Happy Pie." Students are instructed to divide their "pizzas" into slices and label each slice with something that makes them happy. Then the same exercise is repeated with the "Sad Pizza Pie."

Drawing Exercises. Drawings that depict children in difficult and/or ambiguous situations serve as the focus for small-group discussions. The pictures (given to each student to color) include different scenes, such as a child in court, a child whose braided hair is being pulled by a man and a woman on either side of her (see Figure 8.3), a child sitting at a school desk looking very tuned out and preoccupied, a child writing a letter that starts "Dear Mom," and a child carrying his own suitcases and walking toward an airplane.

The discussion manual lists suggested questions for the leader to ask with regard to the subject of each picture. The students then may be invited to write their answers to the questions on a "private" paper. Then group members discuss the drawing and share their feelings.

Many other activities associated with special holidays are included in the manual. One suggests holding an end-of-the-year picnic at which pizza is served and the children make their own banana splits. The school social worker/counselor/psychologist also writes a letter to the parents to invite them to an end-of-the-year coffee and dessert meeting to discuss the group.

FIGURE 8.2. Example of comments elementary students wrote on the Graffiti Wall. Used with permission of Interact.

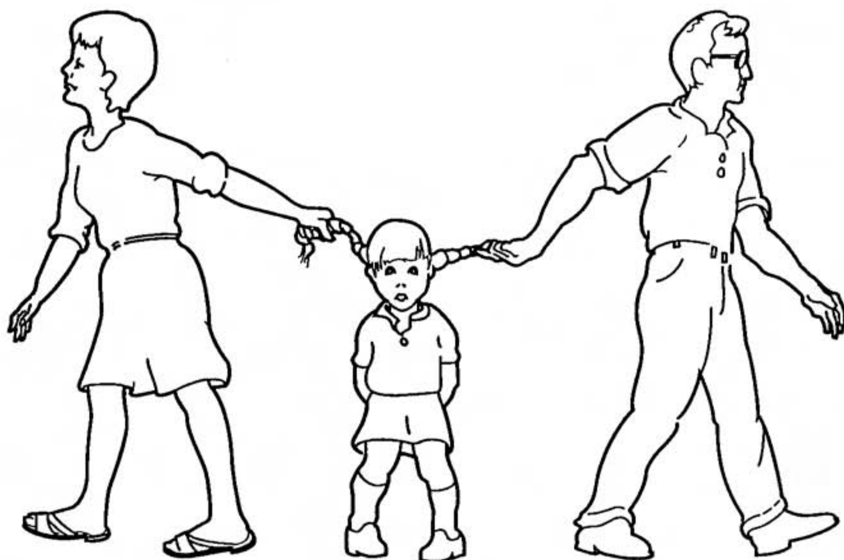


FIGURE 8.3. "Push-me–pull-you" drawing for use in a Banana Splits group. Used by permission of Interact.

Discussion. This program seems very impressive and seems to hold great promise to help children, parents, and school personnel understand and cope with the family changes as a result of divorce. Logistically, however, I think that many schools would find it difficult to implement the program because of the large numbers of children in "split" families and the realities of other demands on the time of school professionals. Graduate interns certainly could lead some of the groups, providing they are supervised. Another possibility is to train volunteers to offer this service in the manner in which hospice uses non-professional staff to run many of their groups and provide associated services. Children clearly stand to benefit from this validating and supportive program.

CRISIS INTERVENTION GROUPS FOR CHILDREN

Both natural and human-made disasters (e.g., natural disasters; explosions; bus, airplane, and train crashes; terrorist attacks; and random shootings) occur with distressing frequency and unpredictability in our world. The "normal" responses to such "abnormal" events include a range of anxiety reactions related to the stress and associated with the perceived threat to personal and physical safety. Children, like adults, experience

fear and anxiety when they witness "unthinkable" events, such as the collapse of a building, the flooding of their home and community, or the random shooting of classmates on their school playground.

Our growing knowledge about the impact of trauma on the lives of children (and adults) has led to intervention models focused on timely outreach to the survivors of the crisis situation. The intent is to facilitate expression of feelings associated with the crisis so that underlying anxiety will not continue to create uncomfortable symptoms. When a community or group of individuals has experienced a crisis, the preferred method of intervention is to conduct a crisis debriefing group. The group format permits individuals to offer support to one another, even as they identify reactions in other survivors that are similar to their own.

The state of California has pioneered the use of crisis groups with children following earthquakes. These groups employ a format and procedures that can be adapted to various crisis situations (Federal Emergency Management Agency, 1991b, 1991c; Santa Clara County Health Department, 1990).

Tasks in a Crisis Group for Children

In any crisis situation, rumors abound. Children are particularly vulnerable to anxiety related to incorrect information or a partial or total lack of information; indeed, adults may unwisely seek to "protect" them by withholding information. Furthermore, children trying to understand puzzling events will often create their own explanations of why something happened and who was to blame. When children have experienced a frightening event together, it is advisable to convene them as a group to talk about, or "debrief," each child's experience of what happened. Clearly, the first task of the leader in such a crisis group is to give information. In language appropriate to the age of the individuals, they should be told about what happened and about the efforts to help survivors like themselves.

A second step in crisis intervention groups with children is to encourage each child to tell his or her own story, giving details and providing vivid descriptions. The leader should ask for specifics related to the individual's perceptions through all five senses. In other words, the child should be asked about what he or she heard, smelled, felt, and tasted during the crisis experience, in addition to describing his or her visual memories. Traumatologists (e.g., van der Kolk, 1987; Eth & Pynoos, 1985; Lindy, 1986) have learned that the detailed and timely recall of traumatic memories helps in the prevention of posttraumatic stress disorder. Because children have limited ability to articulate their experiences in words,

drawing and play activities can be utilized to assist them in externalizing their feelings about traumatic events. An excellent videotape illustrating school-based interventions with children following earthquakes is available from the Federal Emergency Management Agency (1991a). This tape demonstrates a classroom debriefing that includes drawing activities in addition to class discussion. Figure 8.4 shows a sample drawing made by a child in a debriefing session following an earthquake.

The individual storytelling and the drawings provide the leader of the crisis group with the opportunity to universalize reactions to the crisis, so that group members do not feel peculiar or stigmatized because of the nature of their feelings. Sometimes parents and other adults unwisely minimize children's feelings, thereby depriving them of the opportunity for validation that occurs in a debriefing group. This validation is supportive and helps children put the frightening experience in the past so that they can move on with their lives.

A final task of the crisis group is to help the children identify the strengths resulting from their having survived the experience. Implicit in the circumstances of both natural and human-made disasters is a sense of helplessness. Although it would be unrealistic to assure children that they can *always* survive future disasters, it is helpful to assist them in identifying what they have learned from this experience and even to in-

FIGURE 8.4. Child's drawing in a debriefing group following an earthquake. Drawing courtesy Katharyn E. K. Ross, National Center for Earthquake Engineering Research, State University of New York College at Buffalo. Used with permission.

dicate ways in which they may feel stronger and better prepared to meet frightening experiences in the future.

In summary, the following tasks guide the work of leaders in crisis debriefing groups with children:

1. Give information about the crisis in language comprehensible to the children.
2. Encourage detailed recounting of the crisis experience by each group member.
3. Universalize and normalize personal reactions to the crisis.
4. Identify strengths and new coping abilities learned as a result of the crisis experience.

Case Example 1: The World Trade Center Bombing, February 26, 1993

In a previous publication (Webb, 1994a), I analyzed and made recommendations regarding the intervention of a school-based crisis team following the February 1993 terrorist attack on the World Trade Center in New York City, during which 17 kindergarten children were trapped in an elevator for 5 hours. Although I was not a member of that crisis team, I read numerous accounts about their interventions and spoke to various school personnel who were involved in the aftermath of this crisis. For the purposes of this chapter, I want to invite the reader to attempt to apply the principles of crisis debriefing to this event.

The facts of the situation are as follows. The children, from nearby Brooklyn, were on a school-sponsored field trip to the second tallest building in the world; they had enjoyed the view from the observation deck on the 107th floor and eaten lunch. As they were descending in the elevator, preparing to take the bus trip back to their school, the elevator suddenly stopped between the 36th and 34th floors. No one in the elevator knew that there had been a bomb blast; however, the lights and ventilation went off, and the children could smell smoke. There was no communication between the elevator and the outside world for several hours. On the eventual rescue and safe return of the children to their school many hours later, the bus was greeted by camera crews and the crisis team carrying balloons. Several parents were described as "hysterical," and most parents preferred to take their children immediately to the safety of home for the weekend, rather than accept the invitation of the crisis team to attend a group meeting when they descended from the bus. Only a few families attended this first debriefing session.

The next involvement of the crisis team took place in the kindergarten classroom the following Monday morning (the bombing had occurred the previous Friday). According to the oral reports and accounts of teaching personnel, the team members spent approximately half a day in the classroom; they engaged the children in play activities, using blocks and other play materials to reenact the explosion in the building, which had been repeatedly portrayed on TV over the weekend. The crisis team also encouraged the children to draw pictures of their experiences.

Was this intervention sufficient to relieve the tension and fears these children may have experienced during their 5-hour ordeal of being trapped in a dark, hot elevator? For some children it may have been, as we know that simple exposure to a traumatic event does not automatically result in traumatization for all individuals. In fact, the available research indicates that "even after extreme trauma, . . . only approximately 40% of an exposed population develop Posttraumatic Stress Disorder" (McFarlane, 1990, p. 74). However, there is no way to distinguish those who are vulnerable from those who are not, so a group intervention targeted to the entire exposed population offers the most prudent means for a prevention of severe reactions at a later date.

Ideally, such an intervention should involve every child in a verbal and play reenactment of what he or she experienced. We do not know about the specific meaning of a crisis to each individual involved until we ask and listen. Because young children's verbal abilities are limited, play approaches (together with verbal inquiries) are necessary. Let us consider what could have been done in this case, using the four tasks described above as a guide.

1. *Give information about the crisis.* In this event, as in many crisis situations, there was a lot of confusion about what actually happened and who was to blame. In trying to explain these circumstances to 5-year-olds, a simple statement such as, "Something very bad happened, and we don't know yet who or what caused it" would have conformed to the truth; it would also have permitted a reassuring follow-up about the fact that they were safe now and the police would take charge of the situation. Such an explanation, in language children can understand, permits the children to leave the matter in adult hands so that they themselves can proceed with their lives.

2. *Encourage detailed recounting of the crisis.* Each of the 17 children should have been given the opportunity to describe what he or she experienced. Although it probably would not have been feasible for each

5-year-old to listen to the accounts of 16 other children, it would have been possible to divide the group in half, so that each child would have heard about the experiences of 7 or 8 other children. In view of the children's young ages, their accounts would probably have been rather brief; nonetheless, they would have offered a trained observer an insight into the degree of each child's perceived stress in this situation. Children appearing to be seriously stressed could have been identified for further follow-up on an individual basis.

3. *Universalize and normalize personal reactions*. After several children had expressed their feelings, either verbally or through drawings or play, the leader could have begun to draw parallels (where appropriate) and to ask whether others felt the same way. Even when expressed feelings were not shared, the leader could have validated each child's individual experience.

4. *Identify strengths and new coping abilities*. The sense of helplessness and dependence on adults typical of young children may actually have helped these kindergarteners. Whereas with older children the ability to control their anxiety might have been most important, the younger children in this situation who were able to lie down on the floor (at the adult's instructions) and go to sleep may have fared better than some others, who tuned in to the anxiety of the adults and began to cry for their mothers and experience somatic reactions. The crisis group leader would have needed to emphasize that *all* the children survived a difficult situation, even those who were very worried. Feelings of gratitude about being rescued and about cooperating with the rescue personnel would have helped restore a sense of security to these young children.

Case Example 2: The World Trade Center Attack, September 11, 2001

It is chilling to face the reality that terrorism has increased so significantly since the first World Trade Center bombing in 1993. The truck bombing of the Alfred P. Murrah Federal Building in Oklahoma City killed 168 people and injured more than 500 others (Kight, 1998) and the four plane crashes on September 11 killed almost 3,000 and affected hundreds of thousands of citizens who watched the events unfold on television and who joined in the national grieving process.

After September 11, I developed a new tripartite formulation for the assessment of the traumatically bereaved child (Webb, 2002b). This formulation specifies factors that are particularly compelling with regard to traumatically bereaved children following terrorist attacks. These factors include the following, which are fully discussed in *Helping Bereaved Children* (Webb, 2002a):

- Extent of violence/trauma/death (including degree of destruction and proximity to the event)
- Degree of life threat
- Solitary versus shared experience
- Loss of a family member (typically a parent)
- Loss of a predictable future

To what extent can crisis or bereavement groups help children who have experienced traumatic grief under these unique circumstances? Do the guidelines I wrote for the first edition of this book and reviewed earlier in this chapter apply in a crisis of this magnitude?

Because I live in the greater New York suburbs, where there were many families of victims of the World Trade Center attacks, I know that there was a great lag in response to agencies' attempts to set up bereavement services. Initially, this was understandable, because many bodies were missing for months or indefinitely, and families were not ready to grieve because they were still focused on the identification of remains and hoping for a miracle.

Certainly, the first guideline, "give information about the crisis," was operative here insofar as the families needed to know if their loved one had been found. Information was very slow in coming, which added to the stress, to the continuation of hope for a miracle, and to denial about the death and postponement of funerals and memorial services.

The second principle, "encourage detailed recounting of the crisis," was not appropriate due to the traumatic nature of the deaths and the probable mutilation of the bodies. Developmental factors would affect children's ability to comprehend or accurately envision the nature of the deaths. Many children and adults saw bloodied people running from the scene in television playbacks. Some schools, in well-meaning efforts to help, encouraged children to draw or write about what they saw, and a number of children drew pictures falling bodies of people who chose to jump rather than to wait for certain death in the raging fires. The question of whether children who drew these pictures and wrote stories or poems about the event were traumatized or relieved by doing so remains to be studied.

The third principle, "universalize/normalize individual reactions," certainly is relevant here. Parents and children need to be given information that some of their reactions, such as sleep difficulties, are related to their traumatic bereavement. Information about posttraumatic stress disorder helps older children and parents understand some of their symptoms. However, many children, even those who attended bereavement groups, could not bear to talk about their losses until after the 6-month anniversary (Hartley, in press). So the timing of normalization has to occur in synchrony with the children's readiness to share some of their reactions.

The fourth principle, "identification of strengths and new coping," also is time sensitive. It is difficult for people to comprehend that they might gain strength through surviving a loss of this magnitude. Most would rather turn back the clock and resume their previous lives. Many would resent anyone suggesting that they will "grow" from the experience, and this abstract idea would be lost on most children.

However, the outpouring of gifts and offers to help in the form of teddy bears and other toys probably did have an effect on many children who may have marveled that people they do not know from all parts of the country and world tried to help them. Until studies are done questioning families and children about what was helpful to them, this possibility remains speculative. Of course, any research with these families needs to proceed with utmost sensitivity and compassion.

CONCLUDING COMMENTS

This chapter, emphasizing the wide applicability of groups with children, recommends a helping approach that combines play and art activities as a means of furthering communication with young clients. The group modality appeals to youngsters, who benefit from the sense of belonging and peer support intrinsic to an effective group. In group work with children, activities are considered as therapeutic tools, so the distinction that is sometimes made between "activity groups" and "therapy groups" does not apply. Instead, I have proposed an integrated model that joins both approaches.

It is important for the success of a group that the leader or leaders plan its composition and involve the members in adopting certain guiding principles that will assure each person confidentiality and respect. When these procedures are followed, the group can result not only in improved social interactions but also in increased feelings of self-esteem among individual members.

The special circumstances and guidelines for conducting crisis debriefing groups have been presented. Unlike other groups, which require prior screening of members, a crisis group consists of all individuals who shared a traumatic event. Timely and detailed attention to the emotional state of each individual helps prevent future possible symptom development, even as it helps group members realize that many of their feelings are shared by others. Bereavement groups with traumatically bereaved children must respect their varying abilities to deal with their painful traumatic memories. Acceptance of the support of others can help them heal, even as they can gradually reach out to other group members.

I hope that this chapter will encourage more social workers to use groups with children and will thereby reduce the neglect of this helpful modality in work with young clients.

DISCUSSION QUESTIONS AND ROLE-PLAY EXERCISE

1. Review some of the advantages of group interventions for children. What is the appropriate manner for preparing a child to enter a group?
2. Imagine that in a group for children with divorced parents, the male and female leaders disagree about the issue of visitation with the noncustodial parent. Consider the ideal way for the leaders to resolve their differences and speculate about the possible repercussions in the group if the matter remains unresolved.
3. How would you begin a group composed of 6- to 8-year-old children whose parent died in a traumatic explosion? Role-play what you would say and how you might deal with the silence of children who cannot talk about the death because it is too painful.
4. Identify a crisis event involving a group of children that was reported in the news media. Outline a model preventive intervention approach that would utilize group debriefing with the child survivors.

❖ CHAPTER 9 ❖

School-Based Interventions

Next to the family, the school is probably the biggest influence on a child's life. In fact, because the school assumes responsibility for students during the time the children are on the school premises (i.e., the majority of children's waking hours), the school's role has been described as *in loco parentis* ("in place of the parents"; Allen-Maeres, Washington, & Welsh, 2000). This shared responsibility for the well-being of the dependent child makes the liaison between school and home both logical and essential.

SCHOOL–HOME–COMMUNITY PARTNERSHIPS

In addition to the natural link between school and home, an even broader liaison exists between the school and community agencies. This reciprocal community–school relationship includes, on the one hand, school-initiated efforts to involve the community in matters related to children's safety and well-being and, on the other hand, the community's vested interest in obtaining the school's participation and involvement in projects outside the school that have an impact on children. Examples of the former efforts are school-initiated programs that link latchkey children with senior citizens, so that these children have regular, planned telephone contacts with adults after school. Conversely, an example of a program initiated in the community and later implemented in the schools is the "Good Touches/Bad Touches" curriculum (Turkel & Fink, 1986), which was developed in a mental health agency because of community concern about sexual abuse of children. It subsequently received state approval and is used in many New York State elementary schools.

Thus school-based interventions necessarily include work with the community and with parents, in addition to individual and group work with children. Helping children through school-based interventions includes work "from the outside in" (collaboration initiated by professionals outside the school system), as well as work "from the inside out"

(efforts initiated in the school and reaching out into the family and community).

"From the Outside In": Essential Communication with the School

Any effort to help a child must *always* consider the nature of the child's functioning in school. Because learning requires psychic energy, a kindergarten child's preoccupation with her mother's impending surgery, for example, may cause the child to have trouble concentrating and to appear "spacey" to the teacher. (See Chapter 12 for details about such a case.) Ideally, the medical social worker, knowing that the mother has a young child, would obtain the mother's permission to contact the school in order to inform appropriate personnel about the impending surgery and hospitalization. This information would permit the school to connect changes in the child's behavior to her worries about her mother. Referral to the school social worker would insure that the child would receive support during this difficult period.

Professional helpers working with a family in distress should *routinely* ask for permission to contact the school for information about the child's past and current functioning. Sometimes parents (and even professionals) do not perceive the need for this contact, especially in situations that may appear to be non-school-related (e.g., following a death or some other traumatic family event, such as a house fire). However, professionals in the community should point out to the parents the relationship between a child's emotional state and his or her ability to concentrate and learn. In addition, parents need to understand that when *they* are worried, the child usually intuits the parents' concerns, even in the absence of direct information. When social workers in family and child welfare agencies, hospitals, and emergency crisis clinics inform the school about a child's exposure to an upsetting event, this not only sensitizes the school regarding the child's needs but also helps build relationships with relevant school staff members that may pay future dividends by expediting referrals and facilitating future collaboration about the case.

Additional "Outside" Influences on the School: Legislation

Because schools receive their funding from federal, state, and local appropriations, the services offered to children depend on the availability of resources and on legislation approving specific programs. The estab-

lishment of these programs, in turn, affects the role of the school social worker. Hancock (1982), in a statement as true today as it was 20 years ago, summarizes the significance of legislation on school social work practice as follows:

> School social work practice is affected by federal and state legislation and by the resultant school policies. School social workers must become familiar with present laws relating to education and be alert to new legislation. . . . The effectiveness of school social work practice can be greatly diminished by the failure to acquire basic knowledge of legislation pertaining to education and [to keep] up with new developments. It is also essential to be thoroughly acquainted with the policies of the school and sensitive to the need for changes in policy. (p. 41)

Reviews of legislation that influence services to children in schools appear in Costin (1987) and Allen-Meares et al. (2000). The present discussion focuses on the specific laws that have a direct impact on the practice of school social workers: the Education for All Handicapped Children Act (Public Law 94-142, 1975), which was amended in 1990 by the Individuals with Disabilities Education Act (IDEA, Public Law 101-142).

Education for All Handicapped Children Act (Public Law 94-142)

Public Law 94-142, passed in 1975 with no expiration date, guarantees all disabled children between the ages of 3 and 21 years of age the right to an appropriate public education in the "least restrictive environment." This landmark law "requires that an individualized education program (IEP) be developed for every handicapped child and that the IEP specify the educational and related services to be provided." The law specifies that these services are to be provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel (Newton-Logston & Armstrong, 1993, p. 187; see also Assistance to States for Education of Handicapped Children, 1991).

As a result of this law, social workers have assumed a visible and important role as case managers in the schools of many states. It was very significant to the field of social work that Congress specifically mentioned the tasks and services social workers would perform in connection with this legislation (Hancock, 1982; Allen-Meares et al., 2000). Social workers typically coordinate an array of interdisciplinary school personnel in developing the IEP for each student classified as disabled. They also prepare the social history, make sure that all relevant information is considered in formulating goals, and include the parents as equal partners in

the educational planning for their child. The recommendations of an IEP for a classified child are discussed more fully later in this chapter, in connection with the case of Eli.

Classification of disability occurs following a comprehensive evaluation by a team of specialists who gather and review extensive information regarding the child's academic achievement, learning characteristics, social and physical development, and management needs (New York State Department of Education, 2002a). Table 9.1 lists and defines the classification of disabilities according to the latest federal regulations. A full discussion of each of these disabilities is beyond the scope of this chapter; however, Turner (1989) and Mash and Barkley (2003) provide a complete review of child psychopathology, including chapters on behavior disorders, various emotional disturbances of childhood, and learning disorders. A section on children with special needs and a case example involving an autistic child appear later in this chapter.

Individuals with Disabilities Education Act (Public Law 101-416)

The IDEA replaced Public Law 94-142 in 1991. It provides assistance to states in developing early intervention services for infants and toddlers with disabilities and their families, and it assures the education of children and youth with disabilities from birth to age 21. The school social worker is involved in providing a behavioral assessment, including observational data and information about the child's social development. Parents are entitled to participate in the placement decisions, and the social worker often plays an important role in educating parents about the benefits and encouraging their participation. The principle of the "least restrictive environment" emphasizes the expectation that placement should be made with the child's typically developing peers, unless the student's disabilities require a special placement.

OVERVIEW OF THE ROLE OF THE SCHOOL SOCIAL WORKER

"From the Inside Out": Working within the School

Social workers have provided school-based services since the turn of the century, when they were called "visiting teachers" because they made home visits to help orient immigrant families to U.S. culture and the role of the school (Costin, 1969, 1987; Allen-Meares et al., 2000). The nature of the school social worker's role has varied since then, with emphasis shifting from providing casework services to the individual child, to fo-

TABLE 9.1. Classifications of Disabilities

Classification	Definition of the disability
Autism	Autism is a developmental disability that significantly affects verbal and nonverbal communication and social interaction. It is generally evident before age 3. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences.
Deafness	Deafness means a hearing impairment so severe that it prevents processing linguistic information through hearing, with or without amplification.
Deaf-blindness	Deaf-blindness means concomitant hearing and visual impairments that cause such severe communication and other developmental and educational problems that the student cannot be accommodated in special education programs solely for either deaf or blind students.
Emotional disturbance	This term means a condition that is demonstrated in difficulties in school that cannot be explained by intellectual, sensory, or health factors. Over a long period of time, the student is usually unable to build satisfactory relationships, may be generally unhappy, may develop physical symptoms or have fears associated with his or her school experience, or may demonstrate inappropriate behaviors or feelings.
Hearing impairment	This term refers to an impairment in hearing, whether permanent or fluctuating, that adversely affects a student's educational performance.
Learning disability	This term refers to a disorder in one or more of the basic processes involved in understanding or using spoken or written language. A child who is learning-disabled has difficulty listening, thinking, speaking, reading, writing, or doing arithmetic. This child's disability results in a severe discrepancy between his or her ability and achievement. A learning disability is not primarily due to a physical, mental, or emotional disability or to environmental, cultural, or economic disadvantage.
Mental retardation	This term means significantly subaverage general intellectual functioning that exists concurrently with deficits in adaptive behavior. This condition adversely affects a child's educational performance.
Multiple disabilities	This term means concomitant impairments that result in multisensory or motor deficiencies and developmental lags

(*continued*)

TABLE 9.1. (continued)

Classification	Definition of the disability
	in the cognitive, affective, or psychomotor areas. The combination of these disabilities causes educational problems that cannot be accommodated through a special education program designed solely for one of the disabilities.
Orthopedic impairment	This term means a severe orthopedic impairment that adversely affects the child's educational performance. Included are the impairments caused by congenital anomalies, impairments caused by disease, and impairments from other causes (e.g., cerebral palsy, amputation, and fractures or burns that cause contractures).
Other health impairment	This term refers to having limited strength, vitality, or alertness due to chronic or acute health problems that adversely affect educational performance. These problems may include a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, Tourette's disorder, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes.
Speech impairment	This refers to a communication disorder such as stuttering, impaired articulation, a language impairment, or a voice disorder that adversely affects a child's educational performance.
Traumatic brain injury	This term means an acquired injury to the brain due to open or closed head injuries caused by an external physical force or by medical conditions such as encephalitis, stroke, aneurysm, anoxia, or brain tumors. The injuries result in mild to severe impairments in one or more areas, including cognition, language, memory, attention, reasoning, abstract thinking, problem solving, sensory/perceptual and motor abilities, psychosocial behavior, physical functions, information processing, and speech. The term does not include congenital injuries or impairments caused by birth trauma.
Visual impairment	This term means an impairment to vision that, even with correction, adversely affects educational performance.

Note. Adapted from New York State Department of Education (2002a, pp. 10–12, section 200.1 (zz)).

cusing on the problem rather than on the person, to the more recent conceptualization of facilitating home–school–community collaboration (Franklin, 2000). Ambiguity about their role continues to plague many school social workers, however. Sometimes administrators expect social workers to teach health classes and even to serve as attendance officers of a sort, checking up on the status of children who are chronically tru-

ant. Although some teaching assignments may be relevant to the social worker's role, and although many truant children may be in drastic need of social work services, social workers often resent these job assignments when they occur haphazardly rather than in a preplanned, agreed-upon manner. If school social workers *themselves* feel uncertain about the boundaries of their role, it is understandable that administrators and other professionals are similarly confused about it. Hancock (1982, p. 247) describes this lack of role clarity as follows:

> The role of the school social worker is difficult for others to grasp for it varies in some ways from one school social worker to the next and is susceptible to many interpretations. In addition, school social workers themselves are seeking clarification of their roles. School social workers are not vague about what they are doing in the school, but many of them probably wonder whether they are doing what they should be doing.

This anxiety can be fueled by teachers who expect the social worker to "fix" children, yet fail to understand and accept the necessity to take the children from their regular schoolwork for counseling sessions.

The parameters of the school social worker's role are specified by Costin (1987), who identifies the following roles and tasks:

- Identification of children in need.
- Extending services to pupils.
- Work with school personnel.
- Educational planning for disabled children.
- Work with parents.
- Community services.

All of these important responsibilities are carried out within a "host" setting in which social work is *not* the dominant discipline. Because the main purpose of the schools is education, social workers in school settings must help fulfill this educational purpose. According to Hepworth and Larsen (1982, p. 283), the goals of the school social worker "center upon helping pupils attain a sense of competence, [and] a readiness for continued learning. . . . Increasingly, the focus of school social work is on cognitive areas—learning, thinking, and problem-solving—as well as the traditional areas of concern, i.e. relationships, emotions, motivation, and personality."

In order to facilitate the child's learning, the school social worker serves as a liaison *within* the school system between the children and the school staff and *outside* the school system with the parents and commu-

nity personnel. This role may include, but is not limited to, the following tasks:

- Collecting information about a child for a social history.
- Conferring with teachers, school nurses, and other staff members about methods for helping a child.
- Planning meetings for parents, with speakers and discussions focusing on topics of child behavior, parenting techniques, and relevant community concerns.
- Working with community agencies to establish Big Brother/Big Sister connections for children in need.
- Collaborating with foster care, family, welfare, probation, and other social service agencies that are involved with the child and family.

According to Franklin (2000), the school social worker's very diverse roles encompass consultation, facilitation, collaboration, education, mediation, advocacy, and intervention. Readers who want a comprehensive presentation of the history and scope of school social work services may consult Allen-Meares et al. (2000). The present chapter provides an introduction to the specialty field of school social work through a case presentation of a child with autism in order to demonstrate how a school social worker helped a 7-year-old boy and his family receive needed special education services.

Necessary Knowledge and Skills

The multidimensional role of school social workers requires both generic and specialized knowledge and skills. The *generic* base of knowledge and skills includes the ability to do the following:

- Think systemically.
- Formulate a comprehensive biopsychosocial assessment.
- Appreciate ethnic diversity and its effects on children's socialization.
- Establish and maintain relationships with parents and with personnel relevant to the work with a child.
- Help all parties formulate specific goals related to the child's needs.
- Link the family system to community resources.
- Monitor the progress and involvement of the child and others with respect to the goals.

The core of *specialized* knowledge required for competent practice as a school social worker includes the following:

- An understanding of special education and of the related laws.
- Knowledge about children's rights and parents' rights.
- The ability to work on a team and to communicate effectively with professionals who are not social workers.
- The ability to work within the bureaucratic structure of the school system.
- The ability to implement cognitive-behavioral treatment with children, families, and teachers.
- An understanding of the impact of physical, sexual, and emotional abuse and neglect on a child and knowledge of how to respond appropriately when children are affected by these and other traumatic situations.
- The ability to provide therapeutic intervention with children and families in both one-to-one and group formats.
- The ability to apply crisis intervention theory appropriately, including an understanding of when to utilize appropriate community agencies in a crisis situation.

The school social workers I have interviewed about the nature of their role emphasize the necessity of being able to "think on their feet" and to be able to respond quickly and directly. For example, a teacher in the cafeteria may make an unexpected request for help, or a fight may break out in a corridor that demands prompt intervention by the social worker, who just happens to be in the vicinity. Ginsburg (1989, p. 87) states that "the school social worker should not be hiding in an office. Rather, it is important to be visible and well aware of the school's agenda and of what is happening there."

In 1992, NASW developed a School Social Work Specialist (SSWS) credential and administered the first exam as the basis for the credential. Although this credential is voluntary and not yet required for state social work certification, it represents a step toward establishing national standards of knowledge and practice for school social workers.

ISSUES IN INTERPROFESSIONAL COLLABORATION

Teamwork

Social work with children *always* involves interactions with family members, as well as with others who know the child and who may be able to offer a perspective on the child that enriches the worker's solitary view. Teamwork is fundamental in providing services to the child in the school. The members of the team vary in different settings but often include the

school psychologist, the child's regular teacher and/or special education teacher, a school administrator, and a specialized therapist, in addition to the child's parents.

The Case of Johnny, Age 5

Johnny was referred to the social worker when the child's kindergarten teacher became concerned about his short attention span, aggression toward other children, and impatience about having to take turns on the playground equipment during recess. The teacher asked the social worker to contact the parents to see whether family stress might be contributing to the child's difficulties. In discussions with the child's mother, the school social worker obtained permission to observe the child in the classroom. She also gleaned important information about the family. The parents were actively seeking to adopt a baby; in fact, they had recently left Johnny abruptly to go to a hospital in another state, where a prospective adoptee had just been born. When the birth mother changed her mind, the parents returned home and told Johnny that "the mother decided to keep the baby." Johnny, who knew that he himself had been adopted, became very confused about this sequence of events, as well as about his mother's sadness, irritability, and repeated statements about wanting to "get another baby sooner or later."

Several counseling sessions with Johnny and his mother together provided the opportunity to reassure Johnny that his adoptive parents loved him very much and would never give *him* up, as he had begun to fear. It also permitted both Johnny and his mother to voice their mutual wish to have a little baby in the house, so Johnny could experience being "a big brother." Finally, the mother (with the social worker's guidance) reassured Johnny that if she and his father had to go away again to try to adopt another baby, they would tell Johnny first and say goodbye, even if it was in the middle of the night.

This short-term, school-based intervention brought dramatic improvement in Johnny's peer interactions in school. His ability to focus on his learning also improved, because he was no longer worried about his mother and father's sudden disappearance and about being displaced by a new baby.

This example portrays social worker–teacher collaboration in the ideal situation—one in which the professionals work together to understand the child's problem and in which the parent openly shares the family's concerns with the school social worker. Unfortunately, this ideal state of trust, communication, and cooperation does not always exist.

Ethical Dilemmas: Who Is the "Client"?

Social workers are sometimes uncomfortable with team participation because of the implicit expectation that they share information about families with the other team members. In fact, social workers may feel caught in an ethical bind about disclosing information that was given to them in confidence. Garrett (1994) points out that school social workers may have difficulty determining who the "client" is, as the school, the child, and the family all have a stake in the designated "problem situation." Whereas the NASW code of ethics states that "social workers [should] respect and promote the rights of clients to self-determination" (NASW, 1996, Section 1:02), the application of this principle in school settings requires a concept of the "client" that encompasses the triangle of child, family, and school. Even with this conceptualization, however, the social worker may think it unnecessary and inappropriate to divulge to a child's teacher all the intimate details of the parents' marriage and other sensitive family matters.

Professional discretion regarding sharing of information with other members of the school team, in my opinion, must be guided by the "best interests of the child" and by what will best serve the child's learning experience. Therefore, it may be unnecessary for a teacher to know about a mother's substance abuse background when the mother is in recovery. However, it may be helpful for the teacher to know that this child's working mother leaves her in the care of a babysitter in the evening, as the teacher has noticed that the child yawns a lot and seems tired in school. It is important for the teacher to tell the mother that her child seems tired so that the mother will be able to impress on the child's sitter the need for a regular, specific bedtime.

Parents are often concerned about the nature of the information in their children's school records. As already discussed in Chapter 2, the federal Family Educational Rights and Privacy Act (Public Law 93-380, 1974) gives parents the right to inspect their children's school records. Therefore, all school personnel should be both factual and discreet regarding the information they write in the record. As parents are increasingly encouraged to take an active role in their children's educational planning, school personnel must learn to view parents as partners.

Interprofessional Communication

Because professionals with different backgrounds and training must work together on behalf of the pupils in their schools, it is essential that these professionals understand enough about one another's respective areas of

specialization to communicate effectively. For example, the school social worker needs sufficient knowledge about educational and psychological tests to comprehend their significance in the school psychologist's reports. Similarly, the school social worker should understand the possible contributions of the special education teacher, the speech therapist, and the physical therapist in assisting children with attention-deficit/hyperactivity disorder; they also need to be knowledgeable about the various medications prescribed to alleviate a child's symptoms, especially when fearful parents may ask whether the medications are harmful and if they could cause addiction.

Few school social workers are knowledgeable about the assessment and appropriate intervention for *all* conditions listed as disabling. However, school social workers who become involved in working with such children can build their knowledge base incrementally in order to communicate effectively with their colleagues, as well as with the children's parents, about the children's disabilities and the recommended educational interventions. Because the team approach is inherent in school social work practice, there can be no sense of personal "ownership" of any case; rather, there must be a sharing of responsibility. This mandates interprofessional collaboration, cooperation, and communication.

Working with School Administrators

The role of the school principal has been compared to that of a captain of a ship, insofar as he or she has ultimate responsibility for what happens or does not happen in the vessel or school building. Parents, the school board, and the community expect the principal to be "in charge" and knowledgeable about the curriculum, about after-school activities, and about children who are having difficulties (and the helping plans for such children). Hancock (1982) points out that principals are public figures without job tenure who are vulnerable to pressures from various factions in the community and whose position may subject them to intense scrutiny and even litigation. Skilled principals are described as "able to facilitate and manage change, disperse power, promote schoolwide commitment to learning, encourage experimentation, strongly support teachers while expecting all teachers to participate in the work of the school, and distribute rewards" (Allen-Meares et al., 2000, p. 13). They also influence the climate of their schools through their administrative styles.

Because of the expectations placed on principals, their interest in and need to know about the activities of school social workers and other school employees who interact with parents and agencies in the community is

understandable. Of course, every principal functions according to his or her unique personality and his or her history of relations with past "helpers" (both within the school and without). The attitudes in the community about social workers and their appropriate role and function in the school will also have an impact on the principal.

It is incumbent on school social workers to develop harmonious working relationships with their principals. During the initial phase of their contacts, both parties should articulate and discuss their respective expectations regarding the social work role to avoid future ambiguity and confusion. The common goal of wanting to facilitate the educational experience of the children in the school can serve as the foundation for a solid social worker–principal relationship, which will promote the best interests of the children in the school.

CHILDREN WITH SPECIAL NEEDS

Terminology

The IDEA (Public Law 101-416), as noted earlier, protects the right of children with disabilities to a free, appropriate public education in the least restrictive environment. Before I describe the process of classifying such children, I must first review the variety of general terms used currently and in the past to refer to children with special needs. They have been referred to as "handicapped children," "exceptional children," "disabled children," "defective children," "impaired children," and "children with individual learning differences." When children have more than one special-needs condition, they are referred to as "multiply disabled."

A child may be born with a disabling condition or may become disabled through an accident or injury. Attitudes toward children with disabilities have gradually become more accepting, with emphasis on what the children *can* do rather than on their limitations. Those who prefer to focus on strengths rather than on limitations argue for use of the term "children with special needs." However, the law refers to "children with disabilities," and the classification system uses terms such as "emotionally disturbed," "hearing-impaired," and "learning-disabled" for various categories; such terms emphasize the *losses* or disruptions created by different physical, emotional, and cognitive conditions. It has been said that these views of disability tend to minimize the humanity of the afflicted persons (Lavin, 2002).

In view of the pejorative connotations of most of these labels, the terminology of educators seems appropriately sensitive to children's feelings of being "different" from other children. Thus, being in "special

education" classes or leaving a "regular" classroom to go to the "resource room" does not *ipso facto* imply inferiority (although the children themselves and their classmates often attach their own negative connotations to these terms).

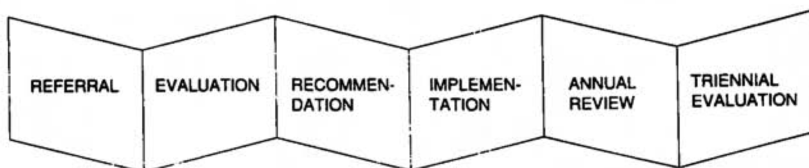
Parents of Special Children

Despite efforts to destigmatize children with special needs, the parents of such a child suffer greatly on learning definitively about their child's specific condition. All parents want their children to be well and to possess the necessary innate abilities to deal effectively with life. When parents are told (either at birth, or later by a pediatrician or other specialist) that there is something wrong with their child, this information stirs up a barrage of feelings, including anger, denial, guilt, and tremendous sadness. Olshansky (1962) coined the expression "chronic sorrow" to refer to the grief of parents in response to the diagnosis of their child's disability and to the recurrence (i.e., chronicity) of that grief throughout the child's life, when it becomes repeatedly apparent that the child's condition requires special assistance from a variety of professionals. Social workers who have ongoing contact with parents of classified children tend to support the view that these parents' grief is chronic and requires sensitive response from school personnel (Rothschild, 1986). The social worker's goals in counseling the parents of a special child, according to Rothschild (1986, p. 42), are these: (1) to increase the parents' acceptance of living with and adjusting to their disabled child and (2) to help the parents develop the tools they need to increase their child's skills through "translating" the processes of children's education to the parents.

Some special education programs offer support groups for parents of special children. Such groups give these parents the opportunity to listen to and discuss both positive and negative feelings and to contribute to and benefit from the solutions of other parents who have similar frustrations and pressures. Dillard, Donenberg, and Glickman (1986, p. 50) point out that "just as a child may experience negative affect and feel separated from the mainstream of school life when placed in a special education class or program, parents may experience similar negative feelings."

The Classification Process

New York State follows a specific procedure in assessing children who have been referred to a committee on special education (CSE) for a comprehensive evaluation. Figure 9.1 illustrates the steps involved in classi-



STEP 1
Referral: Identifying Children Who May Need Special Education

STEP 2
Evaluation: Collecting Information Through Assessment

STEP 3
Recommendation: A Plan for Children's Needs

STEP 4
Implementation: Arranging for Programs and Services

STEP 5
Annual Review: Updating the Program

STEP 6
Triennial Evaluation: Updating Tests and Evaluative Information

FIGURE 9.1. The special education process in New York State for children and youths ages 5–21. From New York State Department of Education (1992, p. 10).

fying a child in New York and following the child's progress, from the referral stage to the optional follow-up evaluations every 3 years. Because school attendance is mandatory in New York State for children between the ages of 6 and 16 (and may extend until age 21 for a child who is classified as disabled), the school and the parents must periodically reevaluate the child's needs for special education. Figure 9.1 and Tables 9.1 and 9.2 are derived from information in a guide for parents (New York State Department of Education (1992) that present a complete, "user-friendly" description of the special education process, in order to provide parents with the knowledge they need to insure appropriate educational programs for their children with special needs. Involvement of the parents is basic to the various procedures, beginning with the referral, which requires parental consent before the evaluation can proceed.

Components of a Comprehensive Evaluation

Once a request for an evaluation has been received and the parents have given their consent, a team of specialists prepares a comprehensive assessment of the child's skills and abilities. The components of an individual evaluation are outlined in Table 9.2. The committee arranges to obtain the necessary information in a timely manner and to schedule discussion of these findings at a CSE meeting, in which parents are urged to participate. The goal of the evaluation is to arrive at a recommendation that summarizes a child's current skills and abilities, establishes educational goals and objectives for the school year, describes programs designed to meet these goals, and lists ways to check the child's progress periodically.

A child may be found ineligible for special education when the committee finds that the student cannot be classified as having one of the disabling conditions defined in Table 9.1. Such "ineligible" children may, however, qualify for educationally related support services (e.g., short-term counseling) or speech and language improvement services, which must be specified on a child's IEP.

On the other hand, when a child is found to be eligible for special education, the IEP details the specific nature of the recommended classes and services, following the principle of the "least restrictive environment." This means that if a child's abilities in a particular area (e.g., math) qualify him or her to participate in a "regular" math class, this placement must be implemented. Special class instruction, when indicated, will specify the student–teacher ratio, with students grouped according to the similarity of their needs.

The Role of the Social Worker in Special Education

Some school social workers work primarily or exclusively in special education programs, but the job descriptions of most school social workers

TABLE 9.2. Components of a Comprehensive Evaluation

An initial evaluation of a child to determine eligibility must include . . .
- A physical examination
- A psychological assessment
- A social history
- Observation in the current educational setting
- Other tests or assessments (such as speech and language, or a functional behavioral assessment)
- Vocational assessments (required at age 12)

Note. From New York State Department of Education (2002a, p. 5).

include work both with children who have been classified as disabled and with children in the general school population. The specific responsibilities of the social worker related to special education includes contact with parents; counseling parents through the evaluation period (and afterward, when indicated); obtaining and writing children's social histories; participating in CSE meetings; advocating for the children; and working with the teachers, special education staff, principal, and families to implement the goals of children's IEPs. Sometimes the social worker provides individual counseling with a child and/or parent or family counseling (which may include home visits); in addition, the worker may provide group interventions with children, as well as with parents who have similar needs.

In summary, the role and functions of the social worker in special education programs are similar to those of any school social worker. However, the special education social worker must also have specialized knowledge regarding classification categories and procedures and the skill and sensitivity to implement this knowledge with other professionals and with parents. Some of these functions are illustrated in the following case.

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THE CASE OF ELI, AGE 7

Family Information

Family members in child's household

Paternal grandmother	Mrs. Yani, age mid–60s.
Father	Mr. Yani, age 35; itinerant construction worker.
Child client	Eli, age 7, second grade (see the following for details of classification and educational placement).

Other family members

Mother (deceased)	Beatriz, died abruptly of complications from a seizure when Eli was 4 and a half.

This is an Iranian family. Mr Yani immigrated to the United States when he was 22 years old, settling in New York. He met and married Beatriz 2 years later. Eli was born a year after that. There was considerable discord in the marriage, and on several occasions Mrs. Yani left, taking Eli with her to live with her parents in Florida.

Beatriz was a native of Honduras and was bilingual in Spanish and English. Mr. Yani is bilingual in Farsi and English. The couple spoke to each

Note. The author acknowledges the contribution of Celeste Theis, CSW, in the preparation of this case.

other and to Eli in English. Eli also had extensive exposure to Spanish during his first 3 years, when he visited his maternal grandparents' home.

Shortly after the Yanis' last reconciliation, Mrs. Yani died in her sleep from a seizure. Eli had been sleeping with her at the time. When Mrs. Yani's body was discovered late the next morning, Eli was found lying naked under the bed in a fetal position, crying.

Within a month, Mr. Yani took Eli back to Iran, where they would both have the support of his family. Eli and his father moved in with Mr. Yani's parents, and Eli began attending school and learning to speak the local language. Mr. Yani stayed with Eli for several months and then returned to the United States to work, leaving Eli with his parents. Eli spent a total of 2 years in Iran with his grandparents, and Mr. Yani visited periodically. Tragically, the area in which they lived was struck by an earthquake, and Eli witnessed the devastation of his school and community, including the death of a young cousin. A month later, Mr. Yani brought his mother and Eli back to the United States to live.

Presenting Problem

Approximately 1 month after returning to the United States, Mr. Yani presented himself at the neighborhood school and asked to speak to someone about his son, whom he had just registered for the new school year. He was referred to the school social worker and the school psychologist. Mr. Yani was proactive in apprising the school of his son's unusual and traumatic history in anticipation that he would have special needs. Mr. Yani alluded to significant difficulties with Eli's behavior at home. Eli was described as a child who was extremely hyperactive, did not sleep at night, was an extremely finicky eater, exhibited oppositional behavior, and became easily frustrated and physically aggressive (throwing himself and/or objects to the floor) when he did not get his way. Furthermore, Eli rarely spoke or made eye contact.

Eli was a 7-year-old child, about to begin school in a new community after being schooled in another country and in another language for the previous 2 years. He had just survived the trauma of a devastating earthquake, which may have rekindled the previous trauma of his mother's sudden death 3 years earlier. Eli was also adjusting to living again with his father and being reintroduced to the English language.

Mr. Yani explained that prior to the latest trauma of the earthquake, there had been serious concerns about Eli's academic and behavioral functioning in the school he attended in Iran. Had they remained in Iran, Eli would have been retained in first grade. His highly distractible and impulsive behavior had prompted the school there to make a referral to

a psychologist, who diagnosed Eli with ADHD. Mr. Yani had not yet followed up on the recommendation for a trial of medication when they left Iran and returned to the United States.

School Placement

Eli began school the next day and was placed in a second-grade class. He presented as a very physically appealing child with light brown hair and sparkling blue eyes. He was quiet and understandably anxious. Although he did not make eye contact, he appeared to understand when spoken to (he had spoken English fluently before moving to Iran). Over the course of the next few weeks, as Eli became acclimated to his new school environment, patterns of behavior emerged that were of great concern. Eli was very hyperactive, distractible, and impulsive. He disrupted the class by making animal noises, crawling on the floor, spitting at his classmates, licking the furniture, and laughing inappropriately. When he did not get his way, he would sometimes become physically aggressive, attempting to bite, kick, or hit his classmates. On occasion he would purposely fall off his chair and repeatedly bang his head on the floor. Eli also presented with compulsive behaviors, such as washing his hands and the furniture repeatedly. If allowed to, he would sharpen pencils all day.

Although his classmates were taken aback by his behavior, some of them did try to befriend Eli. But he did not seem interested in social interaction and showed a clear preference for playing alone.

Eli's academic skills were very limited. He was able to recognize only a few letters and numbers. Although his classwork and homework were modified, Eli refused to even attempt homework. At home, Eli would have violent tantrums when asked to do anything that he did not want to. Mr. Yani, having recently assumed primary parenting responsibility for Eli for the first time, was feeling overwhelmed, helpless, and depressed.

Interventions

Eli was a puzzle. There were so many variables at play in his young life that it was difficult to determine with any certainty what was influencing his behavior. Although there were several diagnostic possibilities, including ADHD, PTSD, depression, anxiety, or just the utter frustration of all the losses, transitions, and upheavals in his life, it was difficult to draw any diagnostic conclusions. From the standpoint of the school, however, certain immediate concerns had to be addressed:

- Eli's aggressive behavior, which posed a safety concern for both Eli and his classmates.

- Eli's disruptive behavior that affected both his own learning and that of his classmates.
- Eli's low academic functioning, which cast doubt on the appropriateness of his placement in a mainstream second-grade class. He clearly needed more individualized and intensive attention, both academically and behaviorally, in order to function in a school setting.
- Mr. Yani desperately needed help in managing Eli's behavior at home. Furthermore, there needed to be consistency between the school and the home in terms of behavior management.

In response to these concerns, the school social worker initiated a number of interventions to address both the school and home issues.

Classroom Behavior

In collaboration with the school psychologist and classroom teacher, a behavior plan was designed and implemented in the classroom, whereby Eli was rewarded for compliant behavior. Given his limited attention span and tolerance for frustration, Eli initially received reinforcement for very brief intervals of compliance. As his behavior improved, the intervals were gradually lengthened. Eli was rewarded with either tangibles (a sticker or pretzels) or a favored activity, such as coloring. A time-out procedure was also implemented, minimizing the disruptive impact of Eli's behavior on the rest of the class.

Referral to the Committee on Special Education

An immediate referral was made to the Committee on Special Education. This involved a thorough evaluation of Eli's cognitive ability, academic skills, and speech/language functioning and a social history.

Once the CSE meeting was held, Eli was assigned a one-to-one aide to monitor the behavior plan, and he began to receive special education instruction that was tailored to his level of academic functioning. He also began speech/language therapy. In addition to services for Eli, it was clear that Mr. Yani would need a tremendous amount of support and guidance. It was decided to schedule monthly team meetings with Mr. Yani, the teacher, and the social worker so that there could be a mutual exchange of information about Eli's school and home functioning.

Data Collection

Unfortunately, records from Eli's previous school in Iran were not available. Mr. Yani did, however, give permission to obtain psychological and

speech records from Florida, where Eli had been evaluated just prior to his mother's death. These proved to be very telling. When Eli was about 4 years old, his parents sought the help of a psychologist out of concern for Eli's unmanageable behavior. At that time he would have frequent tantrums and mood swings. Although Eli's speech and language development was normal when he was a toddler, he suddenly stopped speaking at about 3 years of age and began pointing to what he wanted. Just as Eli had begun treatment, his mother died, and he moved to Iran with his father. This report was helpful in that it revealed that there were significant issues with Eli even *prior* to his mother's death, which were initially attributed to inconsistent parenting.

Referral and Consultation with Mental Health Agency

The social worker made an immediate referral to a local mental health agency at which Eli could receive a psychiatric evaluation and therapy and at which his father could receive consultation regarding parenting, as well as psychotherapy to address his own depression. With Mr. Yani's permission, the social worker served as the liaison between the school and the mental health agency, updating the therapist on Eli's progress at school and providing feedback regarding the effectiveness of the medication that was prescribed.

The therapist and psychiatrist remained baffled for a time regarding Eli's diagnosis and treatment . They proceeded with the working diagnostic hypothesis of ADHD complicated by PTSD. After several months of treatment with minimal progress, Mr. Yani brought Eli to the county medical center, where he had a pediatric neurodevelopment evaluation. It was there that Eli was diagnosed with autism. This diagnosis was initially difficult for Mr. Yani to accept, although it was a relief to arrive at a diagnosis that seemed to explain this boy's behavior. Although Eli had certainly endured multiple traumas, the key to this diagnosis was the careful review of Eli's early development (notably the behavior problems and truncated speech development) prior to his mother's death.

Information and Community Resources

The social worker provided Mr. Yani with educational materials and information about autism, as well as resources for parent support networks. One of these resources was another parent in the school district who had a child with autism. This parent was a dynamic advocate for her own child within the school system and was very knowledgeable about community resources. She made herself available to other parents who needed information and support. (A helpful reference for parents of autistic chil-

dren is Ozonoff, Dawson, and McPartland, 2002; a book on the topic for children is *Russell Is Extra Special*; Amenta, 1992.)

Child Care

Mr. Yani's mother was Eli's after-school caretaker. She was easily overwhelmed by Eli's behavior and tended to give in to him rather than establish boundaries and limits. The social worker helped arrange after-school child care at a local day care center. Mr. Yani's relationship with the director of the day care center proved helpful in paving the way for a child with special needs such as Eli's.

Financial Assistance

Mr. Yani's financial situation was often strained. The social worker apprised him of Eli's probable eligibility for Social Security Disability Insurance, based on his special needs. This additional source of revenue was a help to the family.

Camp and Respite Services

The social worker researched and provided information to Mr. Yani regarding recreational and respite programs that catered to children with special needs. This would provide a much-needed occasional break for Mr. Yani and his mother and provide Eli with additional opportunities for social stimulation and fun.

Summary

Over the course of 2 years, adjustments were made to Eli's medication and to his behavior plan and academic program. Eli made slow but steady progress academically, socially, and behaviorally. A sustained coordinated effort between the school (and the various school professionals within the school), the home, and outside agencies was necessary to ensure Eli's growth. The school social worker was instrumental in establishing and maintaining these linkages.

❖

CONCLUDING COMMENTS

The complex role of the school social worker demands great versatility, the ability to think on one's feet, and awareness of the reciprocity of multiple interacting systems. Liking children and wanting to advocate for

their best interests in the school are only the beginning of the job qualifications of a school social worker. In addition, as illustrated in this chapter, the school social worker must understand and be able to communicate and collaborate with parents and with the various professionals who also participate in and contribute to the child's educational experience.

The whole range of social work knowledge and skills is epitomized in the role of the school social worker, whose regular activities in the course of a week may include such diverse responsibilities as obtaining data and writing a social history; attending and participating in a CSE meeting; identifying and reporting sexual and/or physical abuse; counseling children on an individual and/or group basis; conducting a "Good Touches/Bad Touches" kindergarten class; conferring with teachers about specific children; working with outside agencies and making referrals; conducting parent group meetings; and consulting with the principal about special programs in response to parent concerns about community violence. This demanding role includes the satisfaction of being a child advocate in a manner that seeks to help not only the individual child but also an entire school community of children.

DISCUSSION QUESTIONS

1. Discuss some of the special challenges related to working in a "host" setting, such as a school. How can the social worker maintain a strong sense of professional identity when working with professionals from many different disciplines?
2. What is meant by "the best interests of the child," and how does this apply to the work of school social workers?
3. How can the school social worker create and maintain harmonious and effective relationships with the principal?
4. Consider the various issues that might be raised in an ongoing support group for parents of children with special needs. What is the ideal role for the social worker in such a group?

❖ PART IV ❖

Helping Children in Special Circumstances

❖ CHAPTER 10 ❖

Children Living in Kinship and Foster Home Placements

Once upon a time, everyone assumed that children would be raised in a home with their mothers, fathers, brothers, and sisters and that they would remain at home until they married and moved away to start a family of their own. Is this story realistic today, or does it more resemble a fairy tale? If it still has some validity, does it apply to *all* children or mainly to children in economically secure families, in which the "traditional" roles of father as breadwinner and mother as homemaker permit the children to grow up in a tight circle of nuclear family, church, school, and community? How is this view of children in the nuclear family currently altered because of never-married and divorced working mothers, who must arrange out-of-home child care for their children? What about children whose own parents cannot care for them and who may be placed in kinship homes or in foster homes? How strongly do we continue to subscribe to the ideal that children *should* be raised, whenever possible, by two biological parents?

BELIEFS ABOUT THE BEST INTERESTS OF THE CHILD

Times have changed, but many people still adhere to values specific to a particular lifestyle in the past that may no longer conform to current reality. These values may actually represent ideals that were not universally true even in the past. The portrayal of children as safe in the bosom of the home certainly did not apply to many poor and immigrant families at the beginning of the 20th century, when many mothers worked in factories, farms, or sweatshops, sometimes bringing their dependent chil-

dren to work with them. This belief about the importance of raising children within their family and cultural groups also did not prove true for the thousands of immigrant children in New York who were removed from their parents between 1854 and 1930 and sent to the country in order to offer the children the benefits of fresh air, good food, and a "wholesome" atmosphere—factors supposedly not present in their urban environment (Hall, 1992). Finally, this fairy tale does not apply to the single mother today who relies on limited public assistance to meet the costs of raising her children. The essential question, in the first decade of the 21st century, as in the 1850s when the child welfare movement began, pertains to the relative importance of parental bonds as compared with environmental factors in determining the best interests of the child.

Although some parents become overwhelmed and voluntarily place their children out of the home and others relinquish their infants for adoption, the majority of children in foster and residential placements are there because their parents have been found by the courts to be abusive or neglectful (Kinard, 1987; Children's Defense Fund, 2000; Mannes, 2001). "Children who are found to be neglected, abused, or at high risk in their family situations require specialized protective services from the community and its social agencies . . . *neglect and abuse constitute the major reason for placement of children in foster care*" (Brieland, Costin, & Atherton, 1985, p. 240; emphasis added). This continues to be true, with about 55% of children reported to state child protective service agencies as victims of neglect, 25% as victims of physical abuse, and 12% as victims of sexual abuse (Children's Defense Fund, 2000). Exercising the principle of *parens patriae* (which can be roughly translated as "the state as guardian"), the court uses its power to protect a dependent child by removing the child from home and placing him or her in a foster home or institution.

Approximately half of children in placement are from minority groups, and many are recipients of social work services. Because of the number of children orphaned by the AIDS epidemic (Michaels & Levine, 1992) and the large number of children essentially abandoned by substance-addicted and incarcerated parents, it seems understandable that the number of U.S. children in foster care increased by 23% during the late 1980s and early 1990s (National Association of Social Workers, 1993) and by 35% between 1990 and 1998 (Children's Defense Fund, 2000). The countervailing efforts of mandatory permanency planning to keep children in their own homes has not succeeded in the face of increasing parental substance abuse and other problems.

When parents abandon their children or are found to have been abusive or neglectful, grandparents may step in and assume child care because of their love for their grandchildren and their sense of shame, guilt, and failure about what has happened in their family (Tonning, 1999; Shapiro, Shapiro, & Paret, 2001). There has been a dramatic increase in

the number of grandchildren living with their grandparents during the decade of the 1990s. In 1997 about 5.5% of all children under 18 were living in their grandparents' homes, with 43% of these households maintained by a grandmother only, with no spouse present. Furthermore, in many of these homes the child's parents are not present (Brunner, 2002). This particular form of child care, sometimes referred to as "kinship care" or as "skipped generation kinship care" (Shapiro et al., 2001; Casper & Bryson, 1998), is most prevalent among children of color. Reasons for the growth in grandparent placement include parental drug abuse, teen pregnancy, divorce, single-parent households, child abuse and neglect, and the incarceration of parents.

The focus of this chapter is on methods of helping children who are placed in foster care or who are being raised by grandparents. The values base of family preservation programs includes the belief that the family is the best context in which to rear a child and that the entire family, rather than the individual child or parent, is the client (Hodges, Morgan, & Johnston, 1993; Ronnau, 2001). However, protective intervention through social services often comes at a late stage of a family's problems, after heavy stresses have culminated in neglect or abuse (Brieland et al., 1985) and relatives may be unable or unwilling to assume care for the children. When a child has no grandparents or other family members who can provide care, foster care and small-group homes serve as necessary alternatives that do not necessarily have devastating effects on children, as traditionally believed.

This chapter presents ways to help children and their families when the children are in either foster or kinship care. Whenever family members are available, they must be included as partners in the helping process; when they cannot be located or when they are unable or unwilling, children should be helped to identify and resolve their feelings about their lost or absent "home" and relatives. A child's sense of identity is connected to his or her family, and the process of helping the child requires that the family be included in work with the child, either in reality or symbolically. This issue is discussed in more detail later in the chapter.

DETERMINING THE NEED FOR PLACEMENT

What is the impact of relocating a child to another family for foster placement compared with arranging for the child to move in with a grandparent or other relative? With tongue in cheek, Mishne (1983) points out that many wealthy parents voluntarily send their children to boarding school, with no expectation that the young people will be harmed by the experience of separation from home. Obviously, it is not primarily the *separation* that threatens a child but the circumstances that precipitated

the separation in the first place. If, as previously indicated, the main reason for involuntary placement is parental abuse or neglect, a separation can be viewed as the culmination of *many* past experiences of emotional and/or physical distress because of the adult's behavior. The separation is frequently the outcome of a long, sad history, which often leads the child to mistrust adults. These life experiences of abuse or neglect also contribute to the child's poor ego development and reduced ability to deal with even the everyday difficulties of life, let alone situations of extreme stress. Because every placement decision is different, the interacting influence of many factors must be weighed in determining the specific meaning of the placement to each individual child and family and in outlining a realistic treatment plan.

Evaluating Placement as Crisis: The Use of Tripartite Assessment

In several previous publications (Webb, 1991, 1999, 1993, 2001), I have presented the use of "tripartite assessment" as a method of evaluating the impact of a particular crisis or bereavement experience on a child. As noted also in Chapter 4 of this book, tripartite assessment looks at the interaction of three groups of factors: those related to (1) the individual, (2) the situation, and (3) the support system of family and community. When used by child welfare practitioners, tripartite assessment will assist in evaluating the need for the placement and in weighing the prospects for returning the child to his or her family.

A "crisis" is defined by Gilliland and James (2001, p. 3) as "a perception of an event or situation as an intolerable difficulty that exceeds the resources and coping mechanisms of the person." The out-of-home involuntary placement of a child provokes many feelings in the child and the family, including varying degrees of shame, guilt, and anger. The parents have been publicly exposed as unfit to care for their own child, with the result that the family may experience a "loss of face" and accompanying loss of self-respect. The child, in turn, may feel guilty about his or her perceived role in precipitating the placement. This form of loss generates a state of "disenfranchised grief" (Doka, 1989, 2002), because the stigma associated with the child's placement can be neither openly acknowledged nor mourned. These suppressed, complicated feelings must be recognized and understood by child welfare professionals who work with the child and family. The use of tripartite assessment facilitates this understanding, especially of the complex factors that precipitated the placement decision. Workers who recognize the importance of the multiple factors that culminate in the child's placement will be better able to help the child and the

family acknowledge the loss experience that the placement represents in order to plan realistically for the future. Figure 10.1 diagrams the particular factors that apply to the out-of-home placement of a child.

Determining the Factors Precipitating Placement

The decision to move a child from his or her own home to another setting merits careful deliberation and review of all relevant facts. As previously mentioned, the majority of children in foster care enter the child welfare system because of family problems related to abuse and neglect. The form in Table 10.1 allows the child welfare practitioner to record in

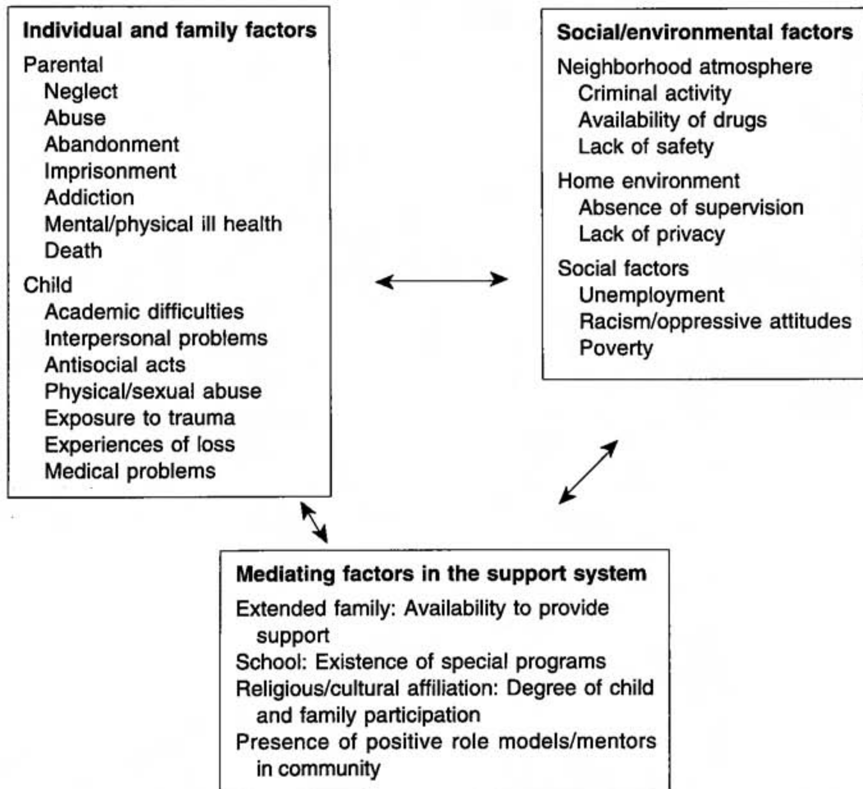

FIGURE 10.1. Interactive components of a tripartite assessment when a child is placed out of the home. From *Social Work Practice with Children* (2nd ed.) by Nancy Boyd Webb. Copyright 2003 by The Guilford Press. Permission to photocopy this figure is granted to purchasers of this book for personal use only (see copyright page for details).

TABLE 10.1. Factors Precipitating Placement Decision

1. Parental behaviors (list all that apply, identify relevant individual, and give dates):
Abuse (describe) ______________________________
____

Neglect (describe) ______________________________
____
____

Abandonment (describe) ______________________________
____
____

Imprisonment (reason) ______________________________
____

Addiction (describe) ______________________________
____

Physical/mental ill health (describe) ______________________________
____
____

Death (give date and cause of death, including child's involvement) ______________
____

2. Child behaviors (describe in detail) ______________________________
____
____

Frequency ______________________________
Responses of adults ______________________________
____
____

Child's reactions to adult interventions ______________________________
____

3. Environmental/social conditions (describe the environment in which the child lived prior to placement) ______________________________
____
____

Presence of after-school activities/sports/recreational programs ______________
____
____

Neighborhood atmosphere (check applicable items):
Safe _____ Unsafe _____
Presence of drugs: Yes _____ No _____ Not sure _____
Influence of peers: Positive _____ Negative _____
Presence of positive role models: Yes _____ No _____ Not sure _____

4. Traumatizing experiences in child's history (list all that apply):
Physical abuse (specify perpetrator, frequency, and form)
____
____
____

(*continued*)

TABLE 10.1. (continued)

Sexual abuse (specify perpetrator, frequency, and form)

____

____

____

Other traumatic experiences, either witnessed or experienced

____

____

____

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detail the key factors contributing to the placement, based on the tripartite conceptualization.

Factors related to the family itself and to its ability to nurture the child are often critical in precipitating placement. Some children (e.g., those with autism or attention-deficit/hyperactivity disorder) make excessive demands on their families because of their special needs and the difficulty they have in controlling their emotions and behavior. Other children may have the misfortune to be born at a difficult time in their parents' relationship or when the added demands of child care may prove too much for immature or overwhelmed parents who themselves feel needy and unfulfilled and who may take out their frustrations on their dependent children. For example, a father who has recently lost his job and whose wife has been diagnosed with cancer may vent his fury on his innocent 9-year-old son, who reminds the father of everything he hoped for in his own life that he now believes has been taken away from him. When the boy asks for money to buy a baseball mitt, the father tells him scornfully that money doesn't grow on trees and that he'd better begin to think about ways to obtain his own money for the things he wants.

Clearly, one isolated episode like this is not likely to propel a boy into a life of crime. However, when it and others like it are combined with pressure from older neighborhood youngsters who serve as drug runners and decoys for drug dealers, it is comprehensible how the boy could become involved in a life of petty crime—one that later may result in placement in a foster home or a residential treatment facility.

Evaluation of significant influences in child placement often hinges on an understanding of interacting individual and family factors. Table 10.2 is a form for recording these specific influences on the placement decision.

TABLE 10.2. Individual and Family Factors Related to Placement

Relevant information from genogram
 Position of child in family ______________________________
 Extended family (location and degree of involvement) ______________________________
____

Status of parents (current, and at the time of child's birth)
 Ages: Mo _____ Fa _____
 Quality of parental relationship ______________________________
____
____

Employment:	Mo	______________________________
	Fa	______________________________
Medical:	Mo	______________________________
	Fa	______________________________
History of addictions:		
	Mo	______________________________
	Fa	______________________________
History of court involvement:		
	Mo	______________________________
	Fa	______________________________
Religious/cultural affiliation:		
	Mo	______________________________
	Fa	______________________________
Achievements/ego strengths:		
	Mo	______________________________
	Fa	______________________________

Status of child
 Age and date of birth ____________________
 School grade and adjustment ______________________________
____
____
 Educational testing results ______________________________
____
 Psychological testing summary ______________________________
____
 Peer involvement (describe in detail) ______________________________
____
 Names of and relationships with siblings ______________________________
____
 Medical history ______________________________

(continued)

TABLE 10.2. (continued)

History of physical/sexual abuse (describe in detail) ____________________
____
____
____

History of exposure to trauma ____________________
____
____

Separation history (including moves and previous placements)
____
____

Past coping/strengths/typical defenses ____________________
____
____

Home environment

Physical conditions (describe in detail, especially regarding child's sleeping arrangements)
____
____

Persons living in the home (give names and relationships to the child, if any) ________
____
____
____

Length of time in current residence ____________________

Previous residences:

Length of time ____________________

Reasons for moving ____________________

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DIFFERENT LEVELS OF CARE

Although it is beyond the scope of this chapter to analyze the wide range of child welfare programs for children, it is important to recognize that there is a continuum of services for children who are dependent and/or who have emotional or behavioral difficulties. These include foster care, residential treatment centers, group homes, day treatment programs, shelters, family and psychiatric clinics, and crisis/respite services. Because of space limitations, I focus here primarily on grandparent and foster placement, with case vignettes to demonstrate the varied circumstances that can lead to child placement. Selected methods for helping children in placement to cope with their feelings about their life situations are presented later in the chapter.

Foster Care

Foster care consists of a *temporary* arrangement for child care in a substitute home when the parents cannot take care of their own child because of some serious situation. The expectation is that the child will return to the parents' home when the conditions precipitating the foster placement have been corrected.

The intent of the Adoption Assistance and Child Welfare Reform Act (Public Law 96-272, 1980) is to provide permanent homes for children who are in the foster care system, either by returning them to their biological parents or by placing them with relatives. The third best alternative is a legally permanent adoptive family, and the fourth best placement is a reasonably permanent foster family (University of Kentucky College of Social Work, 1989; Whittaker, 1987). It is important to note that this law requires that "a variety of placement prevention services . . . ensure that 'reasonable efforts' have been made to preserve the family before a child [is] placed in substitute care" (Pecora, Reed-Ashcraft, & Kirk, 2001, p.15). Therefore, we can speculate that children who are placed with nonrelatives probably come from families with fewer supports and resources.

Although foster care is supposed to be temporary (limited to 18 months), it is often long-term. Frequently, children have difficulty adjusting in the new home, where they may not be able to trust the foster parent or conform to a new routine and expectations. Unable to adapt, many children act out; then they are moved from one foster placement to another, with increasingly negative effects on their sense of security and self-esteem. The increased percentage of children in foster care previously mentioned is not because more children are entering the system but because children already in foster care are staying longer (Children's Defense Fund, 2000). The longer a child stays in foster care, the smaller the child's chances of obtaining a permanent home, according to Brieland et al. (1985).

Kinship Foster Care

The fastest growing form of out-of-home placement in the United States is kinship foster care (Bonecutter & Gleeson, 1997). In 2000, 2.2 million children in the United States lived with a grandparent, aunt, sibling, or some other relative because their own parents were unavailable or unable to care for them (Vallianatos, 2002).

Grandparents provide at least half of the kinship care in this country (Mason & Linsk, 2002). Estimates suggest that the great majority of

Note. The author acknowledges the contribution of Nadine Bean, PhD, in the preparation of this section and in the Kayla case.

these arrangements are made informally between family members in response to emergencies or other situations of need. In fact, the informality and fluidity of these arrangements make it problematic to label them as "placements" (Anderson, 2001).

By contrast, when grandparents or other relatives are *recruited* to take care of children of their relatives, they may enter the formal child welfare system with reimbursement as approved foster parents (Anderson, 2001). Although kinship care is viewed as preferable to placement in a home of nonrelatives because it preserves the family, children in kinship foster care are less likely to return to their biological parents and are less likely to be adopted than are children in placements with nonrelated foster parents (Barth, Courtney, Berrick, & Albert, 1994).

There is a long tradition of kinship care in African American and Hispanic families, in which family and kin networks are utilized when child care is needed (Bean, McAllister, & Hudgins, 2001; Pinderhughes, 1998; Patterson & Marsiglia, 2000). However, the tremendous growth of grandparent-headed households between 1990 and 1997 is not just an African American or Hispanic phenomenon, as might be believed. The growth of European American grandparent-headed households has been the most dramatic during this period (Bean et al., 2001).

However, even when the care of children by grandparents is culturally condoned and frequent, the grandmother may find it burdensome because of health and economic worries of her own. Shapiro, Shapiro, and Paret (2001, p. 126) quote Casper and Bryson (1998), "children who live in grandparent-maintained households, with or without a parent, are more likely to be without health insurance, living in families below the poverty line, and receiving public assistance."

Other stresses in these families sometimes include ongoing family conflicts regarding the custody of the child, especially when the child's mother has a substance abuse problem and the grandmother doubts that her rehabilitation will last. This was the situation in the case of Ricky, discussed later in the chapter. Other difficulties can occur when the child still longs for the mother and wants to return to her despite the grandmother's love and good care. This situation creates a loyalty conflict for the child similar to that felt by many children in divorcing families who feel torn between their parents (Tonning, 1999; Edelstein, Burge, & Waterman, 2002).

Group and Institutional Care

Some children are too conflicted to function well in a foster home, either with grandparents or with nonrelated foster parents. Their complex behavioral/psychological problems require specialized services that are

more likely to be available in residential treatment settings with intensive programs and a multidisciplinary staff. This type of placement should be considered when children demonstrate the following:

- Poorly developed impulse control
- Low self-image
- Poorly developed modulation of emotion
- Deficiencies in forming relationships
- Special learning disabilities
- Limited play skills

Of course, some of these characteristics are found in many children in foster care, as well. All too often, when the child has multiple difficulties, the foster parents cannot manage, and the child is moved to a new home. Repeated placements with repeated failure to adjust create an overlay of additional problems for the child, who often is "blamed" for the placement failure.

TYPICAL ISSUES FOR CHILDREN IN PLACEMENT

The families of children who require placement have histories of substance abuse, homelessness, domestic violence, AIDS, emotional disturbance, poverty, and incarceration (Children's Defense Fund, 2000). Children born and growing up in families struggling with these problems suffer consequences in the form of attachment, trust, identity, and loss difficulties. Often their development has been compromised because of environmental factors that have left their parent(s) overwhelmed, helpless, and hopeless. Growing awareness of the importance of helping the family has resulted in programs that are family-centered and focused on family preservation. Many practitioners now believe that it is artificial and faulty to separate children's issues from family issues (Walton, Sandau-Beckler, & Mannes, 2001). I have repeatedly maintained in this book my own belief that helping the family is essential to helping the child. However, I want to emphasize that a family focus may not be sufficient to help a child whose development has been seriously compromised. Many of these children need individual professional help to overcome their histories of neglect and abuse. Social workers and other practitioners must be sensitive to the impact of a child's history on his or her development and be knowledgeable about some specific child-focused methods for helping. In my opinion, working *only* with the family without devoting additional special attention to the child's individual needs cannot repair the damage caused by years of neglect and/or abuse. Many children in foster care and in other forms of out-of-home placements require interventions spe-

cifically aimed to assist them with their unfinished grief work and with issues related to their identities. In turn, foster parents who assume the care of children with multiple losses need assistance in understanding the children's extensive needs in order to respond to them sympathetically and realistically. The range of intervention methods to meet these diverse needs includes family, group, and individual helping approaches.

INTERVENTIONS WITH THE CHILDREN

Most (if not all) children in foster care and in residential treatment have experienced losses, ranging from multiple moves to parental separation, death, or abandonment. The fact that these experiences are frequent does not minimize their significance in the life of a child. A child who has to enter new schools several times during his or her elementary school years is required to make repeated efforts to make friends and establish "credibility" among children who have already formed peer relationships and who may not openly welcome newcomers, especially when they are different because they are not residing with their own parents. Some schools routinely have time-limited groups in the fall of each year to help integrate new students into the school and also to provide them with a ready-made group of peers with whom to establish friendships. These groups would be helpful to foster children who have been placed in a new school district. Unfortunately, these transfers do not always occur at the beginning of the year, and therefore the groups may not be available when most needed. In any case, the school social worker should be notified when a foster child enters a new school so that this professional can try to provide an appropriate service to the child.

The Case of a Foster Child with a History of Abuse: Dave Pelzer

In three autobiographical accounts (1995, 1997, 2000) Dave Pelzer describes the repeated physical and psychological abuse he suffered at the hands of his mother. Eventually he was removed from his home after school personnel on several occasions noticed his serious bruises. He had difficulty adjusting to a series of different foster homes in which he was placed during the period when he was between 9 and 12 years of age. Pelzer describes how he had feared his mother's wrath if he revealed "the secret" about his abuse to anyone. After his placement, he kept asking himself whether his mother had ever loved him and why she had treated him the way she did. He was admittedly confused and felt that somehow he must have deserved the abuse.

Pelzer refers to experiences that are common among foster children, namely, his difficulty making friends in school and his discomfort about having to admit to his peers that he didn't live with his parents. He also reports his willingness to steal in order to gain acceptance from other children. Fortunately, one of his foster mothers had a great deal of experience and the ability to deal effectively with children who had very troubled backgrounds. Her approach emphasized the children's strengths. She acknowledged Pelzer's potential and warned him that he could end up in residential treatment if he continued to get into trouble. Pelzer's three books about his life (1995, 1997, 2000) present an insider's view about foster care that includes his gratitude toward the foster care system, which he credits with saving him.

The Case of a Foster Child Who Is HIV-Positive: Maria

In the first edition of this book I wrote about the case of Maria, age 10, who was in foster care because her mother had died of AIDS and because she had no known relatives who could care for her. She was placed with her 13-year-old brother, Mario, in a foster home. The foster parents, who had three of their own children, wanted to adopt Maria. Maria felt conflicted because the foster parents did not intend to adopt Mario, who had acted out against them and was placed in a residential treatment center.

Part of my work with Maria consisted of helping her understand and connect with her past, so that she could grieve her serious losses. This was accomplished through having her create a lifebook and write a letter to her deceased mother and through taking Maria and Mario to visit their mother's grave. These activities, which can be adapted for use with other children in placement, are discussed next.

Specific Methods for Helping Children with Grief Work

The following interventions can be used with children in foster placements to help them mourn their losses. They may be used in individual sessions, in tandem meetings with siblings, or in a group of bereaved children. See Webb (1993, 2001) for specific case illustrations of the use of many of these methods.

Lifebooks

A "lifebook" is a document in which an individual records his or her unique life story (Aust, 1981; Backhaus, 1984). When created for the benefit of children in placement, it contains stories and/or factual accounts dictated or written by the child about his or her memories; it also con-

tains the child's own drawings and may include photographs, if available. The use of a "time line" in the lifebook helps the child depict the significant events of each year of his or her life, clarifying various moves and the significant people at each location (Doyle & Stoop, 1991). The purpose of making the lifebook is to help the child understand his or her own history and simultaneously to provide the opportunity for validation and release of feelings connected to the powerful memories.

Letters to Absent or Deceased Family Members and Others

An essential part of grief work involves the expression of feelings related to the unexpected death or departure of a family member. Often when a death or other loss, such as abandonment, occurs, the family members are left wanting to see the person again so that they can ask or tell them something important. This "unfinished business" sometimes consists of expressing anger or sadness at being left. Writing letters to the missing or dead person and reading these aloud in an appropriate setting can relieve the person of some of the burden of sadness, guilt, or anger. This may be relevant for foster children who feel unfairly treated or who have been abused, as well as for children (and adults) who have suffered a loss through death. (See Figure 10.2 for a form letter to a person who died.) The healing dynamic in writing such a letter relates to the individual's taking *action* in a situation in which he or she previously felt powerless. It is not necessary for the letter to be delivered for positive effects to result. However, I do recommend the creation of some kind of ritual or ceremony in which the person can read the letter in front of a picture of the absent person and/or in a meaningful place or time.

The content of such letters, whether to a deceased or absent parent, might include the child's reporting something important about their lives and expressing whatever feelings they have when they think about the person today. Letters can even be written to unknown parents. Children who never knew a parent often have many fantasies and questions about him or her, including the nature of his relationship with the other parent. Although letters to an unknown parent will not be answered, they help the child by putting their questions in writing. When shared with the social worker, the child can receive validation regarding his or her feelings and concerns.

Visiting a Parent's Grave and/or the Child's Birthplace

Sometimes it is possible to arrange a visit to a parent's grave, if the child has never been there and if he or she wants to do this. This was a very powerful and significant experience for Maria and Mario, who had each written letters to their dead mother prior to the visit. They read these silently to her as they stood by her grave.

On this page, write a letter to the person who died. Tell this person all the things you wanted to say but never had the chance. Tell him or her all that is in your heart. Tell the person what you miss about him or her, and what you don't miss, too.

Dear ______________________________,

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FIGURE 10.2. Form for a letter to a person who died.

When a child in placement lacks knowledge about a parent's death or about the circumstances of his or her own birth, it can be helpful to try to obtain death and/or birth certificates and even, where feasible, to visit the hospital where the child was born or the home in which he or she spent his or her early childhood years. In most families parents keep photo albums and tell children stories about their early lives. This family narrative helps create a sense of a family identity and contributes to the child's development of a coherent sense of self (Shapiro et al., 2001). The creation of a lifebook and the other activities described here can help serve this purpose in the absence of parental input.

The Case of a Child Living with His Grandparents: Ricky

Tonning (1999) presents the case of Ricky, age 3, who was removed from his mother's home for chronic abuse and neglect after she left him, when he was 18 months old, home alone with his 6-year-old brother for 3 days. The mother, who was addicted to crack cocaine, was subsequently incarcerated for a year, and Ricky was placed with his paternal grandmother,

who was also caring for the 2½-year-old daughter of another son at that time. The grandmother was concerned about Ricky because he seemed angry, unhappy, and oppositional.

In this African American family, Ricky had quite a bit of contact with his extended family, including weekend visits with his father, who would sometimes leave him with his mother, despite her background of having abused Ricky previously. The boy also would occasionally visit his half brother, who had been diagnosed with ADHD and was living with his paternal grandparents. According to the grandmother, Ricky would return from these visits greatly regressed. She knew that the visits were hard on him, but she nonetheless was unable to set limits and implement a less stressful (shorter) visiting plan, even when she learned after one extended stay that his mother had beaten him. The parents were seeking to regain custody of their son, and the grandmother apparently felt that she had no right to stand between a father and his son. She probably also feared that if she did so she would jeopardize her relationship with her own son. The family abruptly withdrew from counseling in the midst of the custody dispute, and the social worker commented that "the intergenerational conflict over where Ricky belonged and who was his rightful caregiver proved impossible to resolve" (Tonning, 1999, p. 221). Clearly, this child was caught in the middle, and his disturbed behavior could be understood as reactive to the chaos around him.

The Case of a Child Living with Her Grandmother: Kayla

This case involved a German-Jewish grandmother who had custody of her severely emotionally disabled 2-year-old granddaughter (Bean et al., 2001). Kayla had been placed with her grandmother after having been removed from her mother's care three times due to neglect. Both parents were addicted to heroin. Kayla's father (the grandmother's son) was incarcerated for drug trafficking, and her mother had a history of numerous arrests for prostitution. There was the suspicion that Kayla had been sexually abused by various caretakers.

Nadine Bean, with several colleagues, interviewed grandparents and great-grandparents raising grandchildren from various cultures in the United States. This research study looked for recurrent themes in the experiences of the kinship parents. Kayla's grandmother was particularly eloquent in expressing her anguish at seeing her granddaughter so terribly afraid of men and so clingy and fearful. The pain of the grandmother's empathy nearly caused her to end her role as a kinship foster parent, but she changed her mind in view of the child's great needs and the presence of guidance from a supportive social worker. I mention this case to

emphasize the great importance for ongoing counseling and support for all foster parents.

INTERVENTIONS WITH THE FOSTER PARENTS

Most foster parents experience considerable stress in the course of carrying out their parenting responsibilities. Whether the child is related by blood or not, the likelihood is that he or she comes into the placement experience with multiple problems that often include difficulties trusting others, aggressive behavior, sleep and eating difficulties, and possible antisocial behavior, such as stealing. The foster parents must be firm and patient and realize that it will take time before the child develops some sense of trust.

All foster parents would benefit from either individual or group counseling. A parenting support group consisting of other foster parents can provide an outlet and a resource for them. Visitation with the child's biological parents often stirs up feelings of resentment, competition, and conflicts about custody. It is important for the foster parents to have a safe place to discuss their feelings. If and when the child is reunited with his or her biological family, the reunion should be accomplished gradually and with sensitivity to the feelings of all. Obviously, this did not happen in the case of Ricky, despite the social worker's best efforts. Every change of placement is a loss experience for all involved. It is important to find a way to help everyone grieve their losses so that they can accept new relationships.

THE ROLE OF THE SOCIAL WORKER IN CHILD WELFARE

Social workers in child welfare settings have a multifaceted role—one that includes direct work with culturally diverse children and families, work with the family court and the department of social services, and the necessity of functioning on an interdisciplinary team. A social worker often serves as a case manager, coordinating the progress reports of a child's residential staff, educational and psychological reports, and all matters related to setting goals and evaluating the child's progress.

It is important for social workers in this field of practice to have a solid knowledge base in child assessment, including diagnostic classifications, family systems assessment, substance abuse assessment, and evaluation of the impact of trauma on children (especially that resulting from physical and sexual abuse). An administrator of a large residential treatment center identified the issues of substance abuse, HIV/AIDS, neglect, and physical abuse as typical of about 80% of the center's popu-

lation (Webb, 1995). Because many children in foster care and residential treatment have experienced multigenerational losses because of AIDS, it is imperative that social workers who attempt to help these children understand the impact of disenfranchised grief (Doka, 2002) and have a knowledge of methods for assisting with mourning. Because of HIV/AIDS, it is increasingly common for multiple siblings in a family to enter care simultaneously. It may become the social worker's responsibility to coordinate the work with these siblings, which will be greatly facilitated when the children's care is managed by the same agency rather than by several agencies. Social workers need skills in conducting sibling sessions in order to maintain the children's family ties.

Special Challenges

Some of the special challenges to the social worker in child welfare settings relate to the need to work with very resistant and overwhelmed families in a political climate in which funding is decreasing. Sometimes the worker's own feelings of discouragement can be an obstacle, especially when the worker assumes too much responsibility for a child or family and in the process fails to respect appropriate professional boundaries. The worker who shares *all* the pain with his or her clients will soon suffer burnout and become ineffective.

Special Rewards

The child welfare worker does experience moments of great satisfaction in his or her work, despite the difficulty and heart-wrenching circumstances of so many cases. One positive response to my survey question about satisfaction in this work (Webb, 1995) read as follows: "Seeing children go from depression and hopelessness to trust and belief in the possibility of a happy future." Another respondent referred to "clinical moments" at which children are able to verbalize important understandings about their lives, as in the case of a child who finally developed enough trust in his caseworker to tell her how ashamed he felt because no one in his family wanted him! These significant moments help the child welfare worker appreciate the importance of his or her role and (let us hope) will lead to retention of competent workers in the system. There are probably few settings that make as many demands on social workers or in which dedicated workers are more desperately needed. Our profession must acknowledge more fully the vital importance of this work.

CONCLUDING COMMENTS

Children in foster care, through no fault of their own, grow up without the security of a stable family. When extended family members are not available to assume their care, they are thrust into the child welfare system. Unresolved mourning is a vital issue for these children. Children who are moved from one family to another, and who may lose contact with their biological parents through either death or abandonment, need assistance to put their experience into perspective and to realize that they were not to blame.

DISCUSSION QUESTIONS AND ROLE-PLAY EXERCISE

1. Discuss the pros and cons of kinship foster care and foster care by nonrelatives. What safeguards could the social worker implement to avoid custody battles in the family? Role-play a family session with the mother, father, and grandmother in the case of Ricky in which the custody issue is the focus.
2. Consider the matter of a family secret involving a foster child whose parent has a history of substance abuse and physical abuse of the child when drinking and drugging. What kind of help does the child require prior to resuming visitation with this parent? What kind of help should the parent receive?
3. What are some of the key personal issues for the social worker who is employed in a child welfare agency? Describe some ways in which to avoid burnout.
4. Discuss the implications of the position that clinical issues and larger societal issues overlap in child welfare.

❖ CHAPTER 11 ❖

Children in Divorcing and Reconstituted Families

Children in the 21st century come from many different types of families. No longer can teachers or others working with children assume that a child lives in a family with his or her biological father and mother and the siblings from that marriage, although this family form remains the most common. In 1996, about 70% of children were living with both parents. Other family structures included two-parent reconstituted families (i.e., stepfamilies, 15.8%); children living with their mothers (22.9%); children living with their fathers (2.6%); and children living with neither parent (3.7%; U.S. Bureau of the Census, 1999; Brunner, 2002). The category included children living with relatives and children in foster and adoptive families (see Chapter 10 for more details on kinship placement). Children living in gay or lesbian families were probably categorized as living with either their fathers or their mothers. Eleven percent of children were living with a never-married "single" parent; the father was the absent parent in 86% of single-parent situations. Thus, although all children begin life as the result of the biological union of a man and a woman, many of them do not grow up with these two individuals, and some never even know the identity of one or both of their biological parents.

Because of the prevalence of divorce and the upheaval in children's lives that often accompanies the separation of their parents, this chapter focuses on helping children in divorcing families and in the new families that are formed when a parent subsequently finds another partner. In my own clinical practice I have had contact with children from several divorced families in which each parent developed relationships with new partners who also had children. The world of these children therefore consisted not only of their mother, father, and brothers and sisters but also of a stepmother and her children and a stepfather and his children. Sometimes this meant that the child changed residences on weekends and vacations and might have to share a previously private sleeping space

with the "new" stepsiblings. Other times he or she would be the one to "move in" on the stepsibling, who might or might not welcome him or her.

The term "reconstituted family," also sometimes called a "blended family," refers to a family in which one or both partners have been married before and are combining two families into one. According to Harper-Dorton and Herbert (1999), in about one out of every three marriages, one or both parents have been married before.

Despite society's growing tolerance of divorce, remarriage, and single parenthood by choice, children living in these and in various other family arrangements often suffer multiple stresses that are not usually experienced by children in intact, "traditional" nuclear families. Some of these stresses include the following:

- Lower socioeconomic status.
- Custody battles.
- Divided loyalties.
- Changes of school and home environments.
- Reduced or absent communication with the noncustodial parent.
- Adjustment to stepparents and stepsiblings.
- Divergent rules and lifestyles in different homes.
- Uncertainty about information that they are permitted to share with others.
- Confused feelings about where they belong.
- Prejudice or disapproval related to their family's lifestyle.

Of course, every family is unique, but I believe that children in divorcing and reconstituted families have some important issues in common and that we need to consider these issues in our efforts to help them. The most important issues relate to experiences of loss and multiple stressors.

ISSUES OF LOSS AND MULTIPLE STRESSORS

Issues of Loss

In popular books and on television the traditional nuclear family is most typically portrayed as consisting of mother, father, and children. Preschoolers learn before they begin kindergarten that everyone has a mommy and a daddy. When there is no father in the home, a child will usually ask about him; depending on what the child is told, he or she may either accept the explanation or continue to mull it over and wonder when Daddy is going to appear. If a never-married mother speaks disparagingly to her child about the man who impregnated her and then disappeared, the child

picks up the underlying message that his or her father was "bad." This perception may have an ongoing influence on the child's feelings about men and relationships, as well as on his or her own sense of identity.

On the other hand, the preschool child in a reconstituted family who has a stepfather and has ongoing contact with his or her biological father may accept the mother's statement that the child is lucky to have *two* daddies. However, as this same child grows to school age, he or she may intuit differences in the manner in which the stepfather treats him or her and his biological children; the child may then begin to want more time with his or her "real" father, beyond the usual once-a-week visitation. This child may question both parents about why they don't get married or live together any more.

Absent ("lost") parents remain significant presences for children in divorced, single, remarried, and homosexual families. The "ghosts" of missing parents also continue as important influences among adopted children who do not have information about their biological parents (LeVine & Sallee, 1992). My own experience with children confirms that absent parents play important symbolic roles in these children's lives and that the children grieve for the lost parents on significant holidays (e.g., Mother's Day or Father's Day, the child's own birthday, Thanksgiving, and other major holidays when rituals emphasize family togetherness). In psychodynamic terms, such a child has suffered an "object loss," namely the loss of a major attachment figure. Feelings of longing and anger about this loss may persist indefinitely. Sometimes the imagined presence of a "lost" parent serves an important comforting role for a child, similar to the manner in which a child may retain and benefit from the memory of a deceased parent (Silverman & Worden, 1992). The unfortunate aspect of the child's loss in a family with a missing parent, however, is the child's inability to speak openly about it, because the adults with whom the child currently lives usually prefer to deny or minimize the child's feelings of longing or positive connection with this person. The child is unsupported in his or her grief, which cannot be openly acknowledged or worked out. As noted in Chapter 10, Doka (2002) refers to this type of mourning as "disenfranchised grief."

Other losses experienced by many children in divorcing and reconstituted families relate to the reduced economic status and possible changes in schools and living arrangements that often accompany divorce, remarriage, and/or a period of single parenthood. Furthermore, when a parent's marital status changes, relationships with the kinship network also usually alter; in fact, a child may lose contact with a group of grandparents, uncles, and aunts, because the custodial parent no longer feels comfortable in their presence. This is an example of the adult's needs eclipsing those of the child.

In the single-parent home following a divorce, a parent may work long hours and want to devote some time to adult relationships without the child (or children). This can cause a child to feel resentful, rejected, and lonely. A child in a single-parent household may also be expected to share in performing chores and/or to accompany the parent to the supermarket or laundromat. Sometimes the single parent unwisely begins to confide in the child, almost as if the child were an adult. This blurring of parent–child boundaries causes the child to worry about adult concerns prematurely. When this happens, the child is losing his or her very childhood.

Issues of Multiple Stressors

Children do not like to be different; as early as elementary school, many want to dress in a certain way to resemble their peers and to participate in after-school activities with their friends. A parent's reduced income and/or lack of time to go shopping with the child or to attend a school event may mean that the child dresses differently from peers and misses out on activities with them. This may contribute to a feeling of alienation or of "difference" from friends whose parents are able to spend more time, money, and attention on their children.

Furthermore, a child's worry about finances may preclude his or her even asking to participate in certain after-school activities (e.g., baseball or cheerleading, which would involve expenses for a uniform). In times of financial prosperity, many schools have scholarship funds to accommodate the needs of children who cannot, without assistance, afford to participate in sports and other after-school activities. Unfortunately, in times of fiscal constraint, these special funds are not available in many school districts, and children are expected to pay for even basic school supplies. The impact of tighter economic conditions at home and in the community means that children whose family incomes are limited are deprived of certain "extras" that might enrich their lives. It would be understandable if this deprivation, together with the other stresses and losses in these children's lives, resulted in reduced self-esteem and increased anger and alienation. In fact, according to Allen-Maeres, Washington, and Welsh (2000), children in single-parent families are at greater risk of educational difficulties than children living with two parents. "They score lower on standardized tests, get lower grades in school, and are twice as likely to drop out of high school before graduation" (p. 63).

Another source of stress for children in divorced families occurs when they are "put in the middle" (Garrity & Baris, 1994) and asked by one parent to convey messages or to keep secrets from the other. This behavior

creates disturbing feelings of divided loyalties in the children. Wallerstein and Kelly (1980) comment that

> school age children particularly appeared to conceptualize the divorce as a struggle in which each participant demanded one's primary loyalty, and this conception greatly increased the conflict and unhappiness of [such a] child. For, by its logic, a step in the direction of one parent was experienced by the child . . . as a betrayal of the other, a move likely to evoke anger and further rejection. (p. 49)

The case example later in this chapter illustrates a loyalty conflict such as this for a child whose parents were in a custody battle.

Other stresses that may preoccupy children in divorced and reconstituted families relate to worries about their parents' happiness and their own uncertain futures. Rather than assuming that their lives will continue on a certain course, children in these families know that conflict can lead to ruptured relationships and major life changes. Custodial parents may be angry or depressed and thus may lack energy to focus on their children. The children may worry about both the parent with whom they live and the absent parent, in addition to their own futures. These children have personally experienced the fragility and the complexity of life; this experience, although strengthening the coping capacities of some, may also lead to premature suffering and strong feelings of personal vulnerability.

Even children in *stable* single-parent households and in divorced and/or reconstituted families that are not suffering economic hardship may experience stress related to the intolerant curiosity, prejudice, and disapproval expressed by some adults and peers about their families. This could happen, for example, when a divorced mother moves with her children into her boyfriend's home without any plans for marriage. Her children may like the boyfriend and his children and feel comfortable within their new home environment; however, they may find it difficult to explain to their teacher and friends that the man in their new home is not their father nor their stepfather but their mother's friend. Children may feel stigmatized when their families differ from society's norm. Support groups such as "Banana Splits" (see Chapter 8) for children in divorced and reconstituted families can help significantly in lessening children's feelings of isolation and difference.

ASSESSMENT OF THE IMPACT OF FAMILY CIRCUMSTANCES ON THE CHILD

Many distinctive factors interact to affect any given child's reaction to a parent's unmarried status, divorce, or remarriage. It is not the parent's

status itself that causes stress for the child but rather the many circumstances associated with it that may affect the child adversely. Because children are self-centered, the overriding issue for them is how much their lives are inconvenienced. Certainly, not all children in divorcing or reconstituted families develop problems. A child's temperament, a family's overall functioning, and/or the presence of an effective support system can all balance the negative effects of stress on the child.

As discussed in Chapter 10 with regard to the interactive components of child placement, a tripartite conceptualization (Webb, 1999, 2001) can help us understand the reactions of an individual to a specific situation, based on analysis of three groups of factors that interact and determine the outcome of a particular crisis state: (1) the nature of the crisis situation, (2) the characteristics of the individual, and (3) the strengths and weaknesses of the support system. Whereas I originally developed this tripartite model with regard to crisis situations and later adapted it to bereavement, I now propose to adapt it further to make it specifically relevant to children living in divorcing or reconstituted families. In Figure 11.1, I have diagrammed the factors to be considered in the tripartite assessment of children in divorcing or reconstituting families. This diagram may help the practitioner understand why one child has difficulties adjusting to a divorce and changed family situation, whereas another does not.

Table 11.1 presents a form to facilitate the practitioner's use of tripartite assessment to organize, summarize, and understand the unique circumstances pertaining to a particular child living in a divorcing and/or reconstituted family. The practitioner fills out this form on the basis of information available in the family's record and interviews with various family members. Use of the form, together with information from the child's developmental history, will help identify sources of possible stress for the child (and, therefore, areas for possible intervention).

GOALS IN HELPING CHILDREN IN DIVORCING AND/OR RECONSTITUTED FAMILIES

Depending on the circumstances of each case, individual, family, or group methods can help children in divorcing or reconstituted families express and resolve some of their feelings of loss and stress. Regardless of the particular method, the work must emphasize that the adults are responsible for creating and resolving the family difficulties. Children must be reminded repeatedly that they did not cause the situation and that, because they are children, they cannot remedy it. The adults involved have to free the children to proceed with their lives and to leave adult concerns to adults.

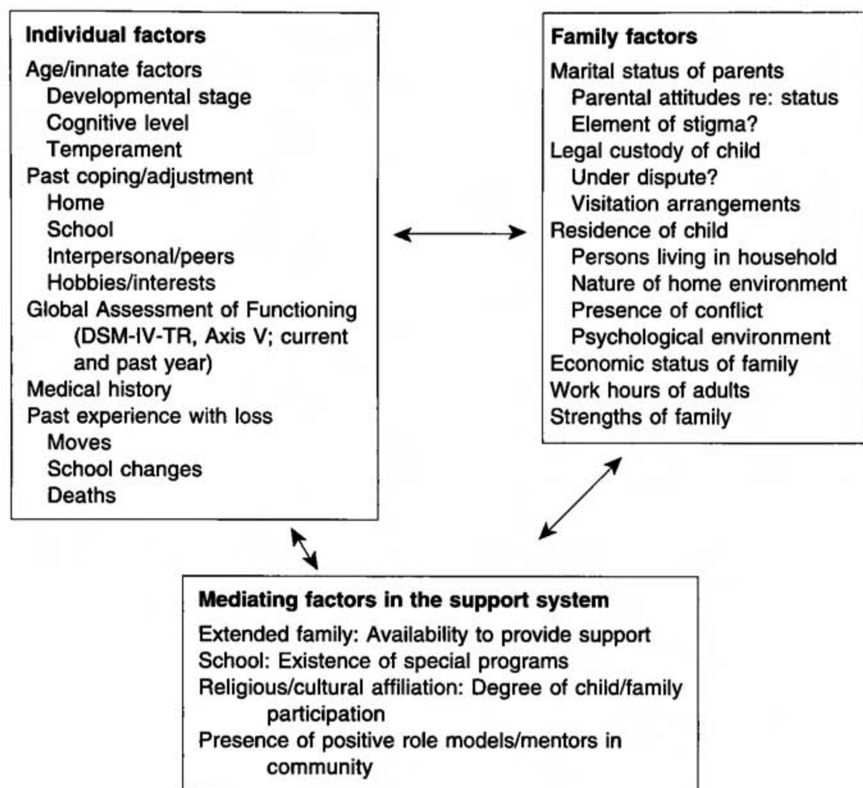

FIGURE 11.1. Interactive components of a tripartite assessment of a child in a divorcing family. From *Social Work Practice with Children* (2nd ed.) by Nancy Boyd Webb. Copyright 2003 by The Guilford Press. Permission to photocopy this figure is granted to purchasers of this book for personal use only (see copyright page for details).

This is generally easier said than done, both for the adults and for the children, who become accustomed to sharing adult conflicts and worries.

Wallerstein (1983) and Wallerstein and Blakeslee (1989) describe six "psychological tasks" that children of divorce must successfully resolve. I propose that these same tasks, with minor adaptations, also apply to children of single (never-married) parents and to children in remarried (reconstituted) families. The tasks are as follows:

1. *Acknowledging the reality* (of the marital rupture, of a parent's remarriage, or of a parent's single status). Children may deny the reality or fantasize about a status or outcome they would prefer. The adults can help the children by providing them with information in terms that the

TABLE 11.1. Tripartite Assessment of Family Circumstances

Marital status of parents
  Mother: Never married ____ Divorced ____ (date) ____ Remarried ____ (date) ____
  Father: Never married ____ Divorced ____ (date) ____ Remarried ____ (date) ____
Parental attitudes re: status
  Mother: Accepting ____ Angry ____ Ashamed ____
  Father: Accepting ____ Angry ____ Ashamed ____
Family composition
  With whom is child currently living? (check all that apply)
  Mo ____ Fa ____ Stepmo ____ Stepfa ____ Mo's boyfriend ____
  Mo's lesbian partner ____
  Fa's girlfriend ____ Fa's gay partner ____ Grandparent(s) (specify) ____________
  Siblings: No ____ Yes ____ Ages ____
  Stepsibs: No ____ Yes ____ Ages ____
  Half-sibs: No ____ Yes ____ Ages ____
  Others living in family with the child ____________________
With whom does noncustodial parent live? ____________________
  Are there children from this relationship? No ____ Yes ____ Ages ____
Child's contacts with parent(s)
  Does child have contact with mother?
  Yes ____ How frequently? ____________________
  No ____ Why not? ____________________
  Does child have contact with father?
  Yes ____ How frequently? ____________________
  No ____ Why not? ____________________
What child has been told about whereabouts of absent parent(s)
  Does child know where parent is? Yes ____ No ____
  If no, has child asked about the absent parent? No ____ Yes ____
  If yes, at what age? ____ What was child told? ____________________
____
Contacts with extended family
  Does child have contact with members of the extended family?
  No ____ Yes ____
  If yes, with whom? ______________ How frequently? ______________
Changes in child's life over past year
  Has there been a change in the family's economic status during the last year?
  No ____ Yes ____ If yes, explain ____________________
  ____
  Has there been a change in the custodial parent's work hours? No ____ Yes ____
  If yes, give details ____________________
  If yes, does this affect the child's schedule? No ____ Yes ____
  If yes, give details ____________________
Child's housing history
  How long has child lived in current residence? ____________________
  Where did child live previously? ____________________
  How long lived there? _____ Why moved? ____________________
  Does child share a bedroom? No ____ Yes ____ If yes, with whom? ______________
  Did child share a bedroom in previous residence? No ____ Yes ____
  If yes, with whom? ____________________

(continued)

TABLE 11.1. (continued)

Child's school history
Current grade ____ Appropriate grade for child's age? Yes ____ No ____
If no, explain ____________________
Current academic performance: Good ____ Fair ____ Poor ____
How long has child been enrolled in present school? ____________________
Was child enrolled in a different school last year? No ____ Yes ____
Child's academic performance in previous school: Good ____ Fair ____ Poor ____
Why has child changed schools? (give details) ____________________

____

Custody issues
Who presently has legal custody of the child?
Mo ____ Father ____ Other (specify) ____________________
Is the child's custody under dispute? No ____ Yes ____ If yes, give details ____________________

____

Presence of conflict
Are the child's parents in conflict? No ____ Yes ____ If yes, give details ____________________

____

____

Is there conflict in custodial parent's home? No ____ Yes ____ If yes, give details ____________________

____

Psychological environment of custodial home
Level of custodial parent's functioning: Good ____ Fair ____ Poor ____
Give details

____

Strengths in custodial family (give details) ____________________

____

____

Problems in custodial family (give details) ____________________

____

____

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children can comprehend, including the reason for the current living situation. This should be done with consideration for the children's feelings and for their limited ability to understand complex adult motivations.

2. *Disengaging from parental conflicts and distress and resuming their own customary, age-appropriate pursuits.* As I mentioned, it is contraindicated for children to spend their time worrying about their parents. This worry takes energy and consumes time and effort that the children otherwise would be able to put into schoolwork or social activities. Parents who may (knowingly or unknowingly) use their children as confidants need to be counseled to find peers with whom to share their concerns.

3. *Resolving the loss*. This refers to a child's feelings of confusion and rejection about an absent parent. Children should be encouraged to talk about their feelings, in group or individual counseling, as well as with their parents in parent–child sessions. In situations in which a child has grown up in a single-parent family and has never known his or her father, the child needs to acknowledge that he or she has a father but that for many complicated reasons his or her parents decided not to live together. The emphasis should be on the fact that this was an *adult* decision.

4. *Resolving anger and self-blame*. It is very common in situations of divorce for children to feel great anger toward one or both parents. Even when they have witnessed years of painful conflict between their parents, many children still cling to the belief that the divorce was preventable. Some children also blame themselves for causing or contributing to the divorce because their parents argued about them or because they did something that upset the parents. Sometimes a child in a single-parent family feels that he or she is a burden to their parent and possibly the reason for the parent's not remarrying. In a reconstituted family, the child's anger may be projected onto the stepparent, who is viewed as the cause of the divorce and of all subsequent difficulties.

Resolving children's anger and self-blame takes time. The parent(s) have an important role in this process, and the children may require additional help in the form of group, parent–child, or individual counseling. There are numerous books written for children of various ages to help them realize that other children have struggled with many of the same complicated, disturbing feelings. (See resources cited at the end of the chapter for a list of selected books for children of different ages in divorced and reconstituting families.)

5. *Accepting the relative permanence of the parental status* (divorce, remarriage, or single life). This goal encourages children to give up their hope of magically remaking their families according to their own preferences. Although as adults we know that nothing in life is truly permanent, children who hang onto a fantasy that their parents will reunite or that their father or mother will leave a new relationship are depriving themselves of the opportunity to invest emotionally in the family in which they presently live. If we are always hoping for something different, we lose what we have.

6. *Achieving realistic hope regarding future relationships*. Some of the longitudinal research on children in divorced families (Wallerstein & Blakeslee, 1989; Guidubaldi, 1989; Wallerstein, Lewis, & Blakeslee, 2000) reports that children of divorce struggle with feelings of anxiety about love and commitment in their own intimate relationships. Hetherington (2002), in a study of 1,400 families, found that about 20–25% of children of divorced parents had later difficulties in adjusting socially and in establishing trusting relationships themselves. Because they had witnessed

unsuccessful marriages, they feared that they would have similar marriages themselves, and, as a result, they had problems with intimacy. However, in an interview with the *New York Times* (Duenwald, 2002), Hetherington emphasized that, although some children of divorce had problems 30 years later, the *majority* were functioning quite well. This seems to attest to the resiliency of many children who managed to overcome the stresses of their parents' divorces.

CUSTODY DISPUTES: CHILDREN "CAUGHT IN THE MIDDLE"

Approximately 10–15% of divorcing parents take their struggles to court in the form of disputes about visitation, financial support, and custody of the children (Wallerstein, Lewis, & Blakeslee, 2000; Hetherington, 2002). In such cases the parents are usually angry and embittered toward each other, and each turns to the court in an adversary proceeding designed to "win" a judgment that will force certain concessions from the former partner. These proceedings prove absolutely contrary to the recommendations discussed herein for assisting children in adjusting to this major change in their lives. Frequently, according to Wallerstein and Kelly (1980), one or both parents will deliberately attempt to sway a child to *their* side; each does this by denigrating the other parent and questioning that parent's interest in and love for the child.

Under these circumstances, it is no surprise that children often become upset and anxious. They are *encouraged* to take sides, which then interferes with any of their own attempts to disengage from the parents' hostility. One child graphically referred to the experience as similar to "being cut down the middle with a hatchet." Another said, poignantly, "My mother doesn't realize that when she shoots arrows at my father they have to go through my body before they reach him!" (Wallerstein & Kelly, 1980, p. 71). The first edition of this book contains a drawing by a 10-year-old in the midst of a custody battle. The picture shows a child with tears coming down her cheeks and with her nerves exposed along the entire exterior of her body (see Figure 11.2).

Effects on Children

In these sad situations, many children develop such problems as deteriorating schoolwork, aggression toward siblings and peers, sleep disturbances, and somatic complaints. Regression is common but is not always present, because mediating influences may exist in the extended family, the child's school, and the community. Table 11.1 can help practitioners

FIGURE 11.2. 10-year-old girl's Draw-A-Person.

identify children who are at risk because of intense family hostility and lack of compensatory supports. These children often come to the attention of social workers and other practitioners through the recommendation of the court, when it becomes evident that the children are reacting to an embattled family situation and the family court judge orders that the children receive counseling. In some cases, the judge may also appoint a guardian *ad litem* to represent a child's best interests. The case of Malcolm, described in the next section, provides an illustration of these circumstances.

The Court-Appointed Guardian

Sometimes referred to as a "mediator" (Rice & Rice, 1986), and in many states as a "guardian *ad litem*" (literally, "guardian at law"), an individual may be hired by the court to represent the best interests of the *child* and to advocate for the child's welfare. The guardian, often a lawyer, may interview both parents and the child preparatory to making recommendations to the judge. In addition, the guardian may recommend psychological and psychiatric exams of the child and the parents, in addition to counseling for the child.

At best, the guardian remains neutral and objective and helps a child feel protected from the warring parents. At worst, a child may be intimidated by the perceived power of this person to decide monumental issues in his or her life, such as with which parent he or she will reside.

According to Koocher and Keith-Spiegel (1990), most states subscribe to the concept of "the best interests of the child" in making legal decisions in court custody cases. The following factors are considered in making such a determination:

- The nature of the child's relationship with each parent.
- The capacity and willingness of each parent to care for the child.
- The presence of a stable environment and the length of time the child has spent in that environment.
- The likelihood that the home will serve as a family unit.
- The nature of the child's adjustment at school and in the community.
- The moral fitness of each parent.
- The physical and mental fitness of each parent.
- The child's own preference.

The next section describes how the law guardian and the social worker attempted to weigh these factors in the case of an 11-year-old boy whose parents were in a custody battle.

THE CASE OF MALCOLM, AGE 11

Family Information

Persons living in the home	
Mother	Debbie, age 30, office worker; history of depression; on medication.
Malcolm's half brother	Terry, age 18 months (his father was not currently involved with the family).
Child client	Malcolm, age 11, fifth grade.
Mother's sister	Erica, age 20, and her baby, 2 months old.
Mother's aunt	Jennifer, age 50, at home.
Jennifer's husband	Bob, age 55, construction worker.
Relatives outside of the home	
Malcolm's father	Ray, age 35, computer programmer.
Ray's wife	Sarina, age 30, receptionist.
Sarina' s daughter	Brenda, age 14, 8th grade.

Note. The author acknowledges the contribution of Meg F. Schneider, CSW, in the preparation of this case.

This was an African American family with strong involvement with their Protestant church. Malcolm's parents had divorced when he was a preschooler, and he had only sporadic telephone contact with his father in the intervening years.

Presenting Problem

Malcolm's father had reconnected with the family for the purpose of obtaining custody of his son. The father had recently remarried, and he wanted Malcolm to live with him and his new wife and her 14-year-old daughter. The father did not reveal the reason for his disappearance and long absence from Malcolm's life. He hired a lawyer to represent him in the custody dispute, and the mother had a court-appointed lawyer. Because of the hostility between the parents, a guardian *ad litem* was appointed to represent Malcolm's best interests. A referral to a family agency was made to help Malcolm deal with these stressful circumstances.

Background

Malcolm's parents married when his mother became pregnant. Their relationship was always stormy, and Ray abandoned his wife and young son when Malcolm was about 2 years old. Debbie then decided to move in with her favorite aunt, Jennifer. Debbie's mother had died of cancer the previous year, and Jennifer had been very close to her and to her family during her sister's terminal illness. Jennifer also provided a room for Debbie's sister, Erica, since that time.

It was a busy household, but it functioned fairly well because the women shared the responsibilities and child care. Debbie relied a great deal on her aunt to take care of Malcolm after school when she was working. Malcolm attended school regularly and had a regular time and quiet place to do his homework. However, he did not have many friends and often played by himself.

His mother reported to the social worker that her work was quite demanding, and she often felt overwhelmed and exhausted. She had had a relationship with a man for about 2 years and would spend several nights a week at her boyfriend's apartment, because she felt that she needed "a break." When she became pregnant, their relationship deteriorated, and toward the end of her pregnancy her boyfriend broke off with her. Debbie became quite depressed for several months after the baby's birth. Although Debbie loved Malcolm very much, she sometimes would forget to take him for his routine dentist and doctor's appointments. Malcolm's father later used this information against Debbie in the custody dispute.

When his father reappeared and wanted to have Malcolm in his life again, the boy was initially pleased, and weekend visits were arranged. Malcolm reported that his dad's wife and her daughter were "nice" but that he was often bored there. He didn't like it when, during the drive back home to his mother, the father would say very negative things about his mother and her family and implied that the mother had prevented him from visiting all those years. Malcolm was afraid to ask his father directly where he had been during this time, stating that he thought his father might hit him if he asked (although there was no reported history of abuse).

It soon became evident that Ray's goal was to try to obtain full custody of his son. Neither Malcolm nor his mother wanted this; nor could Debbie and Ray agree on a visitation schedule. Realizing that the family was at an impasse, the family judge appointed a guardian *ad litem* to represent the child's best interests. The judge also ordered psychological evaluations of each parent and of Malcolm and recommended that Malcolm receive counseling services. A referral was made to the local family service agency.

Assessment and Plan for Intervention

The plan was for the social worker to see Malcolm for weekly play therapy sessions, to maintain contact with each parent on a monthly basis, and to communicate regularly by telephone with the law guardian. The social worker realized that both father and mother would probably try to present themselves as the preferred custodial parent and that Malcolm himself probably was in turmoil over the dilemma of having both parents pulling him in separate directions. It would be the guardian's responsibility to make a recommendation to the judge, based on the reports of the psychologist and the child's therapist.

First Session

In the initial meeting, Malcolm was guarded at first but warmed up quickly when some drawing activities were introduced. The predictions about his anxiety proved quite evident when Malcolm, asked to draw a person, drew a figure he called "little boy Frankenstein" (see Figure 11.3). The face had a very sad expression, and when the social worker asked Malcolm to tell her about the picture, he replied that Frankenstein was lonely and different from everyone else. He felt both sad and mad. The worker asked Malcolm if he ever felt that way, and Malcolm agreed that he had some of the same feelings and, in addition, that he was worried because he didn't know where he would be living.

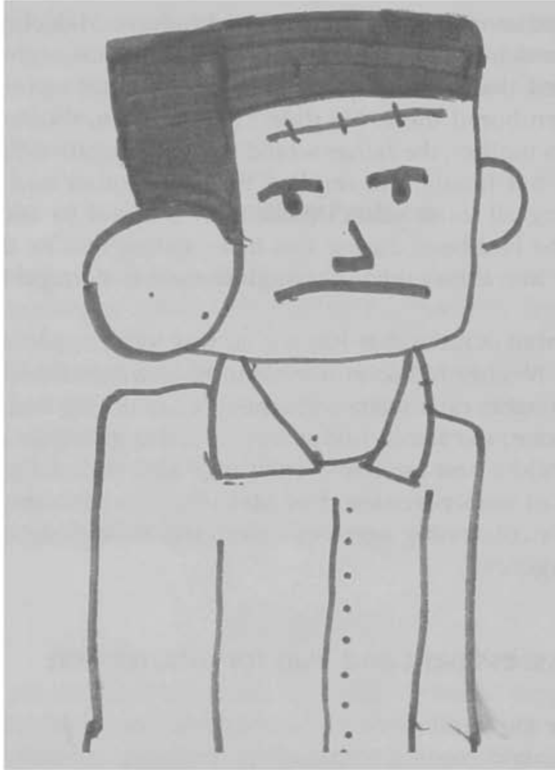

FIGURE 11.3. Malcolm's Draw-A-Person.

In the next session the therapist introduced a version of the therapeutic drawing exercise called the "Squiggle Story Drawing" (Winnicott, 1971; Webb, 1999). She presented the exercise to Malcolm as a "fun art game." This drawing exercise usually consists of the child and therapist making alternating "scribbles" on a piece of paper, then trying to convert these into drawings real or imaginary figures. In this instance the therapist prepared the squiggles in advance herself and then announced that each of them would try to turn the lines on the paper into a picture that each would then show to the other.

Second Session

(See Figure 11.4, Malcolm's drawing of a boat.)

SOCIAL WORKER: Tell me about your picture.

MALCOLM: It's a boy and he's thinking about getting on a small boat and sailing to a special island made of money.

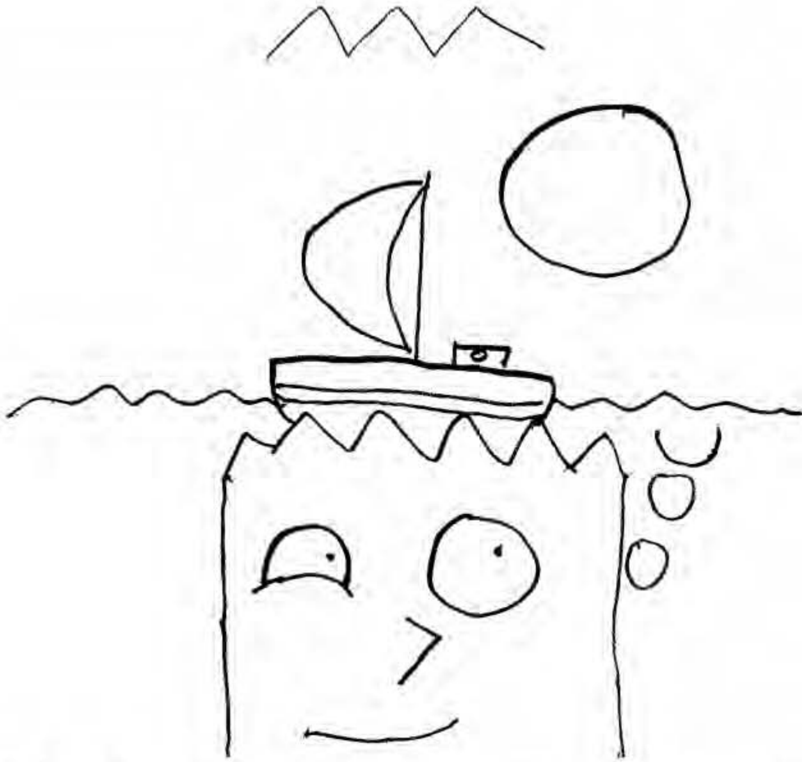

FIGURE 11.4. Squiggle presented to Malcolm (top) and Malcolm's drawing of the boat (bottom).

SOCIAL WORKER: And when he gets there?

MALCOLM: He's going to take as much of it back with him as he can.

SOCIAL WORKER: To use for?

MALCOLM: Clothes and candy and toys and toys and toys!

SOCIAL WORKER: Oh, has he been needing that stuff?

MALCOLM: Not really. But he wants MORE!!

SOCIAL WORKER: (*Laughing*) Does he go on the trip with anyone?

MALCOLM: Oh no, he goes by himself and comes back to surprise everyone. That way they suddenly find out they don't have to fight about money anymore.

SOCIAL WORKER: Who are "they"?

MALCOLM: His mom and dad.

SOCIAL WORKER: Do yours fight about that?

MALCOLM: Maybe. But they won't miss me on this trip because it's a magic trip; it's a long way off but I'll get there in just seconds, and then back again. So we don't have to miss each other that way.

SOCIAL WORKER: Who would miss who?

MALCOLM: I'd miss my family.

SOCIAL WORKER: Can you tell me who in particular?

MALCOLM: My mom, and sister and brother and father and aunt and uncle.

SOCIAL WORKER: So it sounds like you want to magically solve things so that no one has to miss anyone. You can spend all the time you need to spend with everyone.

MALCOLM: That's right.

SOCIAL WORKER: If only things were that simple! Life's not that easy, is it? You can't live with both Mom and Dad at the same time.

MALCOLM: Why can't they just let me do what I want? Live with Mom and see Dad whenever I can?

The social worker then tried to explain how both his parents want him in their life and that the judge will be the person who decides what is best for him.

Third Session

Malcolm immediately asked if he could play the drawing game again. The social worker had come prepared with some more squiggles (see Figure 11.5).

Social Worker: So tell me about your picture.

MALCOLM: It's a big storm and I'm in the middle.

SOCIAL WORKER: I can see that. (*Pointing to the little figure*) That's you right there?

MALCOLM: Yes.

SOCIAL WORKER: What are you doing there?

MALCOLM: I'm in the middle of the storm. It's still.

SOCIAL WORKER: That's known as the eye of the storm.

MALCOLM: Right. It's still there only I'm not really still, because I'm falling, falling, falling, and I can't stop falling, and I'm not landing anywhere. And I'm afraid. I don't know where I'm going to land, and (*in a loud voice*) I WANT TO LAND ALREADY.

FIGURE 11.5. Squiggle presented to Malcolm (top) and Malcolm's drawing of the tornado (bottom).

SOCIAL WORKER: And it looks like things are spinning around you.

MALCOLM: Yes. Those pointing things are dynamite. They're blowing up.

SOCIAL WORKER: That's kind of scary.

MALCOLM: It's dangerous

SOCIAL WORKER: You mean it's dangerous being in the storm?

MALCOLM: Yes.

SOCIAL WORKER: I guess you feel like you're in a kind of storm right now.

MALCOLM: I'm not sure. I guess so.

SOCIAL WORKER: It almost looks like a tornado. Things are spinning so fast.

MALCOLM: That's what I meant to do. I'm kind of all stretched out in the middle.

SOCIAL WORKER: Why are you stretched out, do you think?

MALCOLM: I can't control it.

SOCIAL WORKER: The strong winds are pulling you?

MALCOLM: Yes. That's it.

SOCIAL WORKER: Do you feel like you're falling? I mean in real life.

MALCOLM: Well, kind of. I don't know where I'm going to be living. I want to know already.

SOCIAL WORKER: That's a scary thing. Feeling like you're in danger and not knowing what's going to happen.

MALCOLM: I wish this whole thing was over.

SOCIAL WORKER: It's taking way too long. I don't blame you a bit. No one should have to live with this hanging over them. It isn't fair.

MALCOLM: I'm thinking that maybe I should write a letter to the judge.

SOCIAL WORKER: Great idea. Bring it in and we can talk about it next time.

Summary of the Next 6 Months

A psychologist met with both parents and submitted a report to the guardian recommending that Malcolm should live with his mother but spend 2 months in the summer with his father and 3 weekends a month during the school year. Malcolm was not at all happy about this plan and asked his father about the arrangements for regular contact with his mother over the summer. The father did not give Malcolm any assurance that he would, in fact, be able to see his mother, stating that it "would be up to her." The father planned to enroll Malcolm in a summer camp program, but Malcolm did not want to leave his home, his neighborhood, friends, and family. Also, he really didn't want to go to camp because he didn't know how to swim. He did not want to move in with his father for an extended visit of this kind. He told his father that he wanted to be with him for only 1 month and that he didn't want to go to camp. He also wrote a letter to the judge expressing his feelings. The judge then reconsidered and permitted Malcolm to remain with his mother over the summer, with weekend visits with his father. The father evidently could

not accept this plan, and he subsequently informed Malcolm that he would see him in the fall, again disappearing from the boy's life.

Discussion

The events of this case prevented this child from having an ongoing, nonconflictual relationship with both parents. How could he disengage from the conflict when it had such ongoing repercussions for his life? How could this child participate in age-appropriate pursuits when he was being pulled in two directions and remained uncertain about where he would live?

This case illustrates many of the issues typical for children in divorced and reconstituted families: multiple losses and stressors, custody battles, loyalty conflicts, reduced or absent communication with the noncustodial parent, and adjustment to a stepparent and stepsibling. It also demonstrates the unfortunate reality that help for a child may not be obtained until after years of family instability and stress.

The balancing factors in predicting Malcolm's future adjustment are his own and his mother's strengths, the ability of both to express their feelings appropriately, and their willingness to engage in a helping process in order to obtain the support they need. It is essential that Malcolm continue in counseling, as otherwise he will be vulnerable to problems in relationships himself when he is older. He would benefit from the opportunity to participate in a support group of peers who are also from divorced and remarried families, and he clearly needs a male role model who will demonstrate qualities of dependability and caring.

According to Garrity and Baris (1994), children who are pressured to "take sides" between their divorcing parents often pay the price of "denial of the sense of self" (p. 87). "Lacking the freedom to form their own opinions . . . children grow to doubt their own feelings. Therefore, the most important goal of therapy is to encourage the emergence of the child's separate sense of self" (p. 90). The methods for helping children "in the middle" include the range of play therapy techniques illustrated throughout this book.

ETHICAL ISSUES FOR PRACTITIONERS

Goldman, Stein, and Guerry (1983, p. 4) note astutely:

> In working with children, many ethical issues should be expected to arise. Because children are dependent upon others who are legally re-

> sponsible for them, and because parents are often at legal odds with one another or with juvenile authorities, there are many times when the [practitioner] will be called upon to consider at what point the child is truly served.

The matter of access to the child's records constitutes one such problematic ethical issue. The question of who is entitled to see reports of a child's psychiatric/psychological evaluations and counseling sessions lacks clarity with regard to the legal rights of divorced parents. Often a custodial parent brings a child for an evaluation, hoping to use the resulting information on his or her own behalf in a subsequent divorce proceeding. The noncustodial parent, later learning of this evaluation, may demand to see the record. As discussed in Chapter 9, both parents have the right to see their child's record in some states; in others, only the parent with legal custody of the child is legally entitled to the information. Practitioners should know the status of the law in their particular state.

I have argued previously against putting the ethic of confidentiality between parent and child because of the unfortunate communication barrier this creates. Because it is virtually impossible to promise confidentiality, the practitioner must make process notes with the assumption that these may become open to both parents or to the court at a later date. In situations in which families are involved in litigation, the practitioner must be prepared to have his or her notes subpoenaed. This may present great difficulty, for example, in a situation in which a child has reported instances of verbal abuse and the practitioner wants to explore the matter further before taking action. The practitioner must exercise care in writing detailed notes about matters that may subsequently be used as part of a custody determination. Furthermore, the fact that the record may later be shared with others puts distinct constraints on the relationship, and the practitioner may need to discuss these with the child. According to the 1996 revision of the National Association of Social Workers (NASW) code of ethics, the worker has an *obligation* to clarify with all individuals the matter of "which individuals will be considered clients and the nature of the social worker's professional obligations to the various individuals who are receiving services" (NASW, 1996, Section 1.06(d)).

Another matter that may cause an ethical conflict for the practitioner relates to the relationship between the practitioner and the guardian *ad litem*. When a child enters counseling, the guardian may expect the child's practitioner to offer an opinion regarding the child's and parents' mental state and attitudes. This can cause an ethical dilemma for the worker, because these matters often take considerable time and thought and because the outcome is so critical in terms of the child's future. Many

social workers are not prepared to offer a firm opinion about with which parent a child *should* live, believing that the child's optimal adjustment depends on his or her maintaining an ongoing relationship with *both* parents.

These difficult ethical matters deserve more attention in schools of social work in order to prepare practitioners who work with children for the likelihood that they will be faced with these dilemmas in their future practice.

CONCLUDING COMMENTS

Children who live in divorcing and reconstituted families must cope with numerous stressors and losses. All children are responsive to the conflicts within their families and to the attitudes of others toward their families. When parents divorce, remarry, or decide to remain single, their children must cope not only with their own anxieties about their own lives but also with the responses of people in their network of school and peers about the changes and lack of stability in their families.

Individual, family, and group helping methods can assist children with their confused feelings. However, in situations involving divorce and custody disputes, the children have often experienced years of conflict between their parents before they are referred for counseling. There are probably few other situations in which family therapy is more necessary; it is imperative to reduce the ongoing recriminations and hostility between partners, which continue to damage the child's relationship with each parent. Although the marriage may be beyond repair, the parents should nonetheless be enjoined to act in the best interests of their child or children, in order to prevent further pain to them. The court could play an important preventive role in this regard by insisting on a minimum of three sessions of counseling for divorcing parents, to attempt to orient them to and educate them about their children's needs.

Single parents need support of a different kind, in order to provide them with respite from the fatigue of full-time parenting. Peer groups, located in the community at day care centers and schools, could help connect single parents with their counterparts; this would enable them to offer both emotional and concrete help to one another.

Regardless of the family structure, we must affirm that such families may be different without being deviant. Because of our mission to respect individual differences, we must do everything possible to ease the stresses on the children in these families and to help them mourn their losses so that they may continue with their age-appropriate development.

DISCUSSION QUESTIONS AND ROLE-PLAY EXERCISES

1. How can a practitioner help a single mother tell her preschool child about the child's father, who abandoned her when he learned about the pregnancy? (Imagine that the father is now in jail for crimes committed in connection with drug abuse and that the mother has not seen him since before the child's birth.) Role play this interaction.
2. Many schools offer "banana splits" groups to help children in divorced families talk about their experiences and offer support to one another. What kind of supports and/or programs would you suggest for children with never-married parents?
3. Consider ways in which the court might collaborate with a family agency to assist children and families in the midst of divorce proceedings. What guidelines would you propose in providing services to parents and to children? What would be the purposes and goals of such collaboration?
4. How can the practitioner resolve his or her own feelings of disappointment when a parent continues to put the child in the middle, as in the case of Malcolm?

RESOURCES FOR CHILDREN IN DIVORCED AND RECONSTITUTED FAMILIES

Note: Ages are specified, when indicated.

Brown, L. K., & Brown, M. (1986). *Dinosaurs divorce.* (Young children–early elementary school age.) New York: The Trumpet Club. [Reprinted by Little, Brown and Co, Boston, MA] (Ages pre-school-early school age).

Evans, M. D. (1986). *This is me & my two families. An awareness scrapbook/journal for children living in stepfamilies*. New York: Magination Press. (Parents and children).

Hazen, B. S. (1978). *Two Homes to Live in: A childs eye view of divorce.* New York: Human Sciences Press.

Heegaard, M. (1991). *When Mom and Dad separate: Children can learn to cope with grief from divorce.* Minneapolis, MN: Woodlands Press.

Heegaard, M. (1993).*When a parent marries again: Children can learn to cope with family change.* Minneapolis, MN: Woodlands Press.

Krementz, J. (1988). *How it feels when parents divorce.* (Ages 7–16.) New York: Alfred A Knopf.

❖ CHAPTER 12 ❖

Children in Families Affected by Illness and Death

All children, in the normal course of their development, learn about being sick, and most, by the time they enter school, have at least rudimentary understanding of the word "dead" through the experience of seeing dead insects and animals. However, when a young child lives in a family in which a parent has a recurring illness such as cancer and in which an older sibling dies suddenly of a drug overdose, the child's confusion and anxiety about his or her own personal survival and that of the well parent are entirely understandable. In the case outlined here and described throughout this chapter, we see that this was the family context of illness and death in which young Sabrina completed kindergarten and entered first grade.

THE CASE OF SABRINA, AGE 5¾

Family Information

Child client	Sabrina Rossi, age 5¾, completing kindergarten.
Mother	Lida Rossi, age 46, psychologist (currently unemployed).
Father	Dan Rossi, age 40, editor at publishing house.
Half-brother	John Sand, age 18, unemployed; former college student.
Paternal grandparents	In 70s, living nearby.

Paternal aunt	Carol, age 44, living nearby.
Cousins	Carol's children, Katie and Greg, ages 10 and 4.
Maternal grandmother	Age 70, living out of state.
Maternal aunt	Ann, age 45, living out of state.
Cousin	Ann's son, Steve, age 6.
Maternal aunt	Jean, age 43, living out of state.

Mrs. Rossi had been married previously; her first husband had died of a heart attack at the age of 45, when John was 14. She stated that her husband had a history of depression and alcoholism and that they had been separated since John was 2½. Neither she nor John had contact with any of her first husband's relatives. In fact, she stated that she did not know their whereabouts.

Mr. and Mrs. Rossi have been married 8 years. They are of different religious backgrounds: The father and his relatives are Catholic and Italian, whereas the mother is Protestant and of northern European descent. However, neither Mr. nor Mrs. Rossi attends church services, and both have been interested in Eastern religions; they have a statue of Buddha in their living room.

Presenting Problem

Mrs. Rossi telephoned to request help for her family because she was facing major surgery, and she was concerned about how they would cope with her long postoperative period. Lida had a large tumor that required removal, necessitating both a colostomy and a vaginectomy. She stated that there was a lot of tension and conflict between her husband and her son and that she was quite worried about how they would manage without her presence as a buffer. Although the operation was not considered life-threatening, Mrs. Rossi said that she wanted to work with a therapist who was experienced with both family and bereavement issues.

Assessment and Plan for Intervention

Because the operation was to occur in 10 days, time was limited. Mrs. Rossi had indicated on the phone her reluctance to include Sabrina in the initial family meeting, so I began by seeing the parents and John to address Mrs. Rossi's specific concerns. It was very evident that Mr. Rossi was angry about John's lack of employment or plans for his future. The boy, who looked more like a 14-year-old than an 18-year-old, had over-

dosed on cocaine 6 months earlier, and since then had dropped out of college. He spent most of his days sleeping and his evenings out with friends, drinking beer and drawing graffiti. There was a great deal of tension between Mr. Rossi and John; nonetheless, Mr. Rossi gave John money every week in order for him to buy gas to go job hunting. Recently Mrs. Rossi had insisted that John enter therapy, and he had gone for two or three sessions at the time of the first family meeting with me. Mrs. Rossi herself had been engaged in individual therapy for several years.

I sensed that Mrs. Rossi seemed to be trying very hard to "put her house in order" before going into the hospital. She wanted John and her husband to promise to help her when she came home, when she herself would be too weak to go shopping or perform routine housekeeping tasks. During the session, we listed the chores and obtained agreements about who would do what. It was evident that everything related to John was a struggle; he resisted the idea of doing his laundry regularly rather than leaving it piled up, and he seemed equally reluctant to promise to feed his own cats or to meet Sabrina's school bus, because he "might be sleeping." He did agree to do the shopping, and Mr. Rossi agreed to vacuum and cook. I made an appointment to see Mr. Rossi and John together the day after Lida's operation.

I also expressed concern about Sabrina's reaction to the impending separation from her mother, especially after Mrs. Rossi told me that the child's kindergarten teacher had commented recently about Sabrina's "spaciness" and inability to concentrate. I encouraged Mrs. Rossi to bring her for one session in order to prepare her for her mother's absence.

We agreed that couple, family, and/or parent–child sessions would be planned later, depending on Mrs. Rossi's stamina and the family's needs after her operation.

Mother–Child Session

Sabrina brought a stuffed white toy cat named "Sassy" with her. At the beginning of the session she seemed quite anxious, as expressed in silly, teasing behavior in which she had Sassy crawl all over and tickle her mother.

I explained to Sabrina who I was. I then said that I knew her mother was going into the hospital next week and that I wondered what it would be like for *her* without her mom at home. Sabrina said that she was "mad" because she had to stay at her grandmother's. She had her own room there, but it was dark at night, and she didn't like it. Mrs. Rossi immediately said that they would get a night-light for that room, just like the one she had at home. Sabrina seemed somewhat placated by this idea.

I asked Sabrina to draw a person. The drawing (see Figure 12.1) appeared to be very primitive and almost frightening. The core body was in black, with parts of the hands, legs, and feet outlined in red. Sabrina also outlined the body and arms in purple. The features of the face were minimal, and the figure had no hair. Sabrina declined my invitation to tell me about this person. I considered that it might reflect the child's fantasy about surgery (the distinctive red color could signify blood). I decided to prepare Sabrina for the experience of seeing her mother hooked up to intravenous (IV) lines. I knew that Mr. Rossi planned to take her to the hospital to visit soon after the operation. Therefore, I made a crude drawing of a person in a hospital bed with the IV stand next to it, with connections to the patient (see Figure 12.2). I explained to Sabrina that after an operation people cannot eat as usual and that their food and medicines are given to them in tubes that go into the veins in their hands and noses. Sabrina expressed disgust about the nose tube, but her mother reassured her that it was only for a short time and that it didn't hurt.

I then brought out a doll family and bedroom furniture and suggested that we play out what it would be like to go to visit Mom in the hospital. We set up Sabrina's home in one location, with a toy telephone, and Mom's hospital bed in another, also with a phone. I invited Mrs. Rossi to role-play what it would be like after her operation, suggesting that she

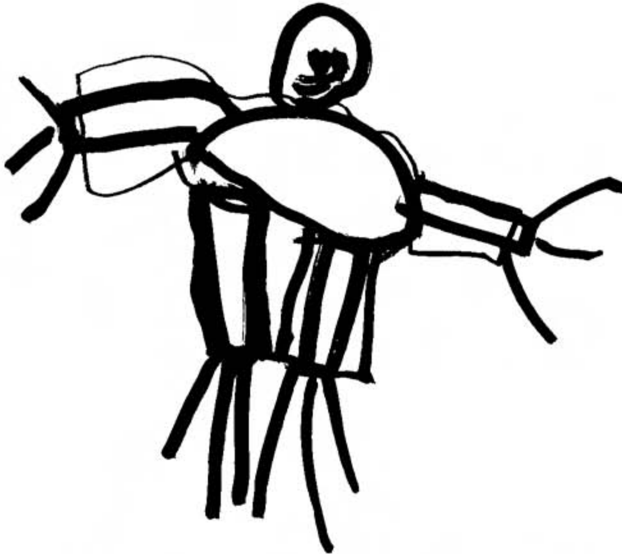

FIGURE 12.1. Sabrina's Draw-A-Person before her mother's surgery.

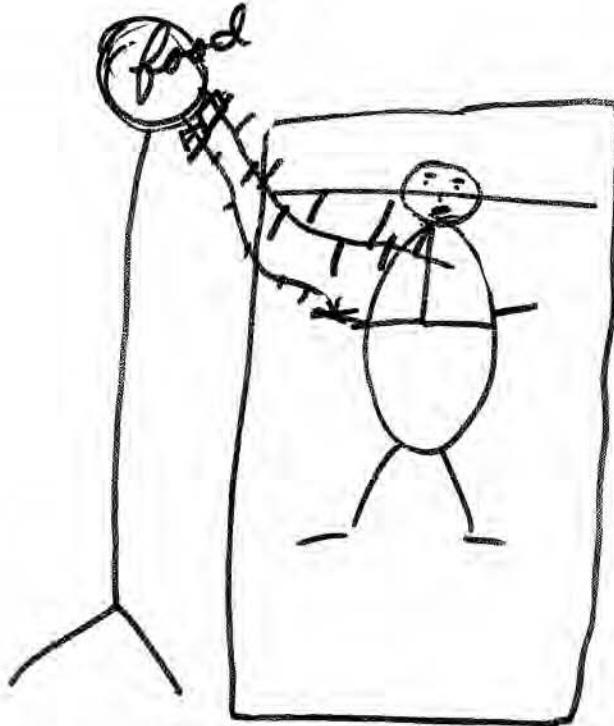

FIGURE 12.2. Therapist's drawing of a person in a hospital bed with IV stand and tubes.

tell Sabrina that she felt very tired and weak but that she would get stronger later. Mrs. Rossi played this scene with Sabrina very effectively, and at the end Sabrina hugged her mother and said, "I'm glad it's not today!"

Summary of Next 8 Months

On the whole, the first several months after Mrs. Rossi's surgery were a period of hope and optimism. Mrs. Rossi had a good recovery from the operation, despite the considerable adjustment in adapting to using the colostomy and urinary bags. No chemotherapy or radiation was prescribed, as Lida had previously undergone a course of radiation in an earlier attempt to shrink the tumor. Mr. Rossi was very supportive of his wife and hopeful that they could resume some form of sexual activity, adapted to his wife's limitations. Mr. and Mrs. Rossi and Sabrina went on a vacation together, and Lida was making plans to resume her pro-

fessional career. John had obtained employment, with the intention of getting his own apartment and returning to school the next semester.

Sabrina was doing well in her first-grade class; she drew a picture of a "princess" (see Figure 12.3) 2 months after she had drawn the primitive, insect-like drawing prior to her mother's hospitalization. Comparing the two drawings now, I believe that the earlier figure reflected the child's fears and regression caused by her anxiety about her mother's upcoming operation and the anticipated separation.

During this period I saw various members of the family at 2-week intervals in different combinations, including the parents together, Sabrina alone, Mr. Rossi and John together, and Mr. Rossi alone. John was continuing sporadically in individual therapy with another therapist. The family mood was positive, despite the ongoing concern about John. Because Sabrina was doing so well in school and at home, it was not necessary to see her weekly.

Eight months after Mrs. Rossi's operation, this period of optimism and hope for the future came to an abrupt and tragic end when John was found dead of a heroin overdose in a friend's apartment. My ini-

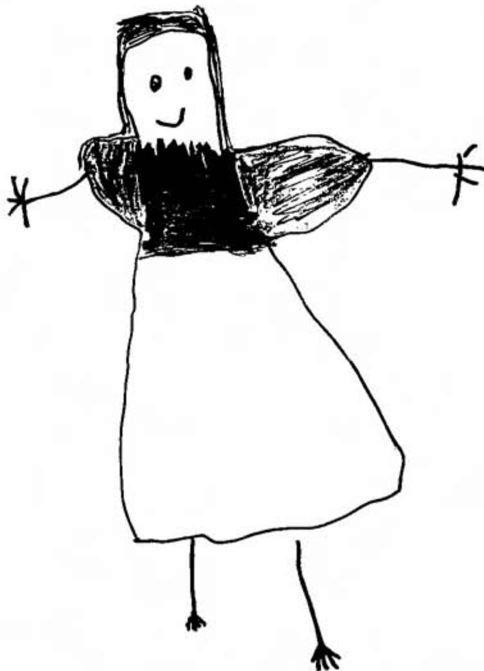

FIGURE 12.3. Sabrina's Draw-A-Person (a princess), 2 months after her mother's surgery.

tial thought upon hearing the news was that it was a suicide, but both Mr. and Mrs. Rossi stressed that John had recently found a job and was in good spirits, talking about getting his own apartment and returning to school. They regarded the death as an accident and believed that John had not used heroin previously. They also criticized the friend who had given it to him because he ignored John when he passed out in a drugged state. Members of both Mr. and Mrs. Rossi's extended families attended the funeral, as did many of John's friends; Sabrina sat in the front row between her parents.

I shall refer to the Rossi family at the time of John's death to illustrate a number of points throughout the chapter.

DEVELOPMENTAL INFLUENCES ON CHILDREN'S UNDERSTANDING OF DEATH

The poet who described childhood as "the kingdom where nobody dies" (Millay, 1934/1969, p. 203) presented an idealistic picture of wishful thinking that certainly is not true in this age of television, war, open discussion about AIDS, and growing awareness among teachers and parents that children should be included in death-related discussions and experiences. Kastenbaum (2001, p. 283) states that "from direct observation, clinical experience, and systematic research there is ample evidence that children do think of death". The child, however, does not begin with the realization that death is inevitable, universal, and final but quickly grasps the implications of separation and loss.

In a previous publication (Webb, 2002a), I presented a review of the child's gradual, progressive understanding about death as related to his or her cognitive development. Using Piaget's work as a guide (Piaget, 1955, 1968, 1972; Piaget & Inhelder, 1969), I connected children's developing ideas about death to the three major phases of cognitive development, as summarized in Table 12.1. The age references in the table should not be taken too literally, as development is an individual process and variations occur depending on a child's unique life experiences. Chronological age is only a very general guideline, indicating the typical gradual progression in children's understanding about death.

Let us now apply the concepts in Table 12.1 to the case of Sabrina. Because of Sabrina's young age (6½) when her brother died, her understanding was still at the preoperational stage. She may have thought that something she did or said led her brother to take drugs or alcohol. She may also have thought that he would return, especially because her parents' religious perspective included the concept of reincarnation. This could have been confusing for Sabrina, because children her age are very

TABLE 12.1. Children's Cognitive Development and Understanding of Death

Age of child	Piaget's stage	Understanding of death
The young child (ages 2–7)	Preoperational Magical thinking Egocentricity	Temporary, reversible, caused by own wishes/deeds
The latency-age child (ages 7–10)	Concrete operational Reduced egocentricity Improved reasoning Awareness of time	Irreversible, final, inevitable (but in future, for "old," not selves); distinction between body and "spirit"[a]
The prepubertal child (ages 11–12)	Formal operational Logical thinking Abstract thinking Tolerance of contradictions and ambiguity	Mature understanding: Final, inevitable/universal, irreversible

Note. Adapted from the discussion in Webb (2002a, pp. 4–7). Copyright 2002 by The Guilford Press. Adapted by permission.

[a]Most experts believe that children acquire a realistic perception of the finality and irreversibility of death at the *end* of this period, by age 9 or 10. This understanding is a *gradual* process.

literal; she could have become angry if she believed John would come back and he did not do so.

THE TRIPARTITE ASSESSMENT OF THE BEREAVED CHILD

Although the child's age and developmental stage should always be considered in assessing the impact of a death experience, these are only a few of the many factors that must be evaluated. In both editions of my book *Helping Bereaved Children* (Webb, 1993, 2002a), I presented the tripartite assessment of the bereaved child as a method for understanding the specific meaning of a specific death to a particular child. The discussion that follows is a further elaboration of the concepts I originally presented there.

As I have indicated in earlier chapters of the present book, a tripartite assessment consists of weighing the interaction of three groups of factors in considering the reactions of a child following a death. These three groups of factors are as follows:

1. Individual factors.
2. Factors related to the death.
3. Factors in the support system (family, social, religious/cultural factors).

In some situations, individual factors, such as the child's past history of death and loss, may have a compelling impact on his or her response. In other cases, the element of trauma related to the death may exert an overriding influence on the child and family. Finally, regardless of the nature of factors related to the individual and to the death itself, the responses of family, religious/cultural, and social networks must always be considered as balancing factors that either support the grieving individual or do not do so. Figure 12.4 illustrates the specific components and interactions among the three sets of variables.

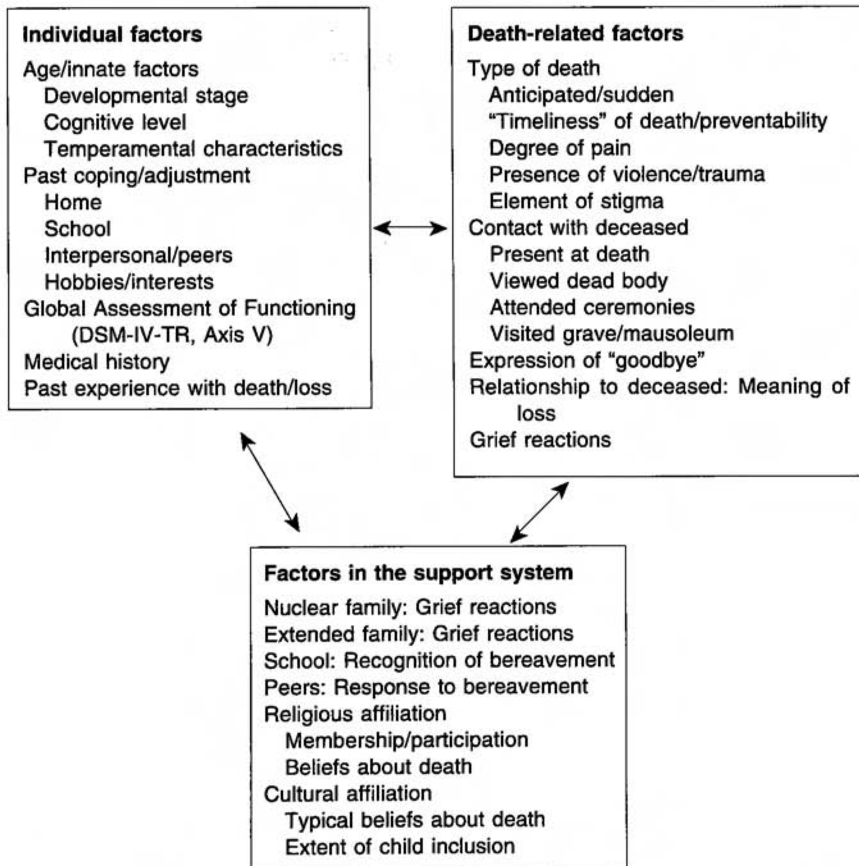

FIGURE 12.4. Interactive components of a tripartite assessment of the bereaved child. Adapted from Webb (2002a, p. 30). Copyright 2002 by The Guilford Press. Reprinted in *Social Work Practice with Children* (2nd ed., 2003) by Nancy Boyd Webb. Permission to photocopy this figure is granted to purchasers fot his book for personal use only (see copyright page for details).

I have developed four different forms to assist the practitioner in highlighting significant factors in the tripartite assessment of the bereaved child. Blank versions of these forms are provided in the Appendices; in the following discussion, I use filled-in versions to demonstrate their application to Sabrina and her family at the time of John's death.

The first form (Table 12.2) facilitates the recording of information about the child's life and general level of adjustment prior to the death. A second form (Table 12.3) records information about the death itself and about the child's degree of involvement in ritual observances connected to the death. A third form (Table 12.4) permits the recording of information about the extended family, about the child's school and peer contacts, and about possible religious and cultural influences on the child following the death. A form for recording the nature of the child's grief

TABLE 12.2. Individual Factors in Childhood Bereavement

1. Age _*6*_ years _*6*_ months — Date of birth ____ Date of assessment ____
   a. Developmental stage:
      Freud _*Late Oedipal/early latency*_
      Erikson _*Industry vs. inferiority*_
   b. Cognitive level:
      Piaget _*Preoperational*_
   c. Temperamental characteristics:
      Thomas and Chess _*Easy*_
2. Past coping/adjustment
   a. Home (as reported by parents): Good _x_ Fair ___ Poor ___
   b. School (as reported by parents and teachers): Good _x_ Fair ___ Poor ___
   c. Interpersonal/peers: Good ___ Fair _x_ Poor ___
   d. Hobbies/interests (list) _*Brownies, ballet*_
3. Global Assessment of Functioning: DSM-IV-TR, Axis V
   Current _*75*_ Past year _*90*_
4. Medical history (as reported by parents and pediatrician)—describe serious illnesses, operations, and injuries since birth, with dates and outcome _*Some earaches and difficult hearing because of allergies; neither problem is severe, according to parents. Otherwise, health is good.*_
5. Past experience with death/loss—give details with dates and outcome *or* complete Wolfelt's Loss Inventory _*No known experience. Maternal grandfather died before she was born. She may be aware that John's father died 5 years ago; however, Sabrina would have been only a toddler of 18 months at the time.*_

Note. This form is one part of the three-part assessment of the bereaved child, which also includes an assessment of death-related factors (Table 12.3) and family/social/religious/cultural factors (Table 12.4). The form itself (not the responses) is from Webb (2002a, p. 31). Copyright 2002 by The Guilford Press. Reprinted in *Social Work Practice with Children* (2nd ed., 2003) by Nancy Boyd Webb. Permission to photocopy this table is granted to purchasers of this book for personal use only (see copyright page for details).

TABLE 12.3. Death-Related Factors in Childhood Bereavement

1. Type of death
   Anticipated: Yes ___ No ___ If yes, how long? ___ or sudden _x_
   "Timeliness" of death: Age of the deceased _19_
   Perception of preventability:
   Definitely preventable _x_ Maybe ___ Not ___
   Degree of pain associated with death:
   None _x_ Some ___ Much ___
   Presence of violence/trauma: Yes ___ No _x_
   If yes, describe, indicating whether the child witnessed, heard about, or was present and experienced the trauma personally. ___

   Element of stigma: Yes _x_ No ___
   If yes, describe, indicating nature of death, and degree of openness of family in discussing. *Since the death was caused by a drug overdose, the family felt ashamed. Sabrina's grandparents never discussed the death with Lida and Dan, although they did attend the funeral.*

2. Contact with deceased:
   Present at moment of death? Yes ___ No _x_
   If yes, describe circumstances, including who else was present and whether the deceased said anything specifically to the child. ___

   Did the child view the dead body? Yes ___ No _x_
   If yes, describe circumstances, including reactions of the child and others who were present. ___
   Did the child attend funeral/memorial service/graveside service? Yes _x_ No ___
   Which? ___
   Child's reactions *Child cried at funeral; there was no graveside service, since the body was cremated.*
   Has the child visited grave/mausoleum since the death? Yes ___ No _x_
   If yes, describe circumstances. ___

3. Did the child make any expression of "goodbye" to the deceased, either spontaneous or suggested? Yes _x_ No ___
   If yes, describe. *Sabrina assisted in writing messages on the exterior of John's casket. The messages said, "Goodbye, John, we love you." She also drew hearts and flowers next to the words.*

Note. This form is one part of the three-part assessment of the bereaved child, which also includes an assessment of individual factors (Table 12.2) and family/social/religious/cultural factors (Table 12.4). The form itself (not the responses) is from Webb (2002a, p. 35). Copyright 2002 by The Guilford Press. Reprinted in *Social Work Practice with Children* (2nd ed., 2003) by Nancy Boyd Webb. Permission to photocopy this table is granted to purchasers of this book for personal use only (see copyright page for details).

TABLE 12.4. Family/Social/Religious/Cultural Factors in Childhood Bereavement

1. Family influences

   Nuclear family: How responding to death? Describe in terms of relative degree of openness of response.

   Very expressive _x_ Moderately expressive ___ Very guarded ___

   To what extent is child included in family discussions/rituals related to the deceased?

   Some ___ A great deal _x_ Not at all ___

   Extended family: How responding to death? Describe, as above, in terms of relative degree of openness of response.

   Very expressive x *(Mother's)* Moderately expressive ________

   Very guarded x *(Father's)*

   To what extent do the views of the extended family differ or agree with those of the nuclear family with regard to the planning of rituals and inclusion of child?

   Very different *Father's* Very similar *Mother's*

   If different, describe the nature of the disagreement *Father's family is Catholic; the service was conducted by a lay reader and held in a funeral home. Since John was not their biological grandchild, this did not prove to be a major issue.*

2. School/peer influences

   Child's grade in school *First*

   Did any of the child's friends/peers attend the funeral/memorial services?

   Yes ___ No _x_ *(However, cousins her age were present)*

   Was teacher informed of death? Yes _x_ No ___

   Did child receive condolence messages from friends/peers? Yes _x_ No ___

   Does child know anyone his/her age who has been bereaved? Yes ___ No ___ Not sure _x_

   If yes, has child spoken to this person since the death? Yes ___ No ___

   Does child express feelings about wanting or not wanting peers/friends to know about the death? Yes ___ No ___ Not sure _x_

   If yes, what has the child said? ________

3. Religious/cultural influences

   What is the child's religion? *Father has recently been taking her to Catholic church with his niece and nephew.*

   Has he/she been observant? Yes *Only recently* No ___

   What are the beliefs of the child's religion regarding death? ________

   What about life after death? *The Catholic religion believes in life after death. Furthermore, the Eastern religious beliefs that are part of the parents' views consider death as a journey, and include the possibility of reincarnation. These latter views were expressed in John's funeral service.*

   Has child expressed any thoughts/feelings about this? *No*

Note. This form is one part of the three-part assessment of the bereaved child, which also includes an assessment of individual factors (Table 12.2) and death-related factors (Table 12.3). The form itself (not the responses) is from Webb (2002a, p. 39). Copyright 2002 by The Guilford Press. Reprinted in *Social Work Practice with Children* (2nd ed., 2003) by Nancy Boyd Webb. Permission to photocopy this table is granted to purchasers of this book for personal use only (see copyright page for details).

reactions (Table 12.5) can be filled out with the assistance of the parent(s) or others who were present following the death. This form probes for specific information related to the nature of the relationship between the child and the person who died.

It appears from Table 12.2 that this child was developing well, without apparent behavioral or emotional difficulties. The mother's only concern about her was her seeming lack of assertiveness with friends; Mrs. Rossi had noticed that Sabrina was usually a follower, not a leader.

Table 12.3, which records information related to the death, shows that this family was in shock following John's death. They also felt shame because of John's drug use. Nonetheless, the parents were concerned about Sabrina's reaction and tried to include her as much as possible in the family rituals. The presence of West Coast relatives and cousins who came for the funeral helped Sabrina engage with children her own age during this intensely stressful time.

On the whole, the members of this family were expressing their grief openly and fully, as Table 12.4 shows.

Sabrina's grief reactions are described in Table 12.5. Sabrina's teacher said that she was continuing to do well in school (she was now in first

TABLE 12.5. Recording Form for Childhood Grief Reactions

Age of child _6_ years _6_ months | Date of birth ______
Date of assessment ______

See the form "Individual Factors in Childhood Bereavement" [Table 12.2] for recording of personal history factors.

Date of death ______

Relationship to deceased _*Half-brother*_

Favorite activities shared with deceased _*Playing with his cats*_

What the child will miss the most _*His jokes; his music*_

If the child could see the deceased again for 1 hour, what would he/she like to do or say? _*"Why did you have to take that drug?"*_

Nature of grief reactions (describe) _*Cried when mother told her that John had died. Now every night when says her prayers, asks God to take good care of John. Mother listens to her prayers and tucks her in, and they cry together.*_

Signs of the following feelings? Y = Yes; N = No

Sadness _*Y*_ Anger _*N*_ Confusion _*N*_ Guilt _*N*_ Relief _*N*_ Other _*N*_

Source of information on which this form has been completed

_*x*_ Parent _*x*_ Observation ___ Other

Note. This form is an extension of "Death-Related Factors in Childhood Bereavement" (Table 12.3), focusing specifically on the nature of the child's grief. The form itself (not the responses) is from Webb (2002a, p. 38). Copyright 2002 by The Guilford Press. Reprinted in *Social Work Practice with Children* (2nd ed., 2003) by Nancy Boyd Webb. Permission to photocopy this table is granted to purchasers of this book for personal use only (see copyright page for details).

grade). However, Mrs. Rossi reported that Sabrina told her that she sometimes went into the bathroom at school and cried. Sabrina was also waking up in the night and sometimes sleeping on the couch. She denied that she had bad dreams or that she was thinking about John. These behaviors could be viewed as normal grief reactions in a 6-year-old child.

ISSUES IN SIBLING DEATH

The death of *any* family member constitutes a crisis (Goldberg, 1973). However, when the death is untimely (Bank & Kahn, 1982; McGoldrick & Walsh, 1991) and/or when the circumstances of the death (e.g., a death from suicide, AIDS, or a drug overdose) cannot be openly recognized or socially supported (Doka, 1989, 2002), the impact on the family can be devastating. McGoldrick and Walsh (1991) point out that an untimely death in young adulthood may generate in the surviving family members "a sense of cruel injustice in the ending of a life before its prime" (p. 33); it deprives the deceased of the opportunity to fulfill his or her life plans and causes the family members "pain and survivor guilt [that] may block [them] from continuing their own pursuits" (p. 33).

The responses of siblings to the death of a brother or a sister reflect not only their own unique reactions based on their personal relationship with the deceased sibling but also the responses of other nuclear and extended family members and of the community in which they live. A systems perspective views the reactions of individual family members as reflective of both those of the family and those of their surrounding social network. Therefore, a great outpouring of support from extended family and friends, expressed through attendance at the funeral and messages of condolence, can help reduce some of the feelings of loneliness that accompany mourning.

The professional literature on bereavement in childhood tends to focus on the impact of a death of a parent (Bowlby, 1969, 1979, 1980; Furman, 1974; Gardner, 1983; Grollman, 1967) or on helping a dying child. A volume titled *The Child and Death* (Schowalter et al., 1983) does not contain a single chapter (among 29) devoted to the topic of sibling bereavement. Exceptions to this unfortunate neglect can be found in the work of Bank and Kahn (1982), McGoldrick and Walsh (1991), Raphael (1983), Rosen (1986, 1991), Davies (1988, 1995, 1999) and Kaplan and Joslin (1993). Some of the main points emphasized by these writers include the following:

1. The death of a sibling creates a sense of vulnerability in the surviving siblings, who may begin to fear that they also may die (Rosen, 1991). However, the loss of a sibling does not present a child with the *intense* survival issues posed by the loss of a parent (Rosen, 1986).

2. Grieving parents have reduced energy and time to carry out their usual parental functions with respect to the surviving siblings. Therefore, a child in a bereaved family loses not only a brother or a sister but also parents who are emotionally available. "The fatality of the sibling casts a shadow across the parents' wounded forms, and thence upon the children" (Bank & Kahn, 1982, p. 273).

3. The child's reaction to the loss depends on how successfully the parents can continue to maintain their parental functions while they mourn (Rosen, 1991). It also may depend on the amount of shared "life space" between the child and the deceased sibling. The greater the shared activities and feelings, the greater the potential for intense stress and disruption during bereavement (Davies, 1988).

4. The child's developmental level has an important effect on his or her bereavement response. The existence of ambivalent and/or hostile feelings toward the deceased sibling may seriously compromise the mourning of survivors. A young, egocentric child may believe that some of his or her earlier hostile thoughts toward the sibling caused the death (Kaplan & Joslin, 1993).

5. The death of any family member requires role realignments and reorganization:

> After a loss, families must be restructured without the dead person, whose roles and functions must be taken over by others. The more important the deceased was to the ongoing emotional or practical functioning of the family, the more difficult it is for those remaining to adjust. When a child dies, family restructuring requires finding another focus for the love and care that previously went to that child. (McGoldrick & Walsh, 1991, p. 51)

In the case of the Rossi family, John's death had different significance to Mr. and Mrs. Rossi and to Sabrina. As a mother, Lida experienced a very strong reaction of anger and terrible sadness; Mr. Rossi was also angry; and Sabrina was very sad. John's death must be understood in terms of the family history and John's role in this remarried family.

Lida and John had lived alone together for about 10 years before Dan entered their lives, and they had gone through some difficult times together. Soon after Lida and Dan married, John was preparing to move in with his own father; unfortunately, however, his father died before that happened. John never accepted Dan's role as stepfather, and their relationship was always stormy. More recently, with John old enough to be on his own, Lida shared Dan's hope that he would find a job or a field of study that interested him. However, this emancipation process did not proceed smoothly. John's involvement with peers who drank and engaged

in antisocial behavior worried Lida, especially after the cocaine overdose, which precipitated a short hospitalization followed by months of daytime sleeping and nighttime alcohol use. Lida was concerned that John would become an alcoholic like his father, and she warned him repeatedly about the dangers of alcohol addiction. However, John continued on his own path; he responded with cursing and rude, self-deprecating remarks whenever either his mother or his stepfather tried to engage him in planning for his future.

In short, John had assumed the role of "black sheep" in this family, and Dan had given up on him. They would go for long periods without speaking to each other, and Lida would finally serve as intermediary. Dan kept telling Lida to "cut the cord," and in several counseling sessions I urged both parents to set age-appropriate, reasonable limits and follow through on them. I was also concerned about John's possible depression and urged Lida to speak with John's therapist about his father's history. She did so and informed me that John's therapist did not believe that John was depressed.

Once John became employed, Lida gave him an ultimatum to move out by a certain date. John's therapist was supporting the plan, and an apartment was located and the deposit paid. Lida had hopes that "the therapy was working" and that John would finally achieve success in his life. Dan was planning to redecorate John's room for Sabrina, who up to this time had been sharing a bedroom with her parents.

John's death ended the universal dream and hope that Lida shared with all parents—the dream of seeing their children happy and successful. Lida had tried very hard to be a good mother, and now her only son's death of a heroin overdose seemed to point to her failure. Certainly John's death represented the end of a very difficult chapter in her life, wiping away all traces of her unhappy first marriage. As Raphael (1983) states, "a child is many things: a part of the self, and of the loved partner; a representation of the generations past; the genes of the forebears; the hope of the future; a source of love, pleasure, even narcissistic delight; a tie or a burden; and sometimes a symbol of the worst parts of the self and others" (p. 229).

Lida's rage was widespread; it was directed most intensely toward John's friends, but it also encompassed Dan, John's therapist, her own therapist, and myself. Sabrina was spared, as evidenced in Lida's statement to me that the only people who *really* cared about John were herself and Sabrina. I understood and accepted Lida's anger as a necessary aspect of her bereavement, especially as related to her displaced rage because John had failed to validate all the years of their special relationship. In fact, the nature of his death shamed her and refuted her consistent belief and hope that he could succeed.

An adolescent like John struggles with issues of identity, sexuality, and separation, which can become very complicated in a remarried family: "To the question of 'Who am I?' is added, 'Who am I in this new family?'" (Rosenberg, 1988, p. 225). It seemed clear to me that John did not want to be in this family and that his life had taken a negative trajectory since the death of his father interrupted his own plans to remain with his father in the familiar neighborhood and school environment of his past. My view of John's situation was that his life had come to a standstill at that time and that the boy's incomplete mourning for his own father contributed to his inability to complete the tasks of adolescence without assuming a "negative identity" (Erikson, 1968). John always impressed me, in both his physical appearance and his manner, as a very *young adolescent*. I think he was "stuck" in the persona of a 14-year-old without a father and unwilling to bond to the stepfather who was willing and waiting to take on that role.

Mr. Rossi's reactions of anger over John's death related to the youth's failure to take advantage of the numerous opportunities he had been given. In addition, Mr. Rossi partially identified with John because he too had found it difficult to break away from his own family of origin. Undoubtedly these feelings contributed to Mr. Rossi's difficulties in being firmer with John.

Another aspect of Dan's anger related to the impact of John's behavior on the family. For example, Dan was completely intolerant of John's habit of returning home in the middle of the night and proceeding to cook hamburgers and other food, when the accompanying odors and noise woke other family members in their small apartment. This behavior continued even during Lida's postoperative period and became the "straw that broke the camel's back," totally alienating Mr. Rossi from his stepson. Nonetheless, Dan felt some affection and admiration for the young man, as expressed in his spontaneous funeral tribute that focused on John's charm and potential, together with his unpredictability and self-centeredness.

For Sabrina, her brother's death converted her into the only child in the family. She told her mother that she was jealous of her cousin Katie, who had a brother. However, because of the big age difference between Sabrina and John, their lives had never overlapped very much. Even on the weekends, when both were home, John usually slept until 2 or 3 in the afternoon, when Sabrina typically would be out of the house playing with friends or engaged in other activities. John rarely ate dinner or other meals with the family, so Sabrina's contacts with her brother were few and possibly weighed toward overhearing arguments between him and her parents. Their shared life space was quite limited.

Raphael (1983) comments that "in losing a sibling the child loses a playmate, a companion, someone who is a buffer against the parents, someone who may love and comfort him, someone with whom he identifies and who he admires. In short, he loses someone dearly loved as well as perhaps envied and rivalrously hated" (p. 114). This may not be true in Sabrina's situation, however, because of the great age and gender difference between her and John. It is probable that this sibling bond was not especially strong and that because Sabrina had strong bonds with other family members, she might be able to tolerate this loss without undue developmental interference (Rosen, 1986). This actually proved true in Sabrina's case, as will be discussed later.

SELECTED HELPING INTERVENTIONS FOR BEREAVED CHILDREN

The goal in helping bereaved children and their families is to facilitate the mourning process and to assist when needed with the necessary realignment of roles. Because the process of children's grief is different from that of adults (Rando, 1988/1991; Webb, 2002a; Wolfenstein, 1966), the worker may need to help family members understand these differences, so that they do not misinterpret a child's interest in playing and participating in fun activities in the midst of the mourning period. Actually, it is *helpful* for the child to return to his or her routine as soon as possible, as children have a "short sadness span" (Wolfenstein, 1966) and cannot tolerate the pain of grief for sustained periods of time. Kliman (1989, p. 61) comments that "during latency, mourning is apt to be particularly silent and slow." This may be related to the fact that latency-age children consider crying to be babyish (Furman, 1974), so they try to act "grown up," which for them means being in control of their feelings.

Play Approaches

The rationale for employing play therapy with a young bereaved child relates to children's reluctance to talk about their feelings, possibly because of the fear of being overwhelmed and then breaking down in tears. Through directed play with a worker/counselor, however, the child can express feelings in a displaced way, using dolls, drawing, games, and other techniques. The method of directed or structured play allows the worker/counselor to deliberately select and offer play materials that will encourage the child to project his or her worries onto the materials and

thus to experience cathartic relief, clarification of misunderstandings, and a corrective emotional experience (Enzer, 1988).

Play Materials

Many of the same play materials that should be available in any office in which children are seen for counseling can be employed in work with bereaved children. I have found that plain white and colored paper, markers, clay, family dolls, and some card and board games are very effective in helping children express their concerns in a displaced manner. Clay is particularly useful in encouraging the release of pent-up feelings of tension and anger; in addition, it permits the child the mastery experience of creating something and then obliterating it (possibly reflecting the child's feelings about having a loved person "disappear" through death).

Depending on the age of the child and the particular circumstances of the death, it may be useful to offer specific toys that will encourage reenactment of the circumstances of the illness and death. Toys in this category include toy ambulances, a doctor kit, and the board game Operation (available from Milton Bradley, Springfield, MA). A therapeutic board game, Gardner's Storytelling Card Game (available from Creative Therapeutics, Cresskill, NJ), contains a cemetery picture that requires the player to make up a story about that background scene. In a previous publication (Webb, 2002a), I discussed the productive use of this game with a 9-year-old boy whose grandmother had died.

In recent years, a number of workbooks have been published that are designed to help children draw pictures and fill in their thoughts and feelings associated with death. These workbooks can guide counselors who lack experience in and confidence about using drawing and play methods with bereaved children, but they should be used *at a very slow pace* that permits a child to reveal and cope with the feelings that will be generated. My advice to students and the workers I supervise is that "less is more," especially when working with the bereaved. Under *no* circumstances should the workbooks be used by the lay public or given to children to fill in without supervision, as the content might overwhelm young children.

Two excellent exercises from the workbook *When Something Terrible Happens: Children Can Learn to Cope with Grief* (Heegaard, 1991) are (1) Feelings Faces and (2) the Body Map of Feelings. In the Feelings Faces exercise, the child is asked to draw faces showing different expressions on circles, with five different emotions named under each circle: "angry," "sad," "afraid," "worried," and "happy." When I use this exercise, I re-

duce the number of emotions to three at most; often I ask a child to draw only the primary emotion that matches his or her feelings when he or she thinks about the person who died. I believe that it is counterproductive to expect a bereaved child to draw five different emotions at one time.

The Body Map of Feelings exercise also can be adapted to conform to a child's developmental and emotional capacity. The body map is an outline of a body, on which the child is asked to use seven different colors to indicate the places where seven different emotions are felt: "sad," "afraid," "guilty," "angry," "jealous," "nervous," and "happy." When I use this, I ask the child to choose which of three feelings he or she would like to draw, and generally this task proves to be sufficient for one time. It is also possible to go very slowly and request only one emotion each session. Because the practitioner and the child use the drawing as an opportunity to talk about a time when the child felt this emotion, it is not desirable to rush the experience. In fact, it may be more helpful to expand on the child's recollection by inviting him or her to draw a picture of that experience.

Individual, Family, and Group Approaches

Grief is a family experience, and the helping person must attend to the needs of the family unit, as well as those of the individual members. In Chapter 6 I recommended an integrated child and family model, which is very appropriate for a bereaved family. Typically I offer to make a home visit when I learn about a death that pertains to a child client. Depending on the circumstances, I may attend the funeral. It is *always* relevant to see the entire family together soon after the death, to offer condolences and to assess the group and individual needs. Following the death of a child, the parents may benefit from some marital counseling, and at some point it may be useful to see individual family members alone (when this is practical). This latter approach permits the expression of frustration or anger toward other family members, without exposing the targets of these strong feelings to the added stress of being blamed when they are already in the throes of grieving. Often it is helpful to see the child with each parent, in order to observe differences in the child's reactions with different parents and to determine each parent's ability to comfort and support the grieving child.

Whenever I see a parent with a child, or the family as a unit, I always invite the parent(s) to participate in whatever play activity I make available to the child. Most parents comprehend that their children are communicating symbolically through play, even though they may have difficulty in knowing how to respond. There are examples of parent–child play in the discussion about Sabrina's family that follows.

Referrals to grief support groups should always be considered, depending on the willingness of the family members to involve themselves in this type of counseling. Many schools offer bereavement groups for children, which can help a child realize that he or she is not the only one who has suffered a loss. Examples of bereavement groups for children, with detailed process notes illustrating specific interventions and the children's responses, are described in Tait and Depta (1993), Hickey (1993) and Dane (2002).

Interventions with Sabrina and Her Parents after John's Death

Initial Interventions

In the month after John's death, I met with Mr. and Mrs. Rossi once, and Mrs. Rossi brought Sabrina for a conjoint session. The meeting with Mr. and Mrs. Rossi was very intense, because Mrs. Rossi was in the throes of grieving and needed to express her anger about John's death. She stated that she did not wish to involve herself with marital counseling because she planned to continue in individual therapy and had also joined a bereavement group. Although I knew that she was angry with me because I had been unable to mend the relationship between John and Dan, Lida did want me to continue to see Sabrina and agreed to bring her alternately with Mr. Rossi.

Dan was very concerned about his wife's pain over John's death. However, he did not feel the same need as his wife did to process the events surrounding the death or to examine how it personally affected him. He declined my offer to meet with him individually, stating that he "might look for a men's group." Perhaps taking his cues from Lida, Mr. Rossi agreed to bring Sabrina for individual play sessions, according to my recommendations.

In the first session with Sabrina after her brother's death, I asked her to draw a picture of John. Sabrina drew a colorful figure, appearing to float in air, with arms outstretched (see Figure 12.5). She declined my invitation to tell me about the drawing, but she did agree to think about some happy memories of John, mentioning sitting on a wall in a favorite park with John and some of his friends.

Individual Session with Sabrina

In a session a month later, Sabrina told me directly that she didn't want to talk about John or "anything else." I then produced a "new" game,

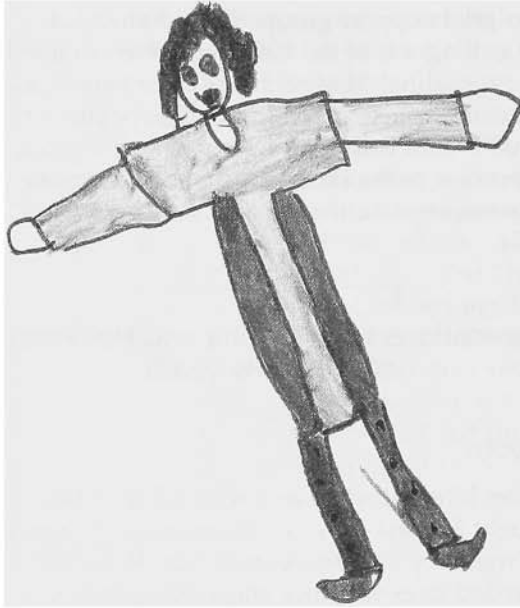

FIGURE 12.5. Sabrina's drawing of John.

Operation; this totally captured Sabrina's interest, insofar as it permitted her to assume a controlling role in regard to "operating" on a helpless patient. The game also permitted me to make connections to her mother's operation. For example, at one point during the play I asked Sabrina whether any of these operations were like those her mother had. Sabrina said, "No, that was *very* different!" I indicated that I knew about the operation and asked Sabrina whether she was worried about her mother now. She said, "Sometimes," but she could not tell me more.

Several times during the play, Sabrina went into the waiting room to say something to her mother. At the end of the session, Sabrina wanted to show her mother the game; she also gave her reward for winning (a wildlife sticker) to her mother.

Session with Sabrina and Her Father

During the first session with Sabrina and her father following the death, I asked how it seemed in the house without John. Sabrina said that she couldn't say, so I suggested that she draw a picture of a face (showing her the Feelings Faces exercise). Sabrina said it was sad and drew a very sad face (see Figure 12.6). The original drawing had one line to denote

FIGURE 12.6. Sabrina's drawing of a sad face.

the mouth, which appeared to convey distress. I responded, "What do we need to help that sad face feel better?" (expecting to lead into a verbal discussion). Sabrina took the marker and drew a full mouth around the straight line she had previously created. I said, "Sometimes we put on a smile when we feel sad inside." Sabrina nodded and then looked toward the doll family and doll furniture she had played with previously. She then proceeded to reenact a scene with the mother doll in the hospital, because "she had to have an operation." The family, around the breakfast table, read the newspaper, and Sabrina announced, "They wrote about Mom in the newspaper." She turned to me (in play) and asked, "What does it say?" I responded, "Mrs. Jones is in the hospital," and Sabrina interjected, "for a very serious operation." I continued, "She has a very good doctor, and we expect her to recover."

Sabrina then asked to go to the bathroom. During this interval, Mr. Rossi, who was in the room observing this play interaction, stated: "I don't know why she does this; she must associate coming here with Lida's operation." When Sabrina returned, she asked to play Operation.

Session with Sabrina and Her Mother 4 Months after John's Death

Prior to the next session with Sabrina and her mother, I had received a telephone message from Lida stating that one of John's two cats had died.

At the beginning of the session, I noticed how attractive both Lida and Sabrina looked. Lida had lipstick on (for the first time in months), and Sabrina was specially dressed for a birthday party immediately after this session.

Sabrina began by telling me that she forgot to bring the picture she had drawn for me last night in bed. I asked her to describe it, and she said it had "a sun, a house, and grass." She then said, handing me two quarters, that she wanted to give me some money "because you invite me to come here." I was very touched and impressed by the apparent meaning of the sessions to Sabrina. I told her that her father already paid me (through insurance), but she insisted, saying, "I *want* to give it to you!" I thanked her very much, continuing to puzzle about the meaning of this behavior.

Telling Sabrina that I knew about the cat's death and that I was sorry, I asked her whether she was surprised that he died. Sabrina said that she was not sure why he died, and Lida reminded Sabrina that the cat's X rays had shown an enlarged heart. At this point, Sabrina could not tolerate any more words, and she began crawling around the floor acting out how the cat had wanted to sleep and stay by himself. I asked about how the other cat was responding since the death of her friend, and Sabrina again acted this out by crawling on the floor and making cat sounds.

I introduced the Body Map of Feelings (Heegaard, 1991) and suggested that Sabrina draw on the body in blue where she felt sad. First she thought this would be in her eyes, but then she said it was in her stomach. She drew a very large blue circle in the center of the body (see Figure 12.7). When I asked Sabrina if she could indicate where in the body she felt afraid, she put a black circle within the blue nucleus of the stomach. She drew orange (nervous) in the neck, and green (jealous) in the head. She said that she couldn't do angry and that happy would be on the face, but she didn't want to mix it with the green color already there.

When we later played Gardner's Storytelling Card Game, one of Sabrina's stories had the theme of feeding a dog, then later calling the dog and he wasn't there.

Comment

The accounts of these sessions graphically depict how this latency-age child used a variety of play materials to project her feelings of bereavement and confusion about the two major crises in her life that occurred within an 8-month span: namely, her mother's serious operation and her half-brother's sudden death. Play, in the context of a therapeutic relationship, truly served as an outlet for this child to express her worries about her mother and her sadness about the loss of her brother.

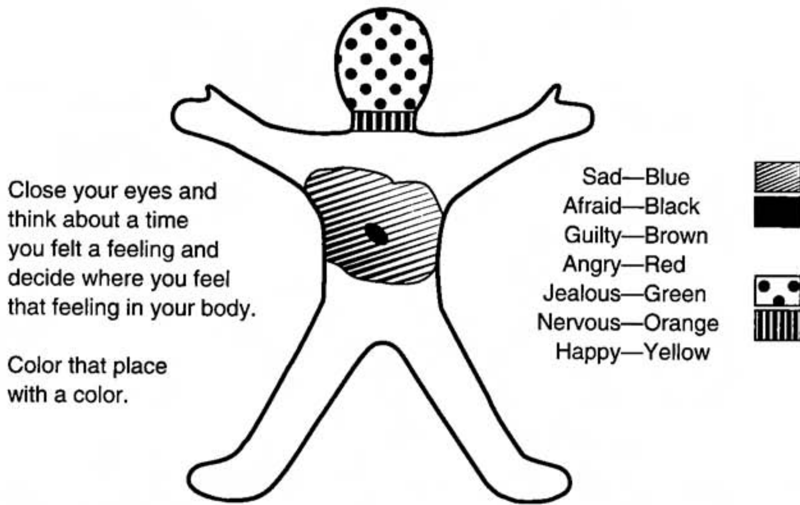

FIGURE 12.7. Sabrina's Body Map of Feelings. The form is adapted from Heegaard (1991, p. 13). Copyright 1991 by Woodland Press. Adapted by permission.

It seems clear from these descriptions that Sabrina continued to be very concerned and protective toward her mother. For example, she presented her mother with her "reward" sticker at the end of a session. In fact, the death of her brother may have assumed major significance to her because it made her mother so very sad. Sabrina continued to be very concerned about her mother's health, which made Mrs. Rossi's prognosis very significant to this child.

Addendum

Approximately a year after John's death, Sabrina's mother died. Gradually, over a 4-month period, Lida's ability to walk and carry on her usual activities had deteriorated. The local hospice provided the necessary nursing and home health care services, and I was seeing Sabrina weekly, sometimes in my office and sometimes at their home.

Even after she was bedridden, Lida could not accept the reality of her impending death. Because I was concerned about preparing Sabrina, I told Lida that it was essential to tell Sabrina about the fact that she (Lida) was not getting better, despite all medicines and the best efforts of the

doctors. Three days after hearing this from me, Sabrina's mother told her, "God wants me and God may be taking me soon." Lida also told Sabrina, "God will take care of you and Daddy, and I'll be watching over both of you." Eight days later, on her own 47th birthday, Lida died.

UPDATE: EIGHT YEARS LATER

I continued to see Sabrina weekly, sometimes separately and often with her father, over the course of the school year following her mother's death. Typically she wanted to play Operation, and I used the game to repeat over and over how hard the doctors try, and yet, despite all the operations, the "patient" may die. Sabrina would name the figure in the game, and I would say comforting and soothing things to him. Mr. Rossi did not really understand the importance of this game to Sabrina, and he would try to use the session to talk about how they were managing and about their plans to move to a house adjacent to his parents. After the first anniversary of Lida's death, Sabrina began to want to play other games. I felt that she had moved beyond her need to play and replay the medical situation. She was doing well in school, had friends, and participated in a number of after-school activities.

During her second-grade year we began to taper off the sessions—initially to biweekly, and then to monthly. In the ensuing years I have seen Sabrina and her father at least once a year, when I call to invite them to come in together. I usually plan this meeting either around Mother's Day or around the time of John and Lida's deaths. A repeated issue that has come up over the years involves their mutual concerns about each other's whereabouts. They each became extremely concerned if the other came home late, for example. I addressed this in the context of being "supersensitive" about the possibility of losing each other, as they had experienced two deaths so close together in time. Stahlman (1996) refers to the "overprotectiveness of surviving siblings toward one another following a death," and I believe that this dynamic was operating in this father–daughter relationship as well. A few years after Lida's death, Dan began dating the divorced mother of Sabrina's best friend. When I asked Sabrina (then age 13 and in 8th grade) how she felt about having her father date, she responded, "It's OK but I want to know where he is, and I stay up until he gets home."

Sabrina has maintained contact with her mother's mother and sister on the West Coast, usually going to visit over the summer vacation. Last year, when she was 12, she and her father went to a special mountain location there, where they scattered Lida's ashes. In my most recent follow-up session, in preparation for the update in this book, Sabrina de-

nied that she thought it was difficult to have two family members die in 1 year. Perhaps trying to present as a "cool" adolescent, Sabrina was not particularly open or responsive to my questions, although she signed the release form without hesitation. Her father told me that he painted her bedroom for her 13th birthday and that she asked him to hang a picture of her (then a 2-year-old toddler) and her mother walking over stones on a beach, with Lida pointing the way for Sabrina to walk. I thought that this seemed a lovely and symbolic way of documenting the "continuing bonds" and the ongoing influence of her mother on this adolescent girl.

CONCLUDING COMMENTS

Children need the stability and security of knowing that the people who love them will remain constant in their lives. When illness and death take precedence over a child's needs, the child may feel abandoned. Actually, children *need* their parents in order to complete certain developmental tasks, such as integrating a firm sense of identity.

It is possible to help children and parents with "the work of mourning" after the death of a family member. These helping methods should be adapted to the age of the individual and to his or her ability to comprehend the reality of what has happened. When a young child is faced with the death of a sibling or the recurring illness of a parent, play techniques can provide the mechanism through which the child can express, in a displaced manner, the conflicts and anxiety he or she is experiencing internally but trying to suppress. The use of directed or structured play therapy can provide such children with relief and the reassurance that an adult comprehends their confused internal state.

DISCUSSION QUESTIONS AND ROLE-PLAY EXERCISES

1. Discuss the implications of young children's magical thinking and egocentricity on their ability to understand death. How can a worker assist a parent in helping a bereaved child who is under 7 years of age? Count off by threes, with one person taking the role of the worker, another that of a parent of a child under age 7 whose older brother died of a drug overdose, and the third person an observer. After the role play, the observer should comment on helpful responses and suggest other possible ways to communicate effectively with the parent.
2. What issues in a remarried family are illustrated in the Rossi case? If you had been the worker, how would you have dealt with the long-standing

conflict between Mr. Rossi and John? Role-play a session in which you address and attempt to modify their hostility toward each other.

3. Consider the pros and cons of having multiple workers/therapists involved in helping a family such as the Rossis. What recommendations would you make to avoid mixed messages and differing goals among the various counselors?
4. How can the worker effectively assist latency-age children who do not wish to talk about their feelings after a death? What play materials might be useful?
5. Compare and contrast the use of individual, family, and group approaches in situations of bereavement.

❖ CHAPTER 13 ❖

Children in Substance-Abusing Families

Many children growing up at the end of the 20th century have been exposed repeatedly to the effects of substance abuse or dependence in their own families, schools, and communities. Television commercials and programs routinely portray scenes of a father drinking beer as he watches a football game, and news reports often feature drive-by shootings and crimes committed by drug addicts and dealers. In some families, children receive their first sip of beer or wine from a parent, and even children whose parents are not users of substances know that many teenagers brag about "getting loaded" on weekends and that some get into trouble when they are drunk or "high." In urban settings, children may watch addicts buying drugs or "shooting up" in empty lots or the hallways of their own apartment buildings. Older siblings or neighbors may introduce 9- or 10-year-olds into the drug trade by making them "runners," thereby insinuating them into an adult antisocial world that welcomes them primarily because of their immunity from prosecution.

What is the impact of growing up surrounded by older people who regulate their moods through use of chemicals and whose lives seem totally dominated by this experience? And what are the effects on a child when one or both parents are abusing or dependent on drugs or alcohol?

CLARIFICATION OF TERMINOLOGY

This section begins with definitions of the terms related to the use of drugs and alcohol and reviews some of the differing effects of various mood-altering chemicals on the individuals who ingest them. The *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM-IV-TR; American Psychiatric Association, 2000), includes the category of substance use disorders and subdivides this category into substance abuse

and substance dependence. The substance that causes a disorder may be either alcohol or one of 11 other substances listed in the DSM-IV-R; polysubstance abuse or dependence is of course also possible.

The DSM-IV-TR term "substance dependence" refers to a dysfunctional pattern of substance use leading to clinically important distress or impairment over a 1-year period, during which tolerance and withdrawal increase, use of and desire to obtain the substance also increase, and other activities are given up because of substance use. (See American Psychiatric Association, 2000, p. 195, for specific criteria.)

"Substance abuse" is not as severe as substance dependence, according to DSM-IV-TR. It refers to a maladaptive pattern of substance use in its early phases, with danger signs such as not fulfilling major role obligations at work or home and continuing to use a substance despite frequent interpersonal or social problems caused by the substance's effects. (Again, see American Psychiatric Association, 2000, pp. 197–199, for specific criteria.) This chapter refers to "substance-abusing parents" in recognition that even in its early phases this disorder can present problems for the entire family.

Straussner (1989) and Lowinson, Ruiz, Millman, and Langrod (1997) classify different psychoactive drugs in terms of their distinctive effects on the central nervous system and thus on a person's thinking and behavior. Table 13.1 presents an adaptation of these categorizations.

IMPACT OF GROWING UP IN A SUBSTANCE-ABUSING FAMILY/ENVIRONMENT

Multiple Stressors

When parents are abusing or dependent on depressants, stimulants, narcotics/opiates, or psychodelics/hallucinogens, their ability to focus on and respond to their children is significantly impaired. Straussner (1989, p. 149) states that "clinicians and researchers have only recently recognized that growing up with a drug- or alcohol-abusing parent is frequently a highly traumatizing experience with long-lasting effects." Among the multiple stressors faced by children in substance-disordered homes is the sad reality that a parent's disorder "is likely to take precedence over [a] child's basic needs" (Tracy, 1994, p. 535). Other stressors on these children, according to Tracy (1994, citing Feig, 1990, and Gittler & McPherson, 1990), include the following:

- Chaotic and often dangerous neighborhoods.
- Poverty and homelessness or unstable housing.

TABLE 13.1. Effects of Different Categories of Substances on Individuals

Category of substance:	Depressants
Effects on brain:	Slow down, sedate brain tissues; alter judgment and behavior; cause agitation (hangover) in coming off.
Names of substances:	Alcoholic beverages; barbiturates and sedatives/hypnotics; minor tranquilizers (Librium, Valium); low doses of cannabinoids (marijuana and hashish).
Category of substance:	Stimulants
Effects on brain:	Increase or speed up function of brain; can produce acute delirium and psychosis (symptoms may include hallucinations, paranoia, and hypersexuality); violent behavior may occur with use of potent forms of cocaine ("freebase" or "crack").
Names of substances:	Amphetamines; cocaine; caffeine; nicotine.
Category of substance:	Narcotics or opiates
Effects on brain:	Decrease pain; create a sedative and tranquilizing effect; may cause stuporous inactivity (daydreaming/fantasies); may cause physical agitation upon withdrawal (panic and violent behavior may occur at this time).
Names of substances:	Opium, morphine, heroin, codeine, paregoric, methadone; Demerol, Darvon, Prinadol.
Category of substance:	Psychedelics/hallucinogens
Effects on brain:	Produce gross distortions of thoughts and sensory processes (e.g., visual hallucinations, distorted body image); may produce depersonalization, depression, hostility; may lead to violence because of anxiety and misperceptions of reality.
Names of substances:	LSD; PCP ("angel dust"); DOM; STP; mescaline; psilocybin.

Note. Adapted from Straussner (1989, pp. 151–152). Copyright 1989 by New York University Press. Adapted by permission.

- Parents who lack an extended family and community support system.
- Parents who may have been victimized themselves as children or adults.
- Parents with poor parenting skills and few or no role models for effective coping.

Johnson (1991, p. 276) points out that "in the chemically dependent family, the child is in a permanent state of crisis, with inconsistency and chaos being the norm." Given this reality it is not surprising that children in

families that utilize substances are at great risk themselves for developing this dependency (Harper-Dorton & Herbert, 1999). The earlier children begin using alcohol and drugs, the greater the likelihood of later development of drug abuse problems (Jenson, 1997). Furthermore, long-term outcomes for such children include a range of conduct problems, delinquency, crime, and arrests (Winters, 1998).

Various forms of child maltreatment often occur in families with substance-abusing parents. These may include neglect, physical abuse, and/or sexual abuse. The concept of "maltreatment" (according to Gonzales-Ramos & Goldstein, 1989, p. 5) refers to *all* physical abuse or marked neglect of children. Specifically, an abused child has parents or caretakers who inflict or permit injury or protracted impairment of physical or emotional health or allow the risk of such injury. A neglected child has parents or caretakers who fail to supply basic care, supervision, or guardianship or who actually abandon him or her.

Numerous studies have found a correlation between child maltreatment and substance use disorders, ranging from 40% nationwide (Daro & McCurdy, 1991) to 80–90% in certain localities (Feig, 1990). The most common form of child maltreatment by substance-disordered parents is child neglect, according to Black and Mayer (1980). The nature of this neglect may range from a general lack of supervision to "total inattention to such basic needs of children as food and clothing" (U.S. Children's Bureau, 1978, p. 59). Tracy (1994) cites Besharov (1989) as reporting that in New York State over 73% of neglect-related child fatalities are attributed to parental alcohol and drug abuse.

Sexual abuse and incest are also common in families that abuse substances (Barnard, 1984; Copans, 1989; Johnson, 1991; Tormes, 1968), possibly because of the diffuse parent–child boundaries in such families, which are characterized by role reversals and inappropriate parental role maintenance. Wertz (1986) suggests that over 50% of physically and sexually abused children come from substance-disordered families. Straussner (1989, p. 151) points out that "any psychoactive substance that produces a state of intoxication . . . can affect parenting behavior," because of alterations in the individual's judgment and behavior. Indeed, substance-disordered parents are often unable to care for *themselves* adequately; thus it is not surprising that they cannot meet the needs of young children.

However, despite this disturbing picture, we must emphasize that the relationship between child maltreatment and substance use disorders is considered correlational, *not* causal. Moreover, the incidence of maltreatment varies according to type of substance used and other factors. Child abuse has been found most frequently in families in which there is an alcohol- or opiate-addicted mother; in families in which parental violence is common; and in families with low financial status and poor liv-

ing conditions (Black & Mayer, 1980). Clearly, many elements in addition to substance use contribute to the constellation of family stress in which a young child becomes victimized (Belsky, 1993).

The child born into a substance-disordered family is at risk for a range of problems in addition to maltreatment. Beginning *in utero*, for example, infants of cocaine-using mothers suffer a decreased growth rate, and their behavior as toddlers tends to be hyperexcitable, fussy, and impulsive (Petitti & Coleman, 1990, as reported in Feinberg, 1995). Even more startling than this information is the finding that "children who were exposed to cocaine use in the *home* had more serious behavior problems than those exposed in the womb" (Youngstrom, 1991, as reported in Feinberg, 1995, p. 241; emphasis added here). In addition to behavior problems, lower intellectual and educational functioning has been found in children whose mothers use drugs of all types (Feinberg, 1995).

According to the Robert Wood Johnson Foundation (2001), "more than 2,000 infants are born every year in the United States with fetal alcohol syndrome, a leading preventable cause of birth defects and developmental disabilities" (p. 17). This extensive report emphasizes that alcohol is the number one drug of choice among both adolescents and adults and that, furthermore, it is the most widely available drug. Although there has been some decline in alcohol consumption over the past 20 years, it remains the most commonly used drug among young people, who may engage in periodic binge drinking that, in time, may result in alcohol dependence for many individuals (Robert Wood Johnson Foundation, 2001).

Multiple Losses

The numerous problems in substance-disordered families make loss an ever-present reality that threatens children's sense of security and safety. On the most basic level, these children are deprived of a structured, predictable routine, because of their parents' inconsistent moods and behavior. The children never know when they may have to take complete care of themselves, in addition to their parents. This uncertainty seriously interferes with the children's ability to become involved with peer activities, as the parents' need may take precedence over the children's wishes for more age-appropriate involvement. Often such a child feels embarrassed, "different," and even ashamed of his or her family circumstances. These feelings can lead to social isolation, loneliness, and depression. The child's very childhood has been lost.

If a child is maltreated and comes to the attention of child protective services, separation of the child and parent may be mandated to protect

the child from additional harm. This separation, unfortunately, constitutes an even more wrenching loss for the child, if he or she is placed with a foster family of strangers. The parent, in turn, may feel that the removal of the child is a punitive response to the addiction rather than a remedial effort to help. Certainly this major loss to the family is one that may be very difficult to reverse in the future, as children from substance-disordered families have low rates of reunification with their biological parents once they enter placement, despite all efforts toward permanency planning (Tracy, 1994, 1999).

ETHICAL DILEMMAS AND PRESSURES ON PRACTITIONERS

Numerous ethical dilemmas and pressures confront practitioners who work with substance-disordered families. Because the use of many substances is illegal, and because many people consider drug or even alcohol abuse or dependence a psychological "weakness" rather than a disease, addicted individuals with substance use disorders tend to deny and hide their problems. In addition, denial is an unconscious defense that permits the individuals to continue their substance use. It is understandable that these persons respond with suspicion and rejection to well-meaning helping efforts, in view of society's tendency to denigrate and stigmatize them. Substance-disordered parents may be oblivious to the havoc of their lives. However, when their behavior puts their young children at risk, then society flexes the muscles of the legal system, challenges these parents' behavior, and insists on detoxification and change as conditions for their retaining custody of their children. The right to self-determination no longer applies to a parent whose disorder interferes with effective parenting and therefore impinges on his or her children's rights.

In circumstances such as this, many ethical dilemmas arise for social workers, who want to advocate for dependent children yet do not wish to alienate the children's parents or to rupture, through mandatory placement, the attachment bond between children and parents. Sometimes workers agree with society's negative feelings about a *mother* who neglects her children, not fully understanding that a substance use disorder can seriously compromise an individual's judgment and behavior. Of course, the absent or neglectful *father* also shares responsibility for his children, but the sexist views of our society exact a higher standard for women; as a result, mothers are often penalized for neglect, whereas similar behavior in men is ignored (Feinberg, 1995; Goldberg, 1995). Of course, in many single-parent families headed by women, the fathers are unknown.

The "Rescue Fantasy"

In teaching, I have found that master's-level students working with substance-disordered families often progress from an initial strong stance of wanting to protect ("rescue") dependent children through filing complaints about neglect or abuse to subsequent observation that the children's situations do not improve appreciably in cases in which placement occurs. Furthermore, the students witness much bitterness and unhappiness connected with these placements. Seasoned workers learn through experience that the concept of "the best interests of the child" has to be weighed against that of "the least detrimental alternative"; this requires "a realistic appraisal of existing resources" (Kamen & Gewirtz, 1989, p. 180) as a basis for determining the choice of child care in a given situation. Sometimes *no* good alternative is available, and a concerted effort to help the family members remain together offers the best prospect for "rescuing" a child.

Weighing Differing Needs of Children and Parents

It may be very stressful for a worker to have to determine the degree of risk to a child in two alternative situations, neither of which appears desirable. As Tracy (1994) states, "although the emotional limbo of being in foster care carries its own set of risks, remaining in a substance-abusing home also carries risks" (p. 535).

The separation of a child from his or her family generates intense feelings for *all* parties involved. This serious move, which is intended to protect the child, allows the laws of the state to intervene in family life and to supersede the rights and authority of parents in situations of suspected child maltreatment. However, the goal of permanency planning, as reflected in the Adoption Assistance and Child Welfare Reform Act (Public Law 96-272, 1980) is to provide intensive preventive services for families at risk, in order to reduce the need for placement and to reunify families in a timely manner when placement has occurred. Thus the role of the social worker frequently consists of offering services to substance-disordered parents (even when they do not want this help) in order to prevent the out-of-home placement of their children. Tracy (1994) points to the need for demonstrating "reasonable effort" to provide services that address the family circumstances (such as parental substance use disorders) that put the child at risk of placement. Clearly, the critical assistance in these cases is to get substance-disordered parents into treatment.

In an ideal world, the removal of children from their parents would never be necessary. If parents were negligent or unable to carry out their child care responsibilities, some form of assistance would be offered to families on a temporary basis, to provide respite and insure the well-being of the children. In essence, this is the purpose of foster care: "not to rescue the child, but to offer respite for the family until life becomes manageable" (Minuchin, 1995, p. 253). However, there is a broad gap between the ideal and the real. Effective treatment for substance use disorders takes time, is costly, and is often characterized by recurrence of the addictive behavior. Social workers and others may doubt parents' ability to complete a detoxification and treatment program and/or to sustain their sobriety after discharge. In truth, although treatment is initially costly, it is highly cost-effective *in the long run*.

Knowledge that a substance use disorder is a "family (i.e., intergenerational) disease" (Straussner, 1989) may perpetuate attitudes of determinism and powerlessness among workers who genuinely want to "rescue" children and who view removal of the children from their "diseased" families as the preferred method of helping. Of course, a child should be removed only if a parent refuses treatment and neglect or abuse continues.

Impact of Mandatory Reporting

Although only about 20% of all reported cases of child maltreatment actually result in court involvement (Kamen & Gewirtz, 1989), every report must be investigated, and the very presence of child protective services can have a profound impact on families because of its implicit challenge to the family's autonomy. It also has a strong impact on the worker, who realizes that his or her report to child protective services will threaten the helping relationship because of the client's inevitable resentment about being reported. A combination of empathy and authority is necessary in working with nonvoluntary court-referred maltreating parents. (See Chapter 14, this volume, as well as Kamen & Gewirtz, 1989, for further discussion of this topic.)

Issues of Confidentiality

Confidentiality has specific limitations in situations in which the court is involved. This can present a formidable additional obstacle in the worker–client relationship, because the client knows that the worker has a legal obligation to report any incidents that indicate recurrence of maltreatment. In such cases, even when the worker informs the client that a report will be made, the parent often deeply resents the worker's actions.

A brief case example illustrates this point. Mrs. Jones, a 25-year-old pregnant mother of three sons (ages 6½, 5½, and 1), was mandated to receive individual therapy with a focus on parenting skills. Her children had been placed in foster care for 8 months because of neglect when she allegedly left them alone for extended periods of time. A neighbor stated that Mrs. Jones took drugs and hung around with drug dealers, but she denied this allegation; she also denied that she had left her children unattended.

Mrs. Jones seemed distant and angry in counseling sessions. She often refused to engage in discussion, answer questions, or talk about her feelings or behavior or about how she was managing now that the children had returned home. She also refused to discuss her pregnancy, stating that she didn't like to have other people "minding her business."

The worker felt that little progress was made in 3½ months, stating in a case summary that "this mother is unresponsive, distant, critical and punitive toward the children, showing them only occasional displays of warmth."

In supervision, the worker recognized that she and the client were both "trapped" in a relationship neither of them wanted. Although the worker admitted her feelings of anger toward the client, she was unable to move beyond this to recognize with the client how the issue of their *mutual* anger and need for control prevented their working together on meeting the children's needs for effective parenting.

This brief vignette illustrates the intense feelings generated by the removal of children from a mother's custody when her allegedly neglectful behavior puts them at risk of potential harm. The possible or even probable substance involvement of a parent merits close attention, but it is not in itself grounds for evidence of child maltreatment in most states (Tracy, 1994, citing English, 1990).

Work with parents who have been charged with some form of child maltreatment requires great sensitivity and skill. Often such parents distrust "the system," and insofar as they view the worker as part of this system, they will be very difficult to engage. The key to effective helping is to discuss a parent's resistance openly, while also identifying the parent's strengths. Referral to a substance abuse treatment agency in which the chief mode of treatment is group therapy may reduce the parent's denial and sense of stigma, while also offering the support of group members and the possibility of identification with peers who share similar challenges and experiences.

Another situation that requires sensitivity and skill on the part of the worker is that in which a child reveals ongoing abuse but asks the worker to keep this revelation a secret because of fear of destroying his or her family. The worker does not really have a choice in this case, because reporting of abuse is mandatory. *Confidentiality cannot be maintained when a child's safety is in jeopardy*. The worker must make this clear to the child, in a manner that assures the child's protection and keeps the child from feeling betrayed by the worker. The revision of the National Association of Social Workers (NASW) code of ethics (NASW, 1996, Section 1.01) points out that social workers' responsibility to the larger society and/or their specific legal obligations may supersede the loyalty owed to clients and that clients should be advised accordingly.

COMBINING INDIVIDUAL AND FAMILY HELPING METHODS

Because substance use disorders affect individuals, families, and communities, a broad approach to helping is necessary, using a combination of psychological, educational, behavioral, and environmental interventions. The primary focus in such a case must be on the substance use problem itself, because, as Copans (1989) has stated, "treating a family with [a substance-disordered] member without acknowledging, confronting, focusing on, and dealing with the [substance use] is generally doomed to failure" (p. 277). Furthermore, after treatment, the best chances for lifetime recovery are afforded by ongoing participation in one of the Twelve-Step self-help groups, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or Cocaine Anonymous (CA). Whereas the use of alcohol or drugs previously dominated the substance-disordered person's life, the focus after detoxification (if needed) and treatment must change to a commitment to remain drug- and alcohol-free. The disorder is not "cured," but, like diabetes, it can be controlled if the individual initiates and sustains a certain lifestyle. This usually entails finding new friends who share the recovering individual's goal of maintaining sobriety. Contacts with the previous network of substance-using peers must cease. Moving to a new neighborhood, when this is possible, symbolizes leaving the past behind and represents a new beginning.

Helping Substance-Abusing Parents

Most specialists in the field of substance use disorder agree that few individuals enter treatment voluntarily. Because of the denial that characterizes the substance-disordered population, a family member usually

must insist on treatment, or another person such as a social worker must threaten to remove a child from parental custody unless the parent agrees to enroll in a detoxification and rehabilitation program.

Many detoxification programs (which are necessary for alcohol and opioid dependence, for instance) are carried out on an inpatient medical or psychiatric unit. This almost always requires a parent–child separation during a 5-day period. Moreover, detoxification is only the first step in treatment; intensive, ongoing educational and other programs are also needed. Goldberg (1995) points out that few treatment programs provide accommodation for children with their mothers, and she believes that the high costs of such programs may limit their widespread development in the future. Ironically, the cost of such treatment is much less than the cost of foster care.

One model program, in existence for more than 30 years, is Meta House in Milwaukee, Wisconsin. This program treats women and children *together*, with the average length of stay between 9 and 18 months. About 25 women complete the program every year (Feinberg, 1995). Treatment is multifaceted and is successful in 90% of cases, with no recidivism. Components of this model program include educational/vocational counseling and training, assistance with housing, monitoring of physical health, legal assistance, and treatment focused on parenting and improvement of the mother–child relationship. Unfortunately, the high cost per family probably precludes broad duplication of this model program, no matter how successful its outcome.

Less costly treatment approaches to helping substance-disordered parents on an *outpatient* basis following detoxification include day treatment, intensive patient rehabilitation programs, ego-supportive individual treatment, various self-help groups, and intervention with family members (Goldberg, 1995; Straussner, 1989). Whatever the modality, attention must be paid to environmental factors, such as housing, employment, and health needs, in addition to counseling focused on building the parents' self-esteem and self-confidence.

Family Approaches

Just as addiction develops over time, the response of a family to a substance-abusing member may vary over time, according to the changing individual and family life cycle stresses that occur during the onset and course of the addictive process (Krestan & Bepko, 1989). Often "the family, as well as the [substance user], develops a rigid system of denial in an attempt to avoid acknowledgment of the problem" (Krestan & Bepko, 1989, p. 486). When parents are at midlife (mid-40s to mid-60s), they are most

likely to seek help for alcohol use disorders; however, this time may come after the children have left home. In contrast, disorders related to the use of illicit drugs may elicit stronger recognition and response by the family, as the addictive process typically is more rapid with drugs than with alcohol. See Straussner (1993) for a discussion of the impact of different substances on the family.

Some general guidelines set forth by Deutsch (1982, pp. 127–128) for the treatment of alcohol problems in the family may, with slight revisions, apply also to the family treatment of other substance use disorders. They are adapted here as follows:

- Make a careful assessment of substance use problems in the two prior generations (i.e., look for evidence of the intergenerational persistence of such problems).
- Insist on sobriety/abstinence as a precondition of treatment. Recommend the attendance *at least six times* of the substance-disordered person at AA, NA, CA, or (when relevant) Parents Anonymous (PA) and of family members at Al-Anon or Alateen.
- Educate the family about substance abuse and dependence.
- Encourage open discussion of the problem among family members and other families with similar problems.
- Pay attention to the special needs of the children. If they have assumed a parentified role, they need permission to give up that role in favor of more age-appropriate behavior; it may require ongoing work to accomplish this goal.

Helping the Children of Substance-Abusing Parents

Hereditary Factors

Children in substance-disordered families are at high risk because chemical dependency is a hereditary disease in the same sense in which heart disease, diabetes, and cancer run in some families. Children with a family history of alcoholism are four times more likely to develop alcoholism or chemical dependency, according to five landmark studies (Goodwin, Schulsinger, Hermansen, Guze, & Winokur, 1973; Schuckit, 1985, 1994; Begleiter, 1988; Vaillant, 1983)

Goodwin and colleagues' 1973 study of adopted children showed that children born of alcoholic parents and raised by nonalcoholic parents had

Note. The author acknowledges the contribution of Madeline Zevon, ACSW, CASAC, MAC, in the preparation of this section and the cases of Vanessa and Vernon.

a very high rate of alcoholism. In other words, it was not the family in which they grew up but their biological parents that determined the higher rate of alcoholism. In 1988 Dr. Henri Begleiter of the State University of New York found similar brain wave patterns in alcoholic fathers and sons. In 1994 Mark Schuckit showed that people with the potential for alcoholism metabolize alcohol differently, thereby pointing to a physiological difference predisposing some young people to develop this disease. Further confirmation of hereditary factors came from George Vaillant's 40-year study of 660 men from adolescence to middle age, which found only one consistent predictor of alcoholism: the presence of an alcoholic parent.

Environmental Factors

Despite this compelling research attesting to hereditary factors, we must also acknowledge the role of the environment in the development of chemical dependency. In our society there are strong pressures on young people to drink and to experiment with drugs (Robert Wood Johnson Foundation, 2001; Nadel & Straussner, 1997). When these influences combine with familial and intrapsychic dynamics and genetic influences, adolescent experimentation may move progressively into substance abuse and even dependence (Nadel & Straussner, citing Feigelman & Feigelman, 1993).

The combination of hereditary and environmental factors puts children of alcoholics and addicts at very high risk. They should be targeted for prevention by giving them factual information about their vulnerability. The emphasis in such preventive education is the message that the disease cannot develop if susceptible individuals abstain from using alcohol and drugs.

Living with a Substance-Abusing Parent

The concept that alcoholism or other substance misuse is a *family* disease recognizes the stresses experienced by all members of the family system (Ficaro, 1999). Children can be taught about the roles they may play inside and outside of their families as part of a family's denial that a parent is drinking. Five different roles have been identified by Wegscheider (1981) to illustrate that no one escapes in a chemically dependent family. These include:

- The enabler
- The hero
- The scapegoat
- The lost child
- The mascot

Ficaro (1999) points out that each role offers its own payoffs for both the individual and the family and ultimately exacts its own price. It is helpful for children to become aware of these family patterns through discussions in groups with peers who have similar family backgrounds.

GROUPS FOR CHILDREN OF SUBSTANCE-ABUSING PARENTS

An open-ended outpatient approach to helping children is exemplified by the Archway Program in Mount Vernon, New York, run by St. John's Riverside Hospital; this provides after-school groups for children of alcoholics and addicts (Zevon, 1990). This treatment program is licensed by the New York State Office of Alcoholism and Substance Abuse Services. A distinctive feature of the program is that children can continue to be served on a long-term basis, depending on their needs and family situation. Children can enroll even if their parents are not receiving simultaneous services, although the goal of the program is to provide recovery groups for each family member in parallel treatment tracks. Most parents are or have been in treatment.

Each after-school group consists of 8 to 10 male and female children within a 2-year age range between the ages of 5 and 18 years. The groups are structured around activities that facilitate open discussion of the impact of alcohol and drug use on family life. One such activity is called the Feelings-in-the-Bottle or Feelings-in-the-Drug-Syringe drawing exercise. The children are given large sheets of poster paper and instructed to draw a bottle, can, syringe, or vial and then to indicate the "feelings" that come out of this container as the substance enters a person's body. Figures 13.1 to Figure 13.3 show some typical drawings that children using this exercise in a group have produced. After the drawings are completed, the group leaders post them on the wall and encourage each child to talk about what he or she drew. This group experience offers a great sense of validation and support to children in substance-disordered families, who up to this point may have felt very alone and isolated with their feelings.

Figure 13.1, for example, reflects an 8-year-old girl's ambivalent feelings—of sadness about a parent's drinking, yet also her feelings of love for the alcoholic parent. Children younger than 8 years often have trouble reconciling two apparently contradictory feelings, such as being angry at someone they love. This would be an important clarifying point for the group leaders to mention as the child displays her drawing.

FIGURE 13.1. Feelings-in-the-Bottle drawing by an 8-year-old girl.

Figure 13.2, by a 12-year-old girl, is replete with a variety of feelings. She mentions "sad," "angry," and "ashamed," as well as "stupid" and "dumb." It's not clear whether these last two terms refer to herself or her alcoholic parent; however, this child recognizes the impact of the drinking on self-esteem. Another cause for concern is this child's phrase

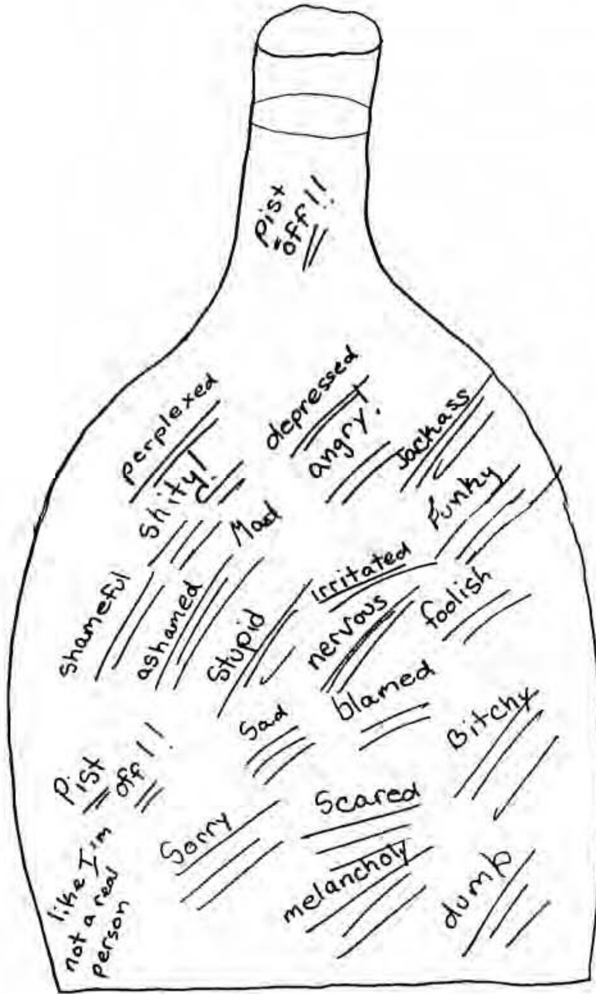

FIGURE 13.2. Feelings-in-the-Bottle drawing by a 12-year-old girl.

in the lower left corner of the bottle—"like I'm not a real person." This seems to refer to her awareness that the alcohol causes her parent to ignore her individual needs because the alcohol takes precedence in the parent's mind. This child needs reassurance that her needs *are* important, even when her parent ignores them. This recognition would be very supportive not only to the child but also to others in the group who also feel as if they are unimportant to their parents.

Figure 13.3, a 15-year-old girl's drawing of a syringe, contains many typical emotions of an injection drug user, including the word "misfit" on the needle. Other feelings mentioned reflect the unhappiness and disgust associated with drug use. Although this girl's age places her beyond the range covered in this book (which does not include the adolescent years), I have included this drawing here because of the probability that the drawings of teenagers who attend separate groups will be seen by younger children on the walls of the group room and the hallway of the agency. The intention is to have *all* children and their parents exposed to the wide-ranging effects of substance use disorders.

Videotapes, Workbooks, and Storybooks for Children

Video and written materials are useful in children's activity and support groups to stimulate discussion and sharing about the experience of growing up in a substance-disordered family. The Children of Alcoholics Foundation has produced an exemplary videotape, *Kids Talking to Kids*, which is a wonderful resource for children's groups. The "Resource Materials" list at the end of this chapter provides sources of information for obtaining this and other videotapes, workbooks, and children's stories that would be useful to leaders of children's groups.

In using a videotape, workbook, or storybook, the group leader tells the children that other children in other places have also grown up in families with substance use disorders and that the video or book tells about one (or more) such examples. The leader also mentions that

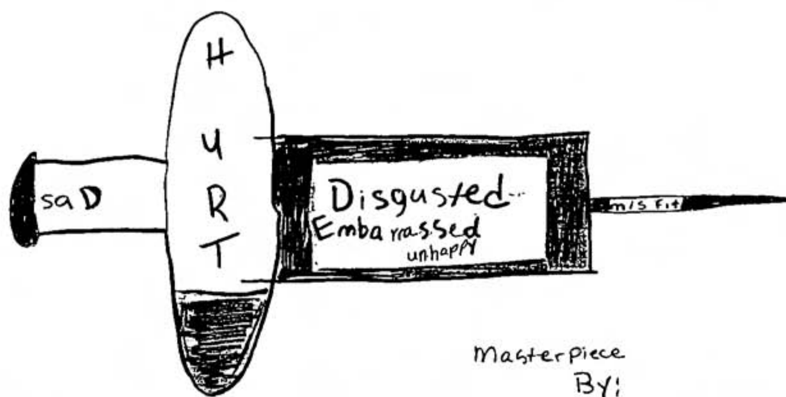

FIGURE 13.3. Feelings-in-the-Drug-Syringe drawing by a 15-year-old girl.

after the planned activity, the children will have the opportunity to talk about their own experience. After trying to elicit from the group some of the universal themes that emerge from the video or book, the leader invites the group members to make comparisons with their own life experiences.

Summary

The group experience combats the isolation and shame of each child, while making explicit the fact that many other children are going through similar experiences. The challenge to the leaders is to provide support to the children, while recognizing each child's need to live in a family in which he or she is the "apple of the parent's eye," rather than an unimportant family member who has to fend for himself or herself.

THE CASE OF VANESSA, AGE 9, AND VERNON, AGE 10

Family Information (at Time of Assessment)

Mother	Pearl, age 38, African American; active alcoholic.
Father	Josef, age 40, African American; history of crack dependence; in prison for selling drugs.
Child client	Vanessa, age 9, fourth grade; poor school functioning; depressed.
Child client	Vernon, age 10, fifth grade; some acting-out behavior.
Maternal grandmother	Sandra, age 62, resides with daughter and children.

Presenting Problem and Background

Vanessa, age 9, was referred to the outpatient program for children of alcoholics (COA) because her mother had come to school intoxicated on several occasions. This time the crossing guard said the mother had passed out in front of the school when she was with her daughter. Although the children's protective services agency was contacted, they were unable to effect any change.

Vanessa's grandmother brought her to the program and gave the following history. She described her daughter, Pearl, as a late-stage alcoholic who coughed up blood at times. The father, a drug addict, was currently in jail for drug-related offenses.

Intervention with Different Family Members

The comprehensive outpatient alcohol and drug treatment clinic encourages the whole family to become involved in the recovery process. Therefore, whenever a child enters the program for children of alcoholics or addicts, the other family members are urged to participate in an educational series. This consists of education about the disease of chemical dependency, about the codependency issues of nonalcoholic family members, about children of alcoholics and addicts and about the recovery process for the entire family.

In this family Vanessa enrolled in a once-a-week after-school group for children of alcoholics and addicts (COA). There were seven other girls in the group between the ages of 9 and 11. Vanessa's mother, Pearl, refused all efforts to become engaged in treatment for herself, as she was in denial about her own alcoholism. However, she allowed her daughter to attend the COA program because of the father's addiction; in fact, she never wanted her daughter to miss a group, and she would call the agency often with complaints when the van to pick up Vanessa was late.

Several months later the father, Josef, was released from jail, and he brought his son, Vernon, age 10, into the COA program. Josef showed much less denial about his addiction than did Pearl, and he enrolled himself into the clinic's day treatment program. Unfortunately, after a few weeks Josef relapsed and was referred to an inpatient rehabilitation program, followed by a long-term residential program.

Pearl telephoned the clinic frequently, usually in a cranky and irritable mood, but she admitted that the children had benefited from the program, and gradually she developed a cordial relationship with the leader of the children's group. One day she came to the agency and asked to go to detox. Her blood alcohol count was .342, usually a toxic level. She was rushed to the detox unit of the hospital, where she remained for 5 days. After discharge she refused to attend the clinic's day treatment program, but she did accept a referral to another site that was more like a private-practice setting. Pearl entered that program and attended it for a year, with very good results.

The Children's Group

Two different curriculum models served as guides for the COA groups. These were Children are People (Hazelden Foundation, 2002), and Moe (1989, 1993). The topics covered included the following:

- The disease concept of chemical dependency
- Feelings
- Families
- Decision making
- Self-esteem

A variety of toys and techniques were used, including puppets, role plays, therapeutic board games, drawing exercises, and videos. Books were read to initiate discussion of sensitive issues (see the list of resource materials at the end of the chapter). Holidays and birthdays were celebrated.

The drawing exercises proved especially helpful for Vanessa and Vernon. Vernon illustrated his feelings in the outline of a beer can (see Figure 13.4), which suggests that he missed his father and was depressed about his mother's drinking. Vernon was a quiet boy who did well in school and was liked by other children. He was not very verbally expressive, and it seemed unlikely that he would have volunteered these painful feelings without the drawing exercise as a stimulus. In his second drawing (see Figure 13.5) he listed his feelings, and, in showing the drawing to the group, he told why he experienced these feelings. Another drawing exercise on paper plates involved drawing the face you show to the world on one side of the plate (Figure 13.6), and how you feel inside on the other side (Figure 13.7). Vernon's illustrations show that he looks happy on the outside but feels disappointed on the inside. This exercise helps children learn about how they defend themselves from anxious feelings.

Vanessa's drawing of her feelings in the bottle showed her mother smoking and the words, "My mom is drunk" with a sad face (Figure 13.8). Another drawing (Figure 13.9) indicates that she is worried about her uncle's drinking. There was a strong history of alcoholism and chemical dependency in this family. Vanessa's paper plate (Figure 13.10) shows a happy face on the outside and someone who feels tired and stressed on the inside (Figure 13.11). Vanessa often put her head down and fell asleep in the group. Because her mother reported that she slept well at night, this could be viewed as Vanessa's way of tuning out her unpleasant thoughts. Vanessa was in a special education class in school and appeared to be depressed.

FIGURE 13.4. Vernon's drawing of Feelings-in-a-Beer-Can.

All the children in the group participated in a variety of group activities and developed a good understanding of their parents' addiction. At the end of each group the members formed a circle and recited the serenity prayer: "God grant me the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference." The children learn that they cannot change their parents because the parent has an illness and needs treatment. One time, after her mother had been in treatment for a while, Vanessa reported that she still wasn't sure that her mother had stopped drinking; she was so used to her mother's deception that it took Vanessa a while to be trustful.

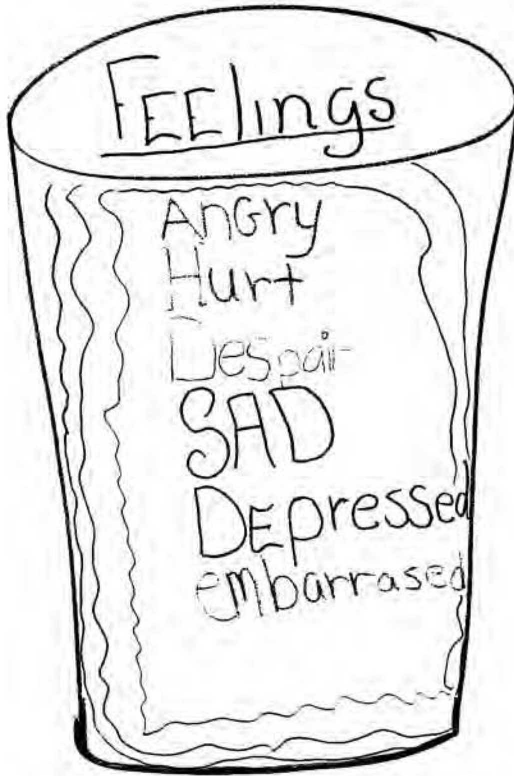

FIGURE 13.5. Vernon's list of Feelings-in-a-Beer-Can.

FIGURE 13.6. Vernon's drawing of his happy face (feelings on the outside).

FIGURE 13.7. Vernon's drawing of his disappointed face (feelings on the inside).

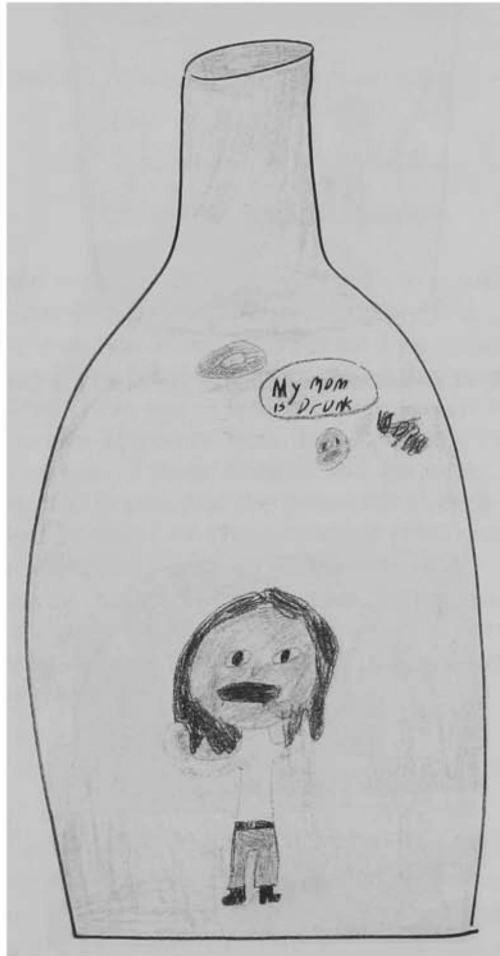

FIGURE 13.8. Vanessa's drawing of Feelings-in-a-Bottle.

FIGURE 13.9. Vanessa's drawing of her uncle's drinking.

FIGURE 13.10. Vanessa's drawing of her happy face (feelings on the outside).

FIGURE 13.11. Vanessa's drawing of her tired, stressed face (feelings on the inside).

Outcome and Discussion

Eventually, Pearl got a job and then went back to school. Josef completed the inpatient rehabilitation program, and both parents were reunited and in recovery. Vanessa was in the program for 4 years, and Vernon participated for 3 years. They left the program when they were ages 13 and 14, respectively. This is the age at which experimentation with drugs and alcohol often occurs. However, with their knowledge and awareness of the hereditary aspects of these diseases and the experience of their parents' treatment, it is hoped that the generational cycle of addiction will not be repeated. In terms of Wegscheider's (1981) roles, Vanessa was clearly the lost child and Vernon, the family hero.

When working with children of alcoholics or addicts, the worker must involve the parents. In this case, the worker started with the children, and the whole family eventually entered treatment and participated in the recovery process.

CONCLUDING COMMENTS

Unlike many of the topics discussed in this book, substance abuse and dependence are lifelong problems with repercussions through the generations. Therefore, the first approach to helping must be education about substance use disorders. Children and adults alike need to understand the implications of having such a disorder, so that they

will be able to make rational decisions for themselves and their family members.

Because a substance use disorder affects not only the individual but also all his or her family members and the community in which the individual lives, the approaches to helping must be comprehensive and long term. Interventions must always begin with a commitment to remain substance-free, but that is only the beginning, as extensive life changes and ongoing treatment will be necessary to maintain sobriety. Counseling for the addicted individual and for the family members and special programs for children are necessary to address this problem adequately. Groups help the addicted person and family members realize that they are not alone. The support given and received in groups can help build self-esteem, even as the group constitutes a new friendship network.

Preventive efforts in the schools have been shown to have positive results in reducing substance use disorders. Because of the serious consequences of such disorders, an argument can be made for implementing substance use prevention groups as part of *every* school's curriculum. In addition, every outpatient treatment program for substance use disorders should have a component for children, in order to help children understand the disease and, it is hoped, to prevent its recurrence in the next generation.

DISCUSSION QUESTIONS AND ROLE-PLAY EXERCISES

1. Discuss the implications of the statement that a substance use disorder is a family disease. How does this apply to the question of which family members to see and to setting up short- and long-term goals?
2. Role-play a situation in which a child reveals recurring physical abuse to a social worker but asks the worker "not to tell" because of fear of reprisal. First, demonstrate what you would say to the child; second, show how you would deal with the parent.
3. How can the worker best respond to a parent's anger at "the system" and tendency to view all helpers as critical and threatening?
4. Discuss the tension between "children's rights" and the rights of the parents as this issue affects appropriate treatment for children in substance-disordered families.
5. Role-play a session in which the worker discusses with a parent the effects of the parent's substance use on his or her children, as preparation for the children's beginning treatment.

RESOURCE MATERIALS

National Organizations

National Association for Children of Alcoholics
11426 Rockville Pike, Suite 100
Rockville, Md 20852
888-554-COAS
www.nacoa.net

Children of Alcoholics Foundation
164 W. 47th Street
New York, NY 10023
212-595-5810, ext. 7760
www.coaf.org

Al-Anon, Alateen
Family Group Headquarters
P.O. Box 182, Madison Square Station
New York, NY 10159
212-686-1100

Videotapes

Kids Talking to Kids
17 minutes ($75)

Children of Alcoholics Foundation
164 W. 47th Street
New York, NY 10023
212-595-5810, ext. 7760
www.coaf.org

Lots of Kids Like Us (Preteen)
28 minutes ($250)

My Father's Son (Teen–adult)
33 minutes ($195)

The Cat Who Drank and Used Too Much (Elementary–adult)
12 minutes ($295)

A Story of Feelings (Grades K–3)
16 minutes ($225)

The Dog Who Dared (Elementary)
25 minutes ($299)

FMS
5320-D Carpinteria Avenue
P.O. Box 5016
Carpinteria, CA 93014
800-421-4609

Soft Is the Heart of a Child (Grades 7–12)
35 minutes ($225)

Different Like Me (Grades 7–12)
30 minutes ($300)

Hazelden Foundation
Box 176
Center City, MN 55012-0176
800-328-0098

Books/Workbooks

Note: Ages are specified, when indicated.

Black, C. (1979). *My dad loves me, my dad has a disease: A workbook for children of alcoholics*. Newport Beach, CA: Alcoholism, Children, Therapy. Available from Hazelden. (Ages 5–10.)

Brooks, C. (1981). *The secret everyone knows*. San Diego, CA: Kroc Foundation. (Older children.)

DiGiovanni, K. (1986). *My house is different*. Center City, MN: Hazelden Foundation. (Ages 6 and up.)

Duggan, M. H. (1987). *Mommy doesn't live here anymore*. Weaverville, NC: Bonnie Brae Publications. (Ages 5–11.)

Hastings, J., & Typpo, M. (1984). *An elephant in the living room*. Minneapolis, MN: Comp Care. (Ages 7–13.)

Jones, P. (1983). *The brown bottle: A fable for children of all ages*. Center City, MN: Hazelden Foundation.

Kenney, K., & Krull, H. (1980). *Sometimes my mom drinks too much*. Milwaukee, WI: Raintree Children's Books.

McFarland, R. (1991). *Drugs and your brothers and sisters*. New York: Rosen. (Ages 10 and up.)

Melquist, E. (1974). *Pepper*. Frederick, MD: Frederick County Council on Alcoholism. (Ages 5–10.)

Seixas, J. (1979). *Living with a parent who drinks too much*. New York: Greenwillow Books. (Ages 8–12.)

Snyder, A. (1975). *First step*. New York: Holt, Rinehart & Winston.

What's drunk, mama? (1977). New York: Al-Anon Family Group Headquarters.

Winthrop and Munchie talk about alcohol. (1983). La Jolla, CA: Operation Cork.

Woods, G., & Woods, H. (1985). *Cocaine*. New York: Watts. (Ages 10–14.)

❖ CHAPTER 14 ❖

Child Victims and Witnesses of Family and Community Violence

The idea of home as a sanctuary has long and deep roots. Most of us expect to feel safe behind the locked doors of our own homes. The poet May Sarton poignantly refers to "a house where every man may take his ease/ May come to shelter from the outer air/ A little house where he may find his peace" (1936–1938/1973, p. 43). This romantic view of almost 70 years ago seems obsolete in the beginning of the 21st century, when kidnappers snatch children from their beds at night and when many children suffer physical and sexual abuse in their homes at the hands of their parents or caretakers.

Similarly, the concept of a safe community neighborhood also is disappearing, especially in large cities in which innocent citizens are killed by the guns of drug dealers, and hundreds and thousands can die suddenly at the hands of terrorists. Even schools can be dangerous places because of gangs and the violence they perpetrate in and around the school buildings. Furthermore, the media guarantees that everyone who can see and has a television will be deluged with images of every type of crime, from murder to terrorist bombings. Children are witnessing countless acts of violence in all areas of their lives; some are themselves victims; and others, through constant exposure, will become desensitized and apathetic about the effects of violence on victims (American Psychological Association, 1993).

This chapter focuses on violence in the home and in the community. Although some important differences exist between the two forms of violence, there also are similarities with respect to the impact on children and in regard to specific treatment strategies.

DEFINITION AND SCOPE OF THE PROBLEM

Family Violence

The term "family violence" refers to acts of physical, sexual, or psychological maltreatment, aggression, and violence that occur in a family unit whereby one family member with more power or authority attempts to gain control over another family member (American Psychological Association Ad Hoc Committee, 1996). Victims may be adults or children, and the perpetrators are usually adults but may also be older children.

Gelles (1979), defining violence as "an act carried out with the intention of physically injuring another person" (p. 78), states that people are more likely to be hit, beat up, physically injured, or even killed in their own homes by another family member than anywhere else or by anyone else in U.S. society (p. 11). This confirms that the home, far from being a sanctuary, is a place of danger and fear for many children.

The topic of domestic violence has attracted growing media attention and increased public awareness and outrage since the mid-1970s. Traditionally, a patriarchal system condoned the battering of women, but the formation of the National Coalition against Domestic Violence in 1978 raised public consciousness and led to the development of shelters, support groups, and improved legislation for battered women. Nonetheless, the problem continues. In the United States approximately 50% of all murders occur between family members and acquaintances (Corr, Nabe, & Corr, 2000) and one-half of those are spouse killings (Margolin, 1979, as reported in James & Gilliland, 2001). Physical and sexual violence against women committed by current or past partners affects approximately 1.5 million women in the United States annually (Kastenbaum, 2001).

Many children both witness and personally experience violence in their families. According to Guterman and Cameron (1997; as reported by Nisivoccia and Lynn, 1999) as many as 80–90% of young children and three out of four elementary and high school students of color in urban areas have witnessed at least one violent act in the home or community (Garbarino, Dubrow, Kostelny, & Pardo, 1992; Lorion & Saltzman, 1993). Furthermore, children themselves can become the targets of uncontrolled rage. In 1997 there were an estimated 1,196 reported child abuse fatalities among the estimated 2.4 million cases of suspected child abuse and neglect reports filed (National Clearing House on Child Abuse and Neglect Information, 2002). From 1% to 5% of children may be victims of incest, and several times that number are subjected to serious physical abuse or see their mothers, brothers, and sisters being beaten.

Community Violence

The term "community violence" refers to assaults occurring outside the home, within the neighborhood, city, suburb, or country; these assaults may be committed by known or unknown persons, and they may result in various degrees of injury, from minor damages to fatalities. The violent events may occur to a single individual, as in a beating witnessed on the sidewalk, or to many individuals, as in a bombing or terrorist attack.

Children witness between 10 and 20% of the homicides in the United States, and they either know about or witness approximately 10% of the rapes (*Harvard Mental Health Letter*, 1991). Other reports of children in New Haven (Marans & Cohen, 1993) and New Orleans (Osofsky, Wewers, Hann, & Fick, 1993) confirm that significant percentages of children are victims of and witnesses to serious acts of violence. Indeed, in 1995, homicide was listed as the third leading cause of death among elementary school children (Kochanek & Hudson, 1995).

IMPACT OF EXPOSURE ON CHILDREN AND IMPLICATIONS FOR TREATMENT

Because children are helpless and terrified in the face of the violent acts of adults, the witnessing and experiencing of this behavior may result in "profound changes in the child's [belief] about the safety and security of future intimate human relationships" (Pynoos & Eth, 1985, p. 27). Unable to trust their parents to serve as protectors, children may be overwhelmed with a sense of fear, betrayal, and loneliness regarding their present and future security. Pynoos and Eth (1985) warn that children who witness extreme acts of violence "represent a population at significant risk of developing anxiety, depressive, phobic, conduct, and posttraumatic stress disorders" (p. 19).

The adverse effect on children's behavior caused by exposure to domestic violence has been cited in the literature since the 1980s (Rosenbaum & O'Leary, 1981; Hershorn & Rosenbaum, 1985; Miller, 1989). "A child may be extremely traumatized by violence exerted by an adult against the child's mother, a family pet, or personal property," according to Miller (1989, p. 419). When the child is personally abused, he or she lives with feelings of dread about future possible repetition and may develop defensive reactions, such as distancing, wariness, and avoidance of the frightening parents and/or other adults. Some of these responses correspond to the criteria for posttraumatic stress disorder (PTSD), which are discussed more fully later in this chapter.

> Psychological trauma is especially damaging when it involves a violation of trust and a distortion of family intimacy. For a child who is repeatedly abused physically or sexually, the stress is constant and the threat is always present . . . *the source of terror is also the only source of comfort* . . . abused children understand little of what is happening, since everyone around them is ignoring it or lying about it. They are systematically confused and misled; *incest is disguised as love, beating as discipline*. (*Harvard Mental Health Letter*, 1991, pp. 1–2; emphasis added)

Children who are exposed to abuse and violence in their families may respond with a wide range of behaviors, including somatic complaints, school-related problems, excessive crying and fear, withdrawal, clinging, aggressiveness, tantrums, anxiety, depression, and self-mutilation. Carlson (1984) cites numerous research articles documenting these findings.

It is often difficult to engage children who have experienced chronic abuse during their formative years. Any person, child or adult, who has been subjected to abuse or trauma begins therapy full of doubts and suspicion about the therapist's motives and ability to help (Herman, 1992). Because of their insecure attachment and inability to form meaningful relationships, it may take from 3 to 11 months for therapists to engage attachment-disordered children, according to Doyle and Bauer (1989).

The process of establishing attachment in older children who have been traumatized may be long and difficult, according to James (1989, 1994). However, the effort put into this may be "the only hope for (the children) ever forming an intimate bond with another person. . . . Children who have learned not to trust adults and who are intimacy-avoidant may not show signs of relationship development with the therapist for many months" (James, 1994, p. 61). The experience of traumatization, abuse, and lack of parental empathy affects the children's developing ability to value themselves as persons and to identify with the emotional states of others (Jordan, 1991).

Furthermore, when children witness repeated violence between their parents, they learn that violence is a way to settle disagreements. This unfortunate and powerful lesson may affect their own present and future relationships, because these children have no experience of nonviolent methods of resolving controversies and conflicts. In addition, their observation of the failure of adults to restrain themselves may seriously jeopardize the children's confidence in their *own* impulse control (Pynoos & Eth, 1985, p. 26). This may be the operating dynamic when we see a child engaging in uncharacteristic aggressive, reckless, or self-destructive behavior after exposure to adult (especially parental) violence. A literature review confirmed that children exposed to violence are more likely to display behavioral and psychological problems than are their nonexposed peers (Shahinfar, Fox, & Leavitt, 2000).

THE ASSESSMENT OF THE CHILD VICTIM AND/OR WITNESS OF FAMILY VIOLENCE

This section deals with the child as both the victim and the witness to various forms of family violence. The topic encompasses both the physical and sexual abuse of a child by another family member and the witnessing by a child of either form of abuse perpetrated by one family member on another.

After discussing the legal mandate to report suspected abuse, I review the specific signs and symptoms associated with physical and sexual abuse.

The Legal Mandate

The Child Abuse Prevention and Treatment Act (Public Law 93-247, 1974) mandates the reporting of child maltreatment in all states receiving certain federal funds. Social workers come into contact with children in a variety of settings. They may become concerned about the possibility of physical or sexual abuse of a child because of certain aspects of the child's behavior or attitude or because of specific physical indications on the child's body.

It is the responsibility of every social worker to know the laws in his or her state about reporting suspected maltreatment, the information that is required in making such a report, and the agency that is responsible for investigating the report. Although reporting to the appropriate agency is *mandatory*, Lukas (1993) cautions about making the decision to report hastily or unilaterally, because of the inevitable complicated repercussions that such a report sets in motion. It is often helpful to a worker to discuss the details of a case with a supervisor or with other experienced workers. Weighing the needs of the child and those of the family may generate ethical dilemmas and pressures on the worker. This is "a powerful responsibility . . . since both a child's safety and the well-being of a family may be at risk" (Lukas, 1993, p. 139). Also, the legal and protective interventions that often follow may be very perplexing and anxiety-provoking for the child (Gil, 1991). The worker must convince the child that he or she will do everything possible to insure the child's safety, even though this may mean that the child will have to live someplace else for a while. This certainly is a very frightening situation for any child.

If it is likely that the child will have to testify in court or to a judge, the worker can help prepare the child for this experience—*not* by rehearsing with the child his or her actual testimony (as this would be considered putting words in the child's mouth) but by briefly and simply explaining the court procedures. It is often helpful to use a workbook for children that shows pictures of a courtroom and descriptions of a child's

participation in typical court procedures. (See Schwab, 1986, for a coloring book to prepare children ages 5–12 to go to court.)

Indicators of Physical Abuse

The indicators of physical abuse listed in Table 14.1 constitute a general guide, rather than positive proof of child abuse, because it is always possible that a child's injuries occurred through play or otherwise accidentally. Obviously, multiple and recurrent injuries and those that do not seem congruent with the description of how they occurred merit further investigation and close monitoring.

THE CASE OF ELISA IZQUIERDO, AGE 6

(All information was reported in *The New York Times* [Bruni, 1995].)

Family Information

Mother	Addicted to crack; history of abuse.
Father	Unknown.
Child client	Elisa, age 6, first grade; in foster care.
Elisa's five siblings:	Ages 2–9; two older than Elisa, three younger.

Presenting Problem

The principal of Elisa's school wrote a letter to the family court judge, outlining the school's suspicion that the child had been physically and emotionally abused during her weekend visits with her mother. Among the indicators noticed by school personnel and by neighbors were bruises and welts on the child's body, nightmares, vomiting, withdrawn behavior, fear of using the bathroom, and "walking strangely." Despite these concerns and the letter written to the judge, her mother was granted custody. A year and a half later Elisa was found dead of bleeding caused by a blunt impact wound to her head.

Discussion

A newspaper account of Elisa's death in New York City (Bruni, 1995) illustrates that children who suffer chronic abuse show many physical and

TABLE 14.1. Physical and Behavioral Indicators of Physical Abuse

Physical indicators	Behavioral indicators
Bruises and welts	Wariness of adult contacts
Marks on face, lips, mouth	Apprehension when other children cry or get hurt
Marks on torso, back, buttocks, thighs	Behavioral extremes (aggressiveness or passive withdrawal)
Symmetrical marks on both sides of body (suggesting that the child has been grabbed by two hands; accidental injuries are not symmetrical)	Obvious fear of parents
Bruises/welts in various stages of healing	Reluctance to go home
Clustered bruises indicating repeated contact with an object	Reports of injury by parents
Patterned bruises that reveal the shape of an object, such as a belt buckle, electric cord, or hairbrush	Frequent weeping in school
Marks on several different areas	Self-mutilating behavior
Marks regularly appearing after weekends, absences, or vacations	
Burns	
Cigarette burns, especially on palms, soles, back, or buttocks	
Immersion burns (matching injuries on both ankles or hands, suggesting that the child was immersed in hot liquid)	
Patterned burns in the shape of an iron or a curling iron	
Rope burns on arms, legs, neck, or torso	
Fractures	
Fractures to skull, nose, face, arms, and legs	
Fractures in various stages of healing	
Multiple fractures, with splintering (caused by pulling or twisting)	
Lacerations/abrasions/bites	
Tears in tissues	
Tears to mouth, lips, gums, eyes	
Lacerations to genitalia	
Bites to buttocks	

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behavioral indicators that are noted by their teachers and neighbors. Elisa's case raises the question about whose rights take precedence—those of the child or those of the mother. The newspaper account (Bruni, 1995) portrays Elisa's mother as an abused woman herself, addicted to crack, who took much of her rage out on Elisa because she thought the child was possessed by voodoo. The caseworker should have noticed the different manner in which Elisa's mother treated her compared with the other children in the family. Exploration of the mother's cultural/religious beliefs might possibly have averted this tragedy. Certainly child safety must always be of paramount concern. Sedlak and Broadhurst (1996) point out that, nationally, approximately 9% of children served by public child welfare agencies are sexually abused and almost 10% are physically abused (reported by Mannes, 2001). Sadly, placement and overseeing by an agency does not always serve the intended child protective purpose.

Elisa was the third of six children, ranging in age from 2 to 9. Although the other children did not show indications of abuse, they certainly were aware that their sister was beaten and that she died at the mother's hands. As witnesses to family violence and homicide, these children will need help for many years.

Indicators of Sexual Abuse

Table 14.2, which lists the physical and behavioral symptoms of sexual abuse, can serve as a general guide for workers who suspect that a child is being sexually abused.

The term "sexual abuse" refers to behaviors in which a child is used for a sexual purpose. This rather simple definition encompasses a broad range of sexual behaviors—from exposing a child to pornographic pictures to touching to various forms of sexual behavior (including oral, anal, or genital intercourse). Lukas (1993) clarifies that the perpetrator may be a man or a woman, that the child involved may be a male or female of any age, and that the abuse may have occurred once or many times. Lukas also reminds us of two important facts about the sexual abuse of children: (1) "Sexual abuse occurs in every race, ethnic group, and economic class in society" (p. 145), and (2) "The perpetrator is most likely to be someone the child knows" (p. 145).

Serious repercussions follow a conviction of sexual abuse, and workers who suspect possible sexual abuse may have to go to court to present the reasons for their concerns. Some guidelines in preparing to document suspicions of sexual abuse include the following:

TABLE 14.2. Physical and Behavioral Indicators of Sexual Abuse

Physical indicators	Behavioral indicators
Pain, bruises, bleeding, or itching in genitals or rectum, or recurrent urinary infections	Sleep disturbances
Venereal disease in mouth, genitals, or rectum	Oversexualized or seductive behavior (including excessive masturbation)
Bedwetting	Preoccupation with own or other children's genitals
Difficulty in walking or sitting	Unwillingness to change for gym or to participate in physical education class
Torn, stained, or bloody underclothing	Poor peer relationships or sudden social withdrawal
Offensive odors	Reports of sexual assault
Preteen or early teen pregnancy	Self-mutilating behavior or suicide attempts
Recurrent vomiting or stomachaches	

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1. Use open-ended questions in obtaining information from the child (e.g., "Tell me more about that," or "Show me with the dolls what happened," rather than "Did Daddy come into your bed every night?").
2. Record information about what happened in the child's own words, using as many specifics as possible.

The Tripartite Crisis Assessment

Even when multiple physical and behavioral indicators of physical or sexual abuse are apparent, and even when a child has verbally confirmed experiences of abuse, we still do not know the *meaning* of the abusive experience to the child. The child's experience of an event can differ significantly from what adults expect: "An event may or may not be experienced as traumatic by a particular child, and it may be traumatizing at one stage of a child's development and not at another" (James, 1989, p. 21). A basic tenet of crisis intervention is that it is not the event itself that constitutes the crisis but rather the individual's *perception* of the event. A full assessment of the event, the child, and the surrounding environment therefore permits us to understand more completely the implications of a particular abuse experience in a particular child's life.

In previous publications (Webb, 1991, 1999, 1993, 2001), and in several chapters of this book (Chapters 4, 10, 11, and 12), I have utilized

variations of tripartite crisis assessment to demonstrate the interactive influences among three groups of factors in evaluating the significance of a particular crisis event or events:

1. Factors related to the individual.
2. Factors related to the crisis situation.
3. Factors in the support system.

Figure 14.1 illustrates the specific elements that must be considered in evaluating the impact of a particular crisis situation, such as physical or sexual abuse in the family. (See Webb, 1999, for a full discussion of this assessment.) Two forms that can be used in recording the individual and situational components of the crisis assessment are reproduced in the Appendices. The eco-map (see Chapters 2, 3, and 4) is useful in assessing essential information about the support system.

When a child is being evaluated for abuse, special attention should be given to the child's history of loss, to recurring experiences of abuse, and to the possibility that the child believed that the abusive experience endangered his or her or another family member's or a pet's life. Fear of death or serious injury is an essential condition for the diagnosis of PTSD (see the next section).

In addition, a child's developmental and cognitive level will determine the manner in which the child interprets the abuse experience. For example, the preschool or early latency-age child (up to approximately age 8) is still egocentric in his or her thinking and may believe that he or she is "bad" and therefore caused the abuse. Of course, a perpetrator, playing into a child's normal narcissism, often reinforces these feelings by using guilt and secrecy tactics to keep the child from disclosing the abuse.

THE ASSESSMENT OF THE TRAUMATIZED CHILD: POSTTRAUMATIC STRESS DISORDER IN CHILDREN

The symptoms of PTSD (American Psychiatric Association, 2000) may develop in children who have been exposed to a life-threatening event (such as community violence) or who have been physically or sexually abused. It is important for child welfare workers and other social workers to be familiar with the signs and symptoms of this condition, because it is often confused with depression or conduct-disordered ("acting-out") behavior. Children with symptoms of PTSD require treatment from someone who is trained both in child therapy and in trauma counseling. Therefore, a referral to a child-trauma specialist may be appropriate once the diagnosis has been made.

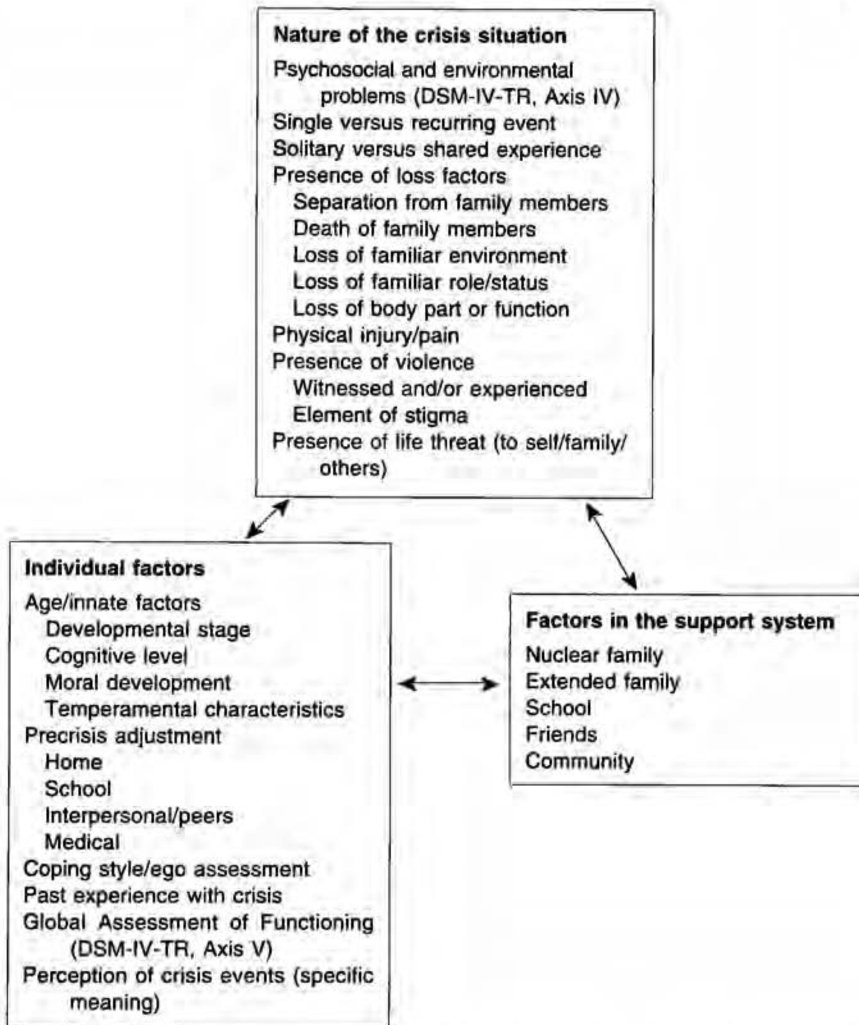


FIGURE 14.1. Interactive components of a tripartite crisis assessment. Adapted from Webb (1999, p. 5). Copyright 1999 by The Guilford Press. Reprinted in *Social Work Practice with Children* (2nd ed., 2003) by Nancy Boyd Webb. Permission to photocopy this figure is granted to purchasers of this book for personal use only (see copyright page for details).

Components of PTSD

The foundation for PTSD was established when a person "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (American Psychiatric Association, 2000, p. 467), causing the person to respond with "intense fear, helplessness, or horror" (p. 467). In response to this traumatic event, the individual with PTSD demonstrates three different types of behavioral reactions over the course of a month or more:

1. *Reexperiencing the traumatic event*. In children, the reexperiencing often occurs through dreams that cause intense fear and helplessness that resemble the emotions associated with the traumatic experience, even though the dreams may not reflect the *exact* circumstances of the traumatic experience. In addition to or instead of dreams, children sometimes engage in repetitive play that symbolizes the trauma.
2. *Avoidance and numbing*. Children may show a restriction in their ability to display positive feelings to others, or they may deliberately avoid people, activities, or places that are associated with the trauma.
3. *Increased arousal*. Children may have difficulty getting to sleep or staying asleep, may be more irritable, and/or may have difficulty concentrating in school or while doing homework.

More details about this diagnosis are available from the American Psychiatric Association (2000). Because the classification of PTSD originated with adult soldiers in the Vietnam War, its application to children is based on the work of child psychiatrists (Eth & Pynoos, 1985; Terr, 1983, 1988, 1989), social workers (James, 1989; Doyle & Bauer, 1989; Webb, 1999), and child psychologists (Gil, 1991; Fletcher, 2003).

Incredible as it may seem, only a fraction of individuals exposed to traumatic experiences demonstrate behavioral responses indicative of PTSD. As previously discussed in Chapter 8, McFarlane (1990) states that "even after extreme trauma, only about 40 percent of an exposed population develop PTSD" (p. 74). According to Fletcher (2003, pp. 337–338) "most research to date confirms the general conclusion that the diagnostic symptom clusters of DSM-IV apply to traumatized children of all ages, from preschool to adolescence, as well as they do to traumatized adults." However, children develop other responses to trauma as well.

Jenkins and Bell (1997, p. 17) have created a table that lists 17 trauma-related disorders other than PTSD in children and adolescents. Some other typical responses of traumatized children, in addition to PTSD, include aggressive or antisocial behavior (about 18% of the time) and regressive

behavior (about 13% of the time; Fletcher, 2003). Whatever the particular responses, we must recognize the serious detrimental effects of traumatic experiences on children's normal developmental course, whether or not they develop full-blown PTSD.

The Distinction between Victimization and Traumatization

It is important to distinguish between victimization and traumatization. Gil (1991) points out that a person may be victimized without being traumatized. That is, the person who experiences trauma is a victim during the traumatic event, but not every experience of being victimized qualifies as a traumatic experience in terms of causing responses of intense fear, helplessness, or horror. Thus, not all children who witnessed the New York World Trade Center bombing or who have been sexually abused react with the intense fear that results in PTSD. Furthermore, resilient children may not exhibit any overt signs of disturbed behavior. However, the fact that children do not respond immediately and conspicuously to the experience of abuse and trauma does not mean that it has had no effect on them.

On an emotional level, child witnesses to family and community violence may experience a range of feelings, from fear to helplessness to violent revenge fantasies. It can be very helpful to them to draw and/or verbalize their wishes for revenge in a debriefing interview that "partially corrects the passive helplessness of the witness role" (Pynoos & Eth, 1986, p. 316).

Another typical reaction of children who witness family and community violence is posttraumatic guilt, connected to the children's imagined failure to intervene and prevent the violence. This response needs to be challenged with gentleness and reality testing, in terms of a child's size and dependent role in a family, in comparison with the size and controlling role of adults. Bevin (1999), in a case demonstration, illustrates how to permit a boy's *wish* for revenge on the man who raped his mother, while realistically questioning the possibility of a 9-year-old's being physically able to defend his mother against the attack of an adult male. Similar responses of gentle disbelief by a social worker can reduce a child's feelings of responsibility about somehow contributing to or failing to prevent a parent's death by not intervening in a situation of community violence, such as a drive-by shooting or a terrorist bombing.

A particularly terrifying experience for a child witness is the death of a sibling, especially when it occurs through the neglect or intent of a parent in a family that routinely uses battering and other forms of vio-

lence to settle marital disputes and to "discipline" children. The case of the siblings of Elisa Izquierdo (Bruni, 1995) illustrates the horror of alleged maternal homicide in families in which the deceased child was both physically and sexually abused by the parents.

Bereavement after homicide routinely generates a pathological response in survivors that is related to the nature of the death, which involves a combination of violence, violation, and volition, according to Rando (1993, citing Rynearson, 1987). The response of a child to a homicidal death in the family or community may be intensified by the "degree of identification with the victim" (Rando, 1993, p. 538). Thus the closer in age and gender the child is to the victim, the more threatening the death. Steele (1998), in a video involving three siblings of a murdered 16-year-old girl, used a drawing method to help each child deal with the traumatic memories by having them draw their mental picture of how their sister's body looked after she was dead. The children appeared to experience relief after completing the drawing, as this allowed them to mourn and to share their internalized trauma picture with the social worker who supported and validated their feelings.

SELECTED HELPING METHODS

Most children in therapy would benefit from activities and exercises that help them learn to identify their own feelings. However, children with chronic abuse histories and associated attachment problems may be very deficient in this area and require a great deal of help in understanding their own feeling responses, as well as the reactions of other people. As previously discussed, these children are confused about the appropriate expression of feelings. The drawing exercises described here help children identify their own feelings and understand more fully how emotions lead to behaviors. The exercises can be used in individual or group therapy.

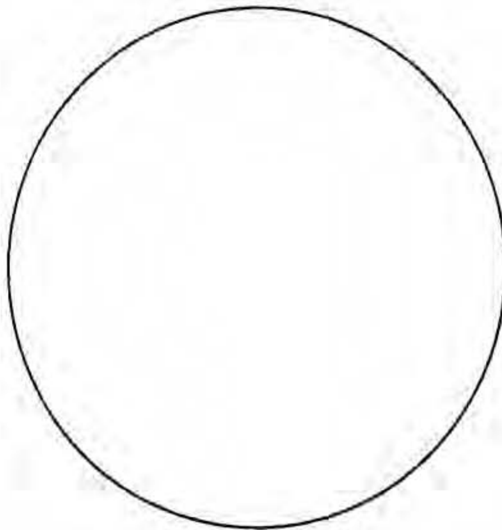
Drawing Exercises to Identify Feelings

Because many abused children come from family backgrounds in which love and aggression were confused, and because this may create uncertainty about how to relate to peers and adults, it is often helpful to establish a therapy goal of naming and talking about a range of different feelings, such as "sad," "angry," "happy," "guilty," and "proud." The task of the social worker and others involved with such children is to help them "own" their feeling reactions to the events in their *present*

lives, with the expectation that this will facilitate the gradual sorting out of the confused feelings related to their past experiences of abuse.

Feelings Faces and the Body Map of Feelings

One method to help children identify and talk about feelings is to ask them to draw faces with different emotional expressions. An exercise that will facilitate this is the Feelings Faces exercise (Heegaard, 1991), discussed in Chapter 12. Starting with a circle to represent a head and the word "happy" underneath, the worker invites the child to draw a happy face (see Figure 14.2). While the child is drawing, the worker asks the child about the kinds of things that make him or her happy and lists these on a separate piece of paper. Next, the Body Map of Feelings (Gregory, 1990; Heegaard, 1991), also discussed in Chapter 12, can be introduced. This is simply an outline of a human body (see Figure 14.3). The worker asks the child to close his or her eyes and think about a time when he or she was very, very happy, then to open his or her eyes and



HAPPY

FIGURE 14.2. Outline for drawing a happy face in the Feeling Faces exercise.

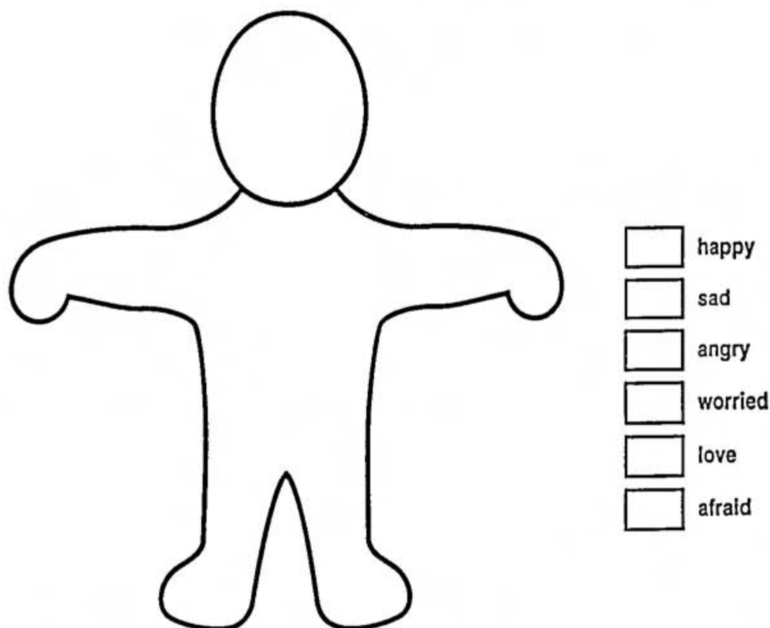


FIGURE 14.3. The Body Map of Feelings. From Gregory (1990). Copyright 1990 by the Family and Community Development Program, Lethbridge, Alberta, Canada. Reprinted by permission. (Although Gregory developed the Body Map of Feelings for use in working with children, neither she nor the Family and Community Development Program claims originality of the idea.)

draw with a yellow marker the places on the body where the child felt the happiness.

This three-step process (Feelings Faces, the list of associated feelings, and the Body Map of Feelings) can be repeated in other sessions for other feelings, such as "sad," "angry," "afraid," "nervous," "guilty," and "jealous." I recommend that initially only *one* feeling be addressed in each session, especially with children who tend to confuse different emotions. Later the worker can introduce the idea of more than one feeling at a time by asking the child to pick two feelings that might coexist and then asking him or her to describe and draw a picture of a situation in which that coexistence happened. The child needs to understand that he or she can have different feelings toward a person simultaneously. This is especially important for abused children, who may have coexisting loving and angry feelings toward their abusing parents.

If all the child's drawings are kept in a folder, the child can later be invited to make "a feelings book" by stapling the separate pages together and creating a special cover for the book.

Stories and Workbooks for Children Ages 4–10

The Bureau for At-Risk Youth (now located in Plainview, New York) has published a series of picture-story workbooks (Alexander, 1992) intended for traumatized children and children who have witnessed and experienced family violence. These story workbooks include sketches of children in frightening situations; one such sketch depicts a small boy listening at night in bed to his parents fighting (see Figure 14.4). On the facing blank page, the child is encouraged to draw and color what happened in his or her own house. Another sketch shows a child talking and playing with a counselor, who is pictured making helpful comments to the child, such as "Lots of people don't hit each other when they have angry feelings." The child, in turn, is pictured as saying, "I'm learning that I can use my words when I feel like fighting. I practice how with my counse-

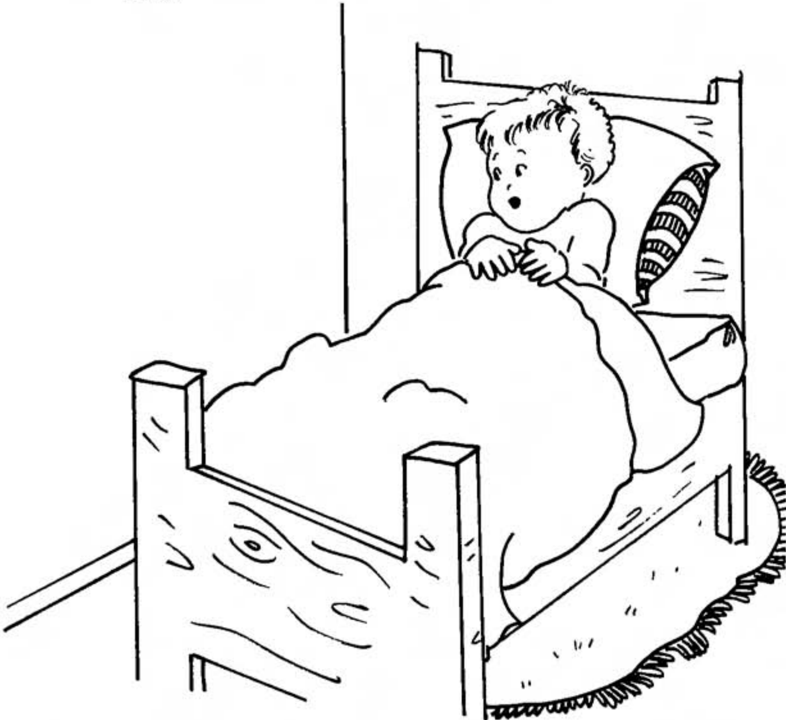


FIGURE 14.4. Child listening to parents fighting. From Alexander (1992, p. 28). Copyright 1992 by the Bureau for At-Risk Youth. Reprinted by Permission.

lor" (Alexander, 1992, p. 16). On the facing blank page, the child is invited to draw what he or she can do instead of fighting. These workbooks are available at discounted rates for bulk orders; they can be used in a group session a few pages at a time or by an individual child and counselor at the child's own pace.

Board and Card Games Dealing with Feelings

Therapeutic board games, such as the Talking, Feeling, and Doing Game and the Feelings in Hand card game (both of which have been mentioned in earlier chapters; see Figure 3.3 and Table 4.1), may be especially useful in work with abused children. They provide structured activities that appeal to school-age children, while also offering excellent opportunities to talk about different feelings during the course of the game.

Children who have problems with aggression may benefit from playing commercial board games such as Sorry! (available from Parker Brothers, Beverly, MA) and Battleship (available from Milton Bradley, Springfield, MA), which provide structured methods for "attacking" the other player while complying with the rules of the game. The worker uses the game to discuss aggressive themes during the play. Docker-Drysdale (1993) points out that children whose histories of deprivation and/or abuse contribute to severe developmental problems need appropriate outlets for their aggression.

Animal-Assisted Therapy

The use of pets in therapy with children dates from the pioneering work of the psychologist Boris Levinson, whose 1969 book describes his accidental discovery of the efficacy of his pet dog in stimulating the conversation of a difficult, previously noncommunicative child (see George, 1988, for a discussion). Levinson's work over the next decade convinced him and others that involvement with an animal helps children develop empathy, self-esteem, and autonomy, while also reducing their feelings of alienation (Levinson, 1978). He also emphasized the value of animal therapy for abused children who are afraid of human contact (Levinson, 1962).

Over the years, animal-assisted therapy has been used effectively, employing horses, dogs, cats, and other animals. For example, teaching physically disabled children to groom and ride horses gives the children a sense of efficacy, empowerment, and improved self-esteem (Pegasus Therapeutic Riding, 2001). In animal-assisted therapy the mental health specialist uses the animal in a deliberate way to communicate with the child and to help the child express a range of feelings.

With an Attachment-Disordered Child

In the first edition of this book, I presented the case of a girl, Dorinda, who had a history of parental neglect and physical, emotional, and sexual abuse and who, in addition, witnessed the violent death of her 18 month-old sister (Webb, 1996). After failing to adapt in five different foster homes, Dorinda was placed in a residential treatment center that employed animal-assisted therapy. There she learned to identify a range of feelings and develop empathy with a pet rabbit. Counseling sessions with a social work student using the rabbit as a "cotherapist" over the course of 11 months contributed to substantial improvements in this girl's ability to relate to her peers and to adults.

In Situations of Crisis/Trauma

Therapy animals, in collaboration with an animal handler and a trained mental health professional, can also assist in situations of crisis or trauma (see Figure 14.5). This collaboration was used very effectively to engage and help many families following the New York World Trade Center and Pentagon terrorist bombings on September 11, 2001. The goals in this form of crisis intervention work depend on the particular situation and the needs of the affected individuals. These may range from providing comfort and pleasure through physical contact with the animal to interactions that are deliberately focused on helping children express their feelings.

FIGURE 14.5 A therapy dog named Diamond, who is trained to interact with children and adults in crisis situations under the guidance of an animal handler. Photo: Barry Rosen.

Note. The author acknowledges the contribution of Kay Scott, ACSW, in this section and in the Marta case.

THE CASE OF MARTA, AGE 5, WHOSE FATHER DIED IN THE NEW YORK WORLD TRADE CENTER TERRORIST ATTACK

Family Information

Marta is a 5-year-old Puerto Rican child whose father worked in a restaurant in the New York World Trade Center. She is an only child. The family is bilingual and has extended family in the metropolitan New York area.

Following the attacks, Marta's mother would sit for hours watching the television replays of the events and the people escaping from the buildings. Holding Marta in her lap, Marta's mother would cry and say, "Watch for Papa. Is he there? Where is he?"

Presenting Problem

Marta's mother had explained to the child that her father was in the towers when they fell. They were waiting for some news about whether he had escaped or was in a hospital or if his body had been found. Marta saw her mother crying and heard the whispers of the relatives and friends who visited them. Marta tried to pretend everything was all right, and she refused to talk about her father. A few days after the attacks, when Marta's mother told her that her father was not coming home again, she began wetting the bed and having bad dreams.

Two weeks later Marta's mother went to the Family Assistance Center with Marta to obtain a death certificate in order to qualify for financial aid. She had been there earlier with Marta to register her husband's name and to leave his razor and comb for DNA samples. Marta's mother told the child that she now believed that her father had died and was not coming home.

Marta's mother spoke to a social worker at the Family Assistance Center, explaining her concern that her daughter did not accept that her father was not coming home. Despite several attempts by the social worker to engage Marta, the child refused to talk. She was playing on the floor next to her mother, ignoring the other children and the social worker, when several therapy animals and their handlers walked by. Marta noticed the large red Golden Retriever. The social worker asked Marta's mother if it was all right for her to introduce Marta to the animal; the mother nodded her agreement. The social worker then motioned to the

therapy dog's handler to bring the dog over. The following interaction occurred:

SOCIAL WORKER: Marta, I saw you looking at the dog; would you like to pet him?

MARTHA: (*Looks up and nods.*) Sí.

(*Handler and dog come over.*)

SOCIAL WORKER: (*To handler*) What's your dog's name?

HANDLER: This is "Tucker." (*To Marta*) Would you like to pet him?

MARTHA: (*Nods "Yes."*)

(*Handler puts dog in down position beside Marta, and places one hand on dog. Marta runs her hand over the dog's fur. The handler shows Marta how dogs like to be rubbed under the ears and along the sides of the body. The handler and the social worker talk to Marta for a moment about the softness of Tucker's fur.*)

SOCIAL WORKER: Marta, you really seem to like the dog and you're very gentle with him. Do you have a dog?

MARTHA: (*Looks up and answers softly.*) Sí. (*She begins to talk about her dog—a boxer named "Tia" who is home in their apartment. Marta says that her father got the dog for her. She talks about how he taught her how to give Tia fresh water.*) He loves Tia. (*She hugs the therapy dog.*)

SOCIAL WORKER: He??

MARTHA: Mi Papa. My dad.

SOCIAL WORKER: So what do you think Tia feels about your dad not coming home?

MARTHA: I know she's sad. She cries at night. I hear her crying.

SOCIAL WORKER: Crying?

MARTHA: Sí. My papa told me that dogs dream. Tia's having bad dreams. She cries like me, like my mama. (*She grows quiet and continues to stroke the dog's fur.*) She misses my Papa.

SOCIAL WORKER: Who misses your Papa?

MARTHA: Mama.

SOCIAL WORKER: And I bet you miss your Papa too. (*Marta nods.*) Can you tell your Mama that you miss your Papa?

MARTHA: (*Looks down.*). She's sad. I don't want to make her sadder.

SOCIAL WORKER: And she'll be sad if you say it to her? (*Marta nods.*) What if you told Tucker? Could you tell Tucker?

(*Marta nods and puts her head against the dog. She whispers to the dog then begins to cry. Her mother puts her arm around Marta and they cry together. They talk softly in Spanish.*)

The social worker decided to refer Marta and her mother to a mental health agency that uses animals as adjuncts in longer-term therapy. She considered the possibility that Marta could be diagnosed with PTSD in the event that her symptoms continued another week, and she wanted to be sure that the child would receive some specialized assistance for her traumatic bereavement. Marta's mother would also be invited to attend a bereavement group at the agency.

Considerations in Animal-Assisted Therapy

Whenever possible, parental permission should be obtained prior to involving animals in an interaction with a child. Different cultures may have views about companion animals that would neither understand nor approve their use in a therapy situation as just described. For example, most Jamaicans keep animals outside and do not consider them as "indoor pets" or as part of the family, in contrast to many families in the United States. And many Muslims consider dogs to be unclean. Therefore, the worker must observe cultural sensitivity about the family's beliefs about animals, ask about these, and always obtain permission prior to beginning animal-assisted therapy.

Social workers interested in using animals as adjuncts in their treatment of children should inquire about the training and screening of the animals and the handlers before involving them in the work. Untrained and unscreened animals should never be used. Training and/or screening for animal–handler teams is conducted by various national, regional, and local animal-assisted-therapy organizations and registries. For example, Delta Society (www.deltasociety.org) offers a publication detailing standards of practice for animal-assisted therapy and activities. Other organizations and registries include: Therapy Dogs International (TDI), Hudson Valley Animal-Assisted Crisis Response Coalition (www.k9crisisresponse.org), and HOPE Crisis Response (www.hopeaacr.org). The latter two organizations provide animals trained for a variety of disaster and crisis situations, including work with the rescuers.

GROUP APPROACHES

For Abused Children

According to the *Harvard Mental Health Letter* (1993),

> there is no accepted formula for treating children and adults who are victims of incest or physical abuse. Since the symptoms vary a great deal, many kinds of psychotherapy and medication may be appropriate, and there are no controlled studies of outcome. . . . Surveys indicate[, however,] that professionals experienced in treating victims of child abuse prefer *group therapy* above all other kinds of treatment, especially for adult female survivors but also for men, adolescents, and *children*. . . . Group members with similar experiences are an ideal audience, certain to understand or sympathize. (pp. 2–3; emphasis added)

Alessi and Hearn (1984) describe a six-session treatment group for children in a shelter for battered women. The children, ranging in age from 8 to 16, showed numerous symptoms of anxiety (e.g., nail biting, headaches, and stomachaches), as well as aggressive behavior toward other children. The group was structured around the following topics:

- Identification and expression of feelings.
- Violence.
- Problem solving (healthy and unhealthy methods).
- Sex, love, and sexuality (for the teenagers).

The two coleaders used each group session to encourage the children to reflect on how their families responded in various situations and on how they were personally affected by events in their families. The children were asked directly whether they thought that hitting is right and whether they thought that they would hit others when they grew up. Role playing of possible family interactions (with both violent and nonviolent approaches to solving problems) helped the children to consider a range of alternatives other than the aggressive responses to which they had been exposed. The directive psychoeducational framework of this group provided a focus, whereas the mutual sharing of family experiences proved very supportive to children who had previously felt stigmatized and isolated because of their family situation.

For Children Exposed to Family and Community Violence

An elementary school-based intervention program used a combination of individual and group psychotherapy and mentorship in an effort to

help children exposed to violent behavior in a community with a high rate of crime and violence (Murphy, Pynoos, & James, 1997). This comprehensive mental health program for children and their families targeted children who had been exposed to violence in their homes and in the community. Many of these children lived with daily exposure to violence in their communities and were preoccupied with aggressive, retaliation/revenge fantasies. The program included specific interventions designed to address these directly, while also promoting more constructive responses through activities, discussion, and ongoing mentorship with adults who offered examples of nonaggressive and constructive responses to community violence.

In an attempt to deal directly with children's exposure to horrific events during the course of the school year, the staff used Pynoos and Nader's psychological-first-aid classroom consultation format (1988, 1993) to open a discussion with the class about their experiences, followed by involving the children in two drawing exercises: one to permit the children to show their feelings about what happened, and the other to show how they wished things could have been different. During this trauma-focused drawing and storytelling activity, each child was seen individually, with referrals to a crisis-trauma group for children most affected by exposure to the violence. This intensive, comprehensive mental health program recognized the detrimental effects of exposure to all forms of violence on children and targeted intervention in an elementary school, based on the belief that schools provide the most accessible, functional, and efficient setting in which to provide these services. A similar point has been made by Garbarino and associates (1992), who state that teachers who let children play out their fears of danger actually serve as psychic healers for children who are living in a state of "chronic, not post-traumatic stress" (p. 221).

PREVENTIVE APPROACHES TO FAMILY AND COMMUNITY VIOLENCE

Helping children cope with their confused feelings related to family and community violence does not deal with the problem at its roots. Unfortunately, U.S. society condones and even glamorizes (in movies and on television) the aggressive, abusive behavior of the strong toward the weak. The stage is set for violence when social values sanction the use of force against women and children and between adults who decide their differences with their fists and weapons, rather than through their brains.

The problem of family and community violence must be confronted on many levels. My emphasis in this chapter on the child witnesses and

victims does not imply disregard for essential interventions on the societal and community levels. Chapter 15 discusses the need for clinicians and advocates on behalf of children to join forces and work toward common goals. Perhaps nowhere is this joining of purpose more essential than with regard to the child's right to grow up in a safe and nurturing home and community environment. It is therefore undeniable that to help children *in the long run*, we must focus on improving the life conditions of their parents, families, and communities.

Teaching School-Age Children Conflict Management Skills

Children learn from examples at home, and what they learn is reflected in their own interpersonal responses with their peers. A school-based peer mediation program (Gentry & Beneson, 1993) attempted to teach anger management in fourth to sixth grades, in the hope that this learning would transfer to the home. This approach to conflict management helped children understand that tensions and disputes can be resolved through the following specific rules of mediation:

- Agreeing to solve the problem.
- Not interrupting.
- Telling the truth.
- Avoiding name calling or putdowns.

Trained peer mediators helped students deal with problems. The rationale for this program rested on the belief that the behaviors of children in one setting would transfer to another. This proved to be the case when conflict management was learned and practiced in the school: The skills appeared to generalize to the home setting, for use with family members, particularly siblings (Gentry & Beneson, 1993, p. 72).

Because all children go to school, the potential of this setting for interpersonal learning must be recognized and used to the fullest. Attempts to teach children constructive methods for dealing with intense emotions constitute a rich opportunity for interrupting the intergenerational transmission of family and community violence.

CONCLUDING COMMENTS

Most social workers whose practice puts them in contact with children will sooner or later become involved with a case of physical or sexual

child abuse; many also will be called to help in connection with conflicts at schools or between neighborhood gangs. Because of the magnitude of the problem, it is unavoidable. Some workers find it impossible to accept the evidence of parental abuse of children, joining in society's denial of the fact that parents, who are supposed to protect their children, can instead sometimes behave in a manner that threatens their children's physical, mental, and emotional health.

As discussed previously in this chapter, a frequent consequence of violence and abuse is an increase in aggressive behavior in the victim (Jenkins & Bell, 1997; Fletcher, 2003). Of course, there are many intervening factors, and other influences besides abusing parents contribute to violent behavior. Perhaps the ultimate question, however, is *why* parents feel the need to resort to hurting their children.

The problem can be addressed on a macro level, recognizing the stresses on parents due to poverty, substance abuse, and ignorance. A wide-angle view focused on social factors clearly has merit. Meanwhile, on a micro level, the children are learning that parents who love them can also hurt them. They are also learning that when our country is attacked, we fight back with weapons of destruction. Violence is pervasive in our society, and it is difficult to counteract the lessons learned at home and in the community.

DISCUSSION QUESTIONS

1. Outline a treatment plan for the five siblings of Elisa Izquierdo, ages 2–9, who were placed in custody following the imprisonment of their mother for the murder of their sister (Bruni, 1995).
2. Consider the probable reaction of a 4-year-old who witnessed the sudden, violent death of a sibling. What interventions would be appropriate to help the preschool-child witness?
3. What are some methods for helping children with their revenge fantasies after they have witnessed the death of a neighborhood friend in a drive-by shooting? Do you think that there is a danger that permitting a child to express these feelings may stimulate him or her to act them out? What can the worker do to avoid this possibility?
4. Discuss the effect on the worker of interacting with a child who has witnessed or experienced severe abuse. How can the worker deal with his or her own reactions?

❖ CHAPTER 15 ❖

The Impact of a Changing World on Practice with and for Children

The beginning of the 21st century compels social workers and other practitioners involved with children to assess their past and current efforts, as well as their future prospects for intervening helpfully in children's lives. The 20th century was sometimes referred to as the "century of the child," because more serious study of children was undertaken during this time than in the entire history of the world, according to LeVine and Sallee (1992). Certainly we would like to believe that we know more about how to help children and that we are doing better as a society and as professionals than we did in the early 1900s.

However, our enhanced knowledge has not prevented the fragmentation of the family and kinship network; nor has it countered the debilitating influences on children of poverty, substance use disorders, violence, and child abuse. There is a disturbing contradiction between the United States' view of itself as a child-centered nation and its fiscal policies, which reveal a "weak and eroding commitment to children" (Hewlett, 1991, p. 17; Edelman, 1998; Children's Defense Fund, 2001). For example, the U.S. budget for fiscal year 2000 failed to provide for any significant increase in the Child Care and Development Block Grant, and allocations for programs for infant/toddler care and research were deleted (Children's Defense Fund, 2000). Practitioners committed to working on behalf of children must avoid becoming demoralized by these double messages as they make decisions about how to respond to the needs of the children in their practices.

THE NEED FOR SHARED RESPONSIBILITY FOR CHILDREN

A philosophy of shared responsibility for the health and well-being of children becomes critical in the face of family breakdown, as I pointed out in Chapter 1. Examples throughout this book have demonstrated the indisputable need for programs and services for children who are homeless, orphaned, maltreated, and disadvantaged. When parents and other family members are absent, addicted, poor, violent, and/or otherwise unable to help their own children, society has a moral responsibility to do so. The slogans "it takes a village to raise a child" and "leave no child behind" deserve to be implemented at every opportunity.

Factors Contributing to the Need for Services

Poverty

Children who grow up in poverty often suffer the associated problems of poor nutrition, inadequate health care, and substandard housing. Furthermore, race and ethnic minority membership often coexist with poverty, thus presenting additional obstacles to children's optimal growth and development. "When children are both poor and members of ethnic minorities, the negative and long-term impact of poverty increases significantly" (Gibbs, Huang, & Associates, 1989, p. 6; Allen-Meares, Washington, & Welsh, 2000).

Pronounced changes are taking place in the demographic composition of the United States. More than 35% of all children 5 to 19 years old were "minorities" in 1998. Furthermore, the U.S. Census Bureau projected that, based on predicted birth and immigration rates, "minorities" are expected to reflect the *majority* of the population by the middle of the 21st century (Shinagawa & Jang, 1998; U.S. Bureau of the Census, 1999). A multidimensional framework of assessment and treatment must include cultural, developmental, and environmental factors as essential to understanding and treating a child, in accordance with a person-in-environment perspective.

Homelessness

In 1997, there were a total of about 850,000 homeless children and youths in the United States, 625,330 of them school age and 216,391 preschool age (Office of Elementary and Secondary Education, 1997, quoted in Children's Defense Fund, 2000). Many homeless children fail to attend school while they are temporarily housed in shelters, motels, and welfare hotels.

The acute shortage of low-income housing, combined with fiscal constraints and restrictions on welfare benefits, does not bode well for homeless families confronted not only with the lack of housing but also with poor health care, disappearing Head Start and nutrition programs, and the threat to their children of violence and exposure to substances in their unsafe neighborhoods. The case of Barbie Smith (Chapters 3–5) illustrates the interweaving of environmental and psychological stressors, as well as the limitations on what practitioners can do in the absence of necessary programs.

HIV/AIDS

The Orphan Project (based in New York city) reports that in the year 2000 approximately 72,000 to 125,000 children had been orphaned by AIDS in the United States; more than 90 percent of AIDS orphans are poor black and Hispanic children (Michaels & Levine, 1992, p. 3456). Because of the social stigma associated with HIV/AIDS, children in families that have been affected experience a sense of isolation and reduced self-esteem, in addition to the various stressful experiences associated with the medical treatment and terminal illness and death of a family member.

HIV/AIDS has been referred to as a "multigenerational family disease" because it crosses generational boundaries and infects many individuals within each family (Steiner, Boyd-Franklin, & Boland, 1995). Furthermore, the accompanying problems (such as homelessness, crime, unemployment, and drugs) that plague inner-city families with HIV/AIDS all call for a coordinated multisystem approach to helping, in order to avoid mixed messages among the different helping systems, overlapping case management efforts, and conflicting treatment plans and goals (Steiner et al., 1995).

Of course, direct work with affected children and families does not preclude advocacy efforts on behalf of funding for research and continuation of services for people with HIV/AIDS. Anyone who has worked closely with a child or family with this terrible illness understands the necessity of finding a cure in time to prevent the future loss of lives.

Merging Goals of Clinicians and Advocates

Faced with the cruel realities of our changing world, practitioners who work directly with children realize that political and economic remedies are required to reduce poverty and bring about improved living conditions. All U.S. citizens who care about children and families must join together to raise the consciousness of the nation, and especially that of

its political leaders, who allocate resources for programs and services. When families suffer the combined throes of poverty, racism, unemployment, and lack of opportunity, its children pay the price. All of us must work together to try to correct this social injustice and help families that are too overwhelmed to help themselves.

A GLOBAL PERSPECTIVE ON CHILDREN'S RIGHTS

Social workers and other practitioners focused on promoting the best interests of the child cannot, in good conscience, limit themselves to U.S. citizens. Problems associated with the health and welfare of children extend to all nations.

The United Nations Convention on the Rights of the Child

In 1989, the United Nations approved the Convention on the Rights of the Child (U.N. General Assembly, 1989), covering three major areas of concern (summarized by Brieland, Fallon, & Korr, 1994, p. 132):

1. Entitlements
   The material provisions and basic services that all children have a right to expect from society.
2. Protections
   The means to safeguard children's well-being.
3. Affirmative Freedoms
   The right of children to think, decide, and act on their own, dependent on their capacities.

The full text of the Convention can be found in the U.N. General Assembly (1989). The United States signed this document in 1995 but has not yet ratified it (ratification indicates consent to be bound by a treaty). Objections to ratification relate to fears about state interference in family life, to the abortion issue, and to the concern that children's rights might give them power to "divorce" their parents (and thus erode parents' age-old right to "possession" of their children). It is not clear whether or how the United Nations will monitor adherence to the various components of the document among all of the nations of the world, it is noteworthy that the United States has taken the first step to affirm its obligation to deal with child poverty, infant mortality, and child health. Furthermore, in May 2000 the General Assembly adopted by consensus two additional

clauses related to the involvement of children in armed conflict and on the sale of children, child prostitution, and child pornography.

Immigration and Adoption of Refugee Children

Many children who are new arrivals in this country come from a background of political upheaval and family displacement related to their status as refugees. The child immigrant to the United States brings with him or her the "excess baggage" of family crisis associated with the often stressful reasons that led to the immigration. There can be many motives for immigration, but it seems obvious that families would not willingly leave an environment in which they felt safe and optimistic about their future. Moving a family to a new country may be the "least detrimental alternative" (i.e., better than remaining home in the middle of a war zone), or it may represent the father's or mother's wish for better family opportunities (Bevin, 1999; Crawford-Brown & Rattray, 2001; Wu, 2001).

Children who leave one country to establish residence in another, regardless of the reason for the major family move, have to cope with numerous losses, which are summarized by Ajdukovic and Ajdukovic (1993) in Table 15.1. Although a refugee child's vulnerability to stress is greatly increased by such losses, these negative effects can be reduced by a supportive family milieu and a supportive community (Ajdukovic & Ajdukovic, 1993). The ability of the family members to adjust in a new environment, moreover, relates to the degree to which the rules and norms of their own culture remain the same and the extent to which role expectations, morals, and values are different and clash with the prevailing norms in the new locale (Crawford-Brown & Rattray, 2001; Webb, 2001).

The school is often the place in which difficulties in adjustment become evident, because the child is thrust into a new situation that expects certain behaviors even as the child is attempting to learn a new language and to establish some peer contacts (Allen-Meares et al., 2000). The role of the school social worker in serving as a bridge between two sets of values is illustrated in the case of Alexa, an adopted 8-year-old Russian refugee with special needs.

THE CASE OF ALEXA, AGE 8

Presenting Problem

Alexa, an 8-year-old Russian child in the second grade of a public school, was referred to an early intervention program (staffed by a local mental

TABLE 15.1. Losses Confronted by Immigrant Children

- *Loss of important others*
  Many immigrant children have witnessed the death of one or both of their parents.
- *Loss of physical capacity*
  Children in war-torn zones may be injured or wounded.
- *Loss of parental support or protection*
  Many children become displaced and separated from their parents under war conditions. This can be very troubling to young children, who, as Garbarino (1992) noted, can cope with the stress of war if they retain positive attachments to their families, and if parents can project a sense of stability, permanence, and competence to their families.
- *Loss of home*
  The meaning of the term "home" is personal and very significant to the child's sense of security; without this anchor children (and adults) may develop symptoms.
- *Living with distressed adults*
  The cumulative, negative effects of displacement produce high levels of distress among adults, which have disturbing reverberations for the children.
- *Family separation*
  Separation from loved ones results in emotional pain and in changes in the family structure.
- *Lost educational opportunities*
  Children in transition from one country to another not only lose the continuity of an educational experience but also need to acquire a new language and the accompanying set of educational expectations in the new environment.
- *Poor physical environment*
  Often refugee families live in crowded shelters with minimal space for play activities or learning. Lack of privacy, high social density, and poor housing are common in immigrant families.
- *Malnutrition*
  Dietary provisions in refugee settings usually are tailored to the needs of adults, not to the nutritional requirements of children.
- *Incarceration*
  Many refugee children are kept in refugee camps for prolonged periods of time. The stresses of an incarceration environment can seriously interfere with the normal growth and development of children.

Note. Adapted from Ajdukovic and Ajdukovic (1993, pp. 845–846). Copyright 1993, with kind permission from Elsevier Science Ltd., The Boulevard, Langford Lane, Kidlington OX5 1GB, UK.

health agency) because of her aggressive behavior with other children, her failure to follow directions, and her immature behavior. She had been a student in the school for 2 years, and in first grade she had been suspended twice—once for slapping another student, and once for hitting a teacher. At the time of intake, she spoke English fluently, but when she arrived in this country she knew no English.

Family Information

Alexa was adopted when she was 4 years old. She had been orphaned during the first year of her life, when both of her parents died as a result of civil unrest in the Ukraine. She was placed in an orphanage with other displaced children at that time.

Alexa's adoptive parents are of Russian backgrounds; they decided to adopt a Russian child when they were unable to conceive a child of their own. Both parents are employed in international business organizations. At the time of intake, the father was 42 years old, and the mother was 37. Alexa is their only child.

Biopsychosocial Assessment

No developmental history is available regarding the first 4 years of Alexa's life. We know, however, that loss of the parents during the first year of life creates a sense of abandonment in the child, with resultant problems in lack of trust and attendant attachment difficulties (Remkus, 1991; Shapiro, Shapiro, & Paret, 2001). We do not know the details about Alexa's parents' deaths, or whether she witnessed one or both of them. These facts may never be known, as the preverbal child lacks the language to convey traumatic experiences, which nonetheless may be imprinted on his or her visual memory (Terr, 1988).

We also do not know the conditions in the orphanage in which Alexa lived until her adoption at age 4, or whether she had any opportunity to form attachment bonds to one or more staff members there. It is likely that this child did receive enough attention and care from *someone* to benefit her development sufficiently that a couple seeking to adopt a preschool child found her to be appealing. However, we know that many children adopted from institutions suffer from various forms of attachment and affective disorders (Shapiro et al., 2001), and they may continue to show difficulties for many years following adoption.

Alexa's anger and frustration when she was uprooted from the orphanage at age 4, brought to the United States, and enrolled in school are understandable from the point of view of her position, in which she was isolated because she did not know the language. Another possible factor contributing to Alexa's aggressiveness could be related to this child's sensitivity to change and to her depleted ability to adapt to the loss of a familiar environment. Shapiro et al. (2001) point out that, although institutional life may have been hard, it was a familiar "home" for the child, and the prospect of leaving and going to a new country with strange parents who spoke a different language could have been very frightening.

The facts that Alexa learned English in 2 years and that she was able to make some friends reflect her strengths and resilience. Her ongoing adjustment, however, required close monitoring.

Treatment Summary

Individual weekly play therapy sessions provided a range of nonverbal methods by which Alexa could express her frustrations symbolically, without the pressure to put them into words. Paper and markers offered a nonstructured method for Alexa to "draw out" her feelings in a safe environment. She sometimes referred to "a faraway place" in her drawings, which seemed to allude to some of the shadowy memories of her past. A dollhouse and family dolls were also available to the child, in addition to a variety of puppets and clay.

Group therapy was also an important part of Alexa's initial treatment, in order to offer her a socialization experience. She participated in a group of four children, two girls and two boys. Other members of the group also had difficulties with peer relationships. The goal for Alexa in this experience was to help her become aware that the other children also had to struggle to control their behavior. A second goal was for Alexa to receive a sense of being accepted by the group.

The involvement of Alexa's adoptive parents in counseling was crucial in promoting the optimal development of their child. It is essential for the child's therapist to meet regularly and work closely with the parents, in order to guide and coach them so that they can support their child most effectively. The school initially focused on Alexa's troublesome behavior, which the social worker "normalized" with the parents in view of this girl's traumatic life experiences. Until the worker presented this perspective to them, the parents were joining with the teacher in viewing Alexa as a "bad" child and responding to her punitively.

Another important goal in ongoing parent counseling is to help Alexa gradually understand her traumatic past. It is quite likely that she remembers some details of her experiences in the orphanage. Both the parents and the therapist must encourage and be willing to listen to the child's memories. Ideally, this recollection will first occur in individual therapy, with later family sessions to sensitize the parents to the ongoing influence of their daughter's early experiences in her present life. Eventually Alexa can be encouraged to construct a lifebook (see Chapter 10), in which she records the significant events of her life—both as she actually remembers them and as her parents help supply missing information.

Discussion

Alexa has experienced multiple traumatic events in her short life. However, the impact of Alexa's major losses during the first year of her life may be underestimated even by trained practitioners who are unaware of the impact of a child's preverbal experience. Terr's (1988) studies of children traumatized during their preschool years confirm that traumatic events create lasting visual images that "seem to last a lifetime" (p. 103). "When a trauma or series of extreme stresses strikes well before the age [of] 28 to 36 months, the child 'burns in' a visual memory of it, sometimes later becoming able . . . to affix a few words to the picture" (p. 103).

Terr's comments have direct treatment implications for Alexa and for other refugee children who may have witnessed multiple frightening events during their preverbal years. The recommended method of helping is to facilitate gradual recollection of the experience, in the belief that this recollection (in the context of the safety of the child's present reality and the support of a warm helping relationship) will reduce the child's anxiety about the trauma. This process should enable the child to locate the experience in the past and thereby to reduce its ongoing influence in his or her present life.

More research needs to be done on different helping approaches for traumatized children. For example, when a child has witnessed one or both parents being murdered, it is difficult to conceive of *any* intervention that will help the child to accept this terrible reality. My own belief, based on many years' experience with traumatized children, is that a child's best interests lie in remembering the experience and then placing the memory in the past, so that the child can carry on with his or her life in a way that honors the lost or deceased parent. In this manner the child holds onto the memory while focusing on the present rather than the past.

TRENDS IN DIRECT PRACTICE WITH CHILDREN

In addition to the merging goals of clinicians and child advocates and the greater sensitivity to children's rights in the international sphere, other trends are becoming apparent in the work of practitioners who deal directly with children. These trends include the following:

- Greater awareness of multiple interacting factors in the etiology of childhood problems, including increased emphasis on biological and environmental influences.

- Understanding and utilizing concepts of risk and resilience, and a strengths perspective.
- Interprofessional collaboration and parents as partners in their children's treatment.
- Practice that is culturally sensitive.
- Practice that integrates child and family therapy.
- Practice that is guided by research and research that utilizes practice experience.
- Practice that employs cognitive and behavioral approaches, where appropriate.

Greater Awareness of Multiple Interacting Factors in the Etiology of Childhood Problems

There are many approaches to the assessment and treatment of childhood disorders, but despite differences in emphasis and methods, most models recognize the role of multiple interactive influences rather than subscribing to unitary causes of behavior (Mash & Barkley, 2003). The literature increasingly acknowledges the importance of biological factors in shaping behavior (Chess, 1988; Karr-Morse & Wiley, 1997; Perry, 1997; Siegel, 1999). It also recognizes the pivotal role of the environment in either protecting or exposing the child to potentially stressful experiences, such as traumatic events that can lead to subsequent psychological and somatic disorders in children (Jenkins & Bell, 1997; Garbarino & Kostelny, 1997). The work of Chess and Thomas (1986) on temperament made a significant contribution to our understanding of the innate temperamental characteristics that influence children's and adults' responses to the world. This temperamental disposition, furthermore, may influence the manner in which the child responds to stress and trauma.

In addition to the genetic reality of temperamental characteristics that we all possess, some children's biological inheritance predisposes them to certain conditions, such as schizophrenia, autism, alcoholism, Tourette's disorder, attention-deficit/hyperactivity disorder (ADHD), and other emotional, learning, and/or behavioral disorders. These conditions are multidetermined, and we do not know the elusive reasons why one child in a family develops a disease or disorder, whereas another child in the same family with the same parents does not. Johnson (1989) states that

> some combination of intrinsic constitutional factors and environmental forces, in continuous interaction with each other, gives rise to conditions classified under disruptive behavior disorder. In some instances, biological factors play the major determining role, in others, environ-

> mental factors predominate, and in still others both biology and environment significantly contribute to an outcome identified as a "behavior disorder." (p. 91)

Furthermore, persistent psychosocial adversity, such as poverty, abuse, or neglect, increases the risk of mental illness in children (Institute of Medicine, 1989, cited in Johnson & Friesen, 1993).

Because of the complexity of conditions with both constitutional and environmental components, a multifaceted, multimodal approach to treatment is recommended. The use of psychopharmacology brings dramatic results for some conditions, but ideally this treatment will be combined with simultaneous parent guidance and possible behavioral approaches with the child.

Understanding and Utilizing Concepts of Risk and Resilience and a Strengths Perspective

Because risk and protective factors often occur simultaneously at multiple system levels, assessments must involve the use of multiple sources of information and multiple methods of data collection (Fraser, 1997). As previously discussed, risks can be assessed as they pertain to the child, to the parental/family system, and/or to the social environment (Davies, 1999). Although multiple risk factors may lead to diminished resilience, "*risk factors are not fate*" (Davies, 1999, p. 81; emphasis added), and clinical experience demonstrates that when protective factors are marshaled, the risk may diminish. For example, Alexa's background of repeated experiences of loss and separation might lead one to expect that she could not overcome the impact of her tragic history. However, the timely interventions of the school social worker on multiple levels brought about gradual improvement in the child's behavior, which in turn resulted in more positive interactions with her teacher and her parents.

Saleebey's (1992, 1996) conceptualization of the "strengths perspective" has had a profound impact in directing social workers to focus on the client's positive attributes and to work with the client in a relationship of respect and courtesy (DeJong & Miller, 1995; Nelson, 1997; Ronnau, 2001; Saleebey, 1992, 1996). This applies as much to work with children as with adults.

Interprofessional Collaboration and Parents as Partners in Their Children's Treatment

We have come a long way from the view that parents (especially mothers) cause or substantially contribute to their children's emotional difficulties.

Our enhanced understanding of the biological components of human behavior, together with a broader awareness of the complexity of behavior, leads us to include parents as partners in helping efforts that involve their children. The Amendments to the Education of the Handicapped Act, which passed in 1986, *mandate* a family-centered approach to provision of services to infants and young children with handicaps (Bishop, 1993; Bishop, Rounds, & Weil, 1993; Allen-Meares et al., 2000). That act, along with programs such as Homebuilders (Kinney, Haapala, & Booth, 1991) and Family-Centered Services (Wilson, Sandau-Beckler, & Mannes, 2001), demonstrate belief in the importance of the parents' role in their children's lives. Studies of early intervention programs for children have shown that the most effective programs actively involve parents along with the children (LeCroy & Ashford, 1992; Groves, 2002).

In addition to the primary role of the parents in helping their own children, many other specialists often participate in the assessment and treatment of some complicated disorders, such as ADHD. For example, special education teachers usually have an essential role in the education of a child with ADHD. In addition, the school nurse often dispenses medication to the child during the day; a pediatrician, neurologist, or psychiatrist prescribes the medication; and various other medical and educational personnel may be involved in providing support services to the child and family. Often the social worker functions as case coordinator to insure that necessary information is transmitted among the different personnel and parents. Interprofessional collaboration and inclusion of parents as partners result in enriched information about the child, which assists the social worker/counselor while also contributing to a sense of teamwork. The ongoing challenge for the social worker is to keep the members of the "team" working together over the necessary period of time, depending on the child's needs.

Practice That Is Culturally Sensitive

Implicit (and often explicit) throughout this book is the recognition that social workers and other practitioners with children must be prepared to work with the many different nationalities, races, and ethnic groups that contribute to the diversity of the United States and the world. Children are products of the particular culture in which they grow up, and an understanding of a particular child (and his or her parents and extended family) depends to a great extent on an appreciation and respect for the uniqueness of a culture that may be very different from one's own.

Social work education requires that students examine their own cultural heritage, values, and biases in order to sensitize them to the feelings

and beliefs of others who subscribe to different points of view. As I have pointed out in Chapter 2, self-awareness about one's own cultural beliefs and an openness to the beliefs of others form the necessary foundation for the ability to interact effectively with a client from a different culture (Webb, 2001). Because no one person can realistically expect to have knowledge about *every* different culture, the essential attitude for the worker is a willingness to put aside his or her own values and to try to identify the assumptions and values of a different culture. The worker must acknowledge and believe in the concept that there is more than one valid way to raise a child. A reference such as *Culturally Diverse Parent–Child and Family Relationships* (Webb, 2001) can guide practitioners who are working with children and families from a variety of cultural backgrounds.

Practice That Integrates Child and Family Therapy

The tension between the child-centered view of assessment and treatment and one that sees the child's problems as reflecting family dysfunction has a long history. In their enthusiasm for a systems view, the early family therapists, according to LeVine and Sallee (1992, p. 107), believed that

> all children's problems were best dealt with by intervening in the family system. Some still subscribe to this position, but a number now agree that the difficulties of the identified child patient may be so internalized that individual therapy is preferred. In other cases, a family member besides the identified child may be so disturbed that individual therapy with [that family member] must precede effective family intervention.

As an experienced child and family therapist and social work educator, I find that the impact of family factors on the child is uppermost in my mind. I always acknowledge the essential role of the family for the child. However, during my career I have not noted a corresponding recognition among family therapists of the influence of the *child's* problems on the family system. In my opinion, many family therapists fail to recognize that children often have their own intrinsic problems, which do not necessarily emanate from some dysfunction in the family. The essential individuality of the child, unfortunately, is thus diminished by many family systems theories and practitioners.

With this point of view as background, I urge an end to the polarization implicit in either a child-centered or a family-centered approach to helping children. It seems patently obvious that children need their families and that families respond to their children, either by giving them a voice or by expecting them to meld into the larger family gestalt. Chil-

dren who have special problems and needs cannot conform to their families' expectations. When this is the case, the best skills of both child and family therapists are required to understand each problem situation and devise an intervention that is respectful of both a child's and a family's needs. A systems view recognizes that a child's fundamental problems will affect the family and that effective helping includes *both* child and family approaches.

Practice That Is Guided by Research and Research That Utilizes Practice Experience

Historically, social work researchers and practitioners have tended to pursue their own interests and goals without much interaction. Practitioners strove to understand a case in all its complexity (as in the tripartite assessment), whereas researchers were more likely to focus their attention on a narrow facet of the problem situation in their effort to measure change.

At the beginning of the 21st century, members of each group are realizing that they can learn from one another and even collaborate on projects that simultaneously benefit clients and generate new knowledge (Hess & Mullen, 1995). More social workers are continuing their educations to the doctoral level, and, in completing the required dissertation, they have learned to appreciate both the complexity and the rewards of carrying out a research project whose findings can help practitioners help other clients. Furthermore, as social workers increasingly collaborate with other professionals who routinely employ empirical research and present their findings in interdisciplinary meetings, the social workers need to understand and use this research language in order to be respected. Thus a worker who previously may have had a somewhat limited vision may begin to appreciate how practice wisdom can be translated into a research protocol that, after testing, can result in findings that will apply broadly to many clients and situations.

Both researchers and practitioners have to bend to the effort to develop research that is grounded in practice. Researchers must consult and confer with practitioners in drafting procedures that "make sense" and that will contribute to the client's treatment, even as the research questions are being investigated. Research using child clients needs to follow certain safeguards in order to conform to the child's developmental level, limited ability to conceptualize, and frequent intolerance with demands and expectations. The key to a successful partnership and collaboration is for researchers and practitioners to learn to talk to one another with

respect and to come to the conclusion that together they will achieve more than either group can accomplish alone.

Practice That Employs Cognitive and Behavioral Approaches, Where Appropriate

A good example of successful blending of practice and research is in the field of cognitive-behavioral therapy. Interest in this treatment approach has increased in recent years because of the research that attests to its effectiveness. In addition, it satisfies the desire of child practitioners to work with children in a manner that conforms to the children's developmental need for concrete, detailed information, combined with a method for tracking their progress. Cognitive-behavioral methods provide a means of contracting and of monitoring success in regard to a specific problem situation. The specificity of this approach also appeals to managed care companies, which view this method as time limited and easy to monitor. From the child's point of view, a behavioral method that can be followed on a chart offers the empowering opportunity to identify and reward his or her own daily successes. Chapter 6 demonstrates the use of a behavioral method with a boy with ADHD, and Chapter 7 illustrates its use with a girl with a sleep disorder. Kendall's (2000) edited book on child and adolescent therapy features clinician-researchers who address specific behavioral and emotional problems such as aggression, ADHD, depression, anxiety disorders, and difficulties faced by children with chronic health problems.

CONCLUDING COMMENTS

As a clinical practitioner, I know that the various methods demonstrated through the case examples in this book can substantially help children living in stressful family and social environments. We know a great deal about how to treat and support families, school personnel, and children themselves who are in distress. However, no matter how successful the outcome of our therapeutic/helping efforts, as thoughtful practitioners we must reflect seriously about the underlying reasons for the children's difficulties and question whether something might have been done *sooner* to forestall the predictable deterioration of the children's untreated situation.

The value of prevention as a worthwhile goal is most appealing. Almost everyone would agree with the wisdom of improving children's lives so that they will not require special remediation services. Over the

years since the Community Mental Health Centers Act of 1963, there has been consistent attention to the three levels of prevention—primary, secondary, and tertiary—originally outlined by Caplan (1964).

Social workers have been especially interested in the notion of "primary prevention," which aims to "keep something unwanted from occurring" (Bowker, 1983, p. 2). This proactive approach seeks to build adaptive strengths through education, especially with groups at high risk (LeVine & Sallee, 1992). A philosophy of primary prevention implies intervening *before* a problem becomes visible; implementing a primary prevention program thus requires a leap of faith and a belief that the desired end product of improved well-being will be worth the costs of mounting such a program. Unfortunately, many politicians prefer to deal with the squeaky wheel instead of applying some oil to prevent the squeak. Therefore, the neglect of children's well-being continues; although we know what to do, we don't do it. Bloom (1981, p. 214), with tongue in cheek, says: "It obviously takes a creative practitioner to prevent problems that don't exist, among persons who don't want to be bothered, with methods that haven't been fully demonstrated to be efficacious, with regard to complex situations and powerfully competing forces."

Actually not *all* children's problems lend themselves to primary intervention, valid as that concept may be for many of the social problems arising from poverty, substance abuse/dependence, violence, and lack of good schooling and nutrition. Some conditions of childhood (e.g., ADHD and other emotional, learning, and behavioral disorders with a constitutional component) may require the combined efforts of social workers and other professionals to provide ongoing necessary services to the affected children and their families. Some problems simply do not get better with the methods we have at present, no matter how skilled the worker or how promptly help is made available.

Helping with a problem in its early phases is referred to as "secondary prevention." For example, in the case of a child with suspected ADHD, a secondary prevention approach emphasizes early screening, testing, and goal setting so that the problem situation can be managed effectively before it reaches a dysfunctional level and requires a "tertiary prevention" approach. When disorders such as ADHD are not diagnosed and treated in an early stage, a child may become unmotivated and disruptive in class to the point that he or she begins to engage in antisocial behavior. In later years, such behavior may result in the need to transfer the child to a residential treatment facility. Tertiary prevention such as this should more appropriately be called "remediation," not "prevention" (Le Vine & Sallee, 1992).

In addition to innate conditions that require intervention in a timely manner, certain life events, transitions, and crises that may occur in the

course of the child's development may create a justifiable need for services. For example, the death of a parent or sibling, parental divorce, and chronic illness in the family all generate stress that may interfere with a child's ability to carry on his or her usual activities. As demonstrated in several chapters in this book, helping interventions focused on either the individual child or the family as a unit can provide a child with the opportunity to express and receive support for his or her feelings. *Timely* interventions in circumstances such as these can prevent the further escalation of the problem.

DISCUSSION QUESTIONS AND ROLE-PLAY EXERCISE

1. Indicate how you might respond to a refugee child like Alexa who refers to a "faraway place" in her drawings. Do you think that it might be too painful for the child to recall these memories, or that this would be beneficial? Give reasons for your opinion.
2. Discuss the role of the social worker as consultant to teachers. Role-play a meeting with a teacher in which the social worker tries to sensitize the teacher to a refugee child's losses as possible determinants of the child's aggressive behavior in school. How is the issue of confidentiality applicable here, and how could this be managed?
3. How can the social worker deal with his or her negative feelings about a client from a culture that puts the parents' needs ahead of those of the child and demands the child's instant obedience to the parents' authority?
4. Identify an issue related to children that you consider as appropriate for uniting child advocates and practitioners around a specific goal or purpose. Outline a plan of action, indicating how this effort would be funded.

Appendices

Child-Related Professional Organizations

American Professional Society on the Abuse of Children
940 NE 13th Street
CHO #B-3406
Oklahoma City, OK 73104
Phone: 405-271-8202
Fax: 405-271-2931
www.apsac.org

Association for Play Therapy, Inc.
2050 North Winery Avenue
Suite 101
Fresno, CA 93703
Phone: 559-252-2278
Fax: 559-252-2297
www.iapt.org

Association of Pediatric Oncology Social Workers
c/o June McAtee, L.C.S.W.
Children's Healthcare Pavilion
Hematology Oncology Clinic
8300 Dodge Street
Omaha, NE 68114-4114
Phone: 402-955-3951
Fax: 402-955-3972
www.aposw.org

Child Welfare League of America
440 First Street NW, Suite 310
Washington, DC 20001-2085
Phone: 202-638-2952
Fax: 202-638-4004
www.cwla.org

Children's Group Therapy Association
P.O. Box 521
Watertown, MA 02172
Phone: 617-894-4307
617-646-7571
Fax: 617-894-1195

Council for Exceptional Children
P.O. Box 79026
Baltimore, MD 21279-0026
Phone: 703-264-9446
Fax: 703-264-9494
www.cec.sped.org

National Association of Perinatal Social Workers
c/o Irene Bruskin, M.S.W.
NAPSW Membership Chair
Children's Hospital of New York Presbyterian
3959 Broadway
CHN 1201
New York, NY 10032
Phone: 212-305-9907
www.napsw.org

Child-Related Professional Journals

Child Abuse and Neglect
Elsevier Science, Inc.
360 Park Avenue South
New York, NY 10010-1710
Phone: 212-989-5800
Fax: 212-633-3990
www.elsevier.com

Child and Adolescent Social Work Journal
Kluwer Academic Publishers
P.O. Box 358
Accord Station
Hingham, MA 02018-0358
Phone: 781-871-6600
Fax: 781-681-9045
www.kluweronline.com

Child and Family Behavior
Haworth Press, Inc.
10 Alice Street
Binghamton, NY 13904
Phone: 800-429-6784
Fax: 800-895-0582
www.haworthpressinc.com

Child: Care, Health and Development
Blackwell Publishing
350 Main Street
Malden, MA 02148
Phone: 781-388-8200
Fax: 781-388-8210
www.blackwellpublishing.com

Child Development
c/o Society for Research in Child Development
3131 South State Street
Suite 202
Ann Arbor, MI 48108-1623
Phone: 734-998-6524
www.scrd.org

Child Psychiatry and Human Development
Kluwer Academic Publishers
P.O. Box 358
Accord Station
Hingham, MA 02108-0358
Phone: 781-871-6600
Fax: 781-681-9045
www.kluweronline.com

Child Study Journal
State University of New York College at Buffalo
Educational Foundations Department
Bacon Hall 306
1300 Elmwood Avenue
Buffalo, NY 14222-1095

Phone: 716-878-5302
Fax: 716-873-5833
www.buffalostate.edu/~edf/csj.htm

Child Welfare (formerly *Child Welfare Quarterly*)
P.O. Box 2019
Annapolis Junction, MD 20797-0118
Phone: 800-407-6273
www.cwla.org

Children and Youth Care Forum
Human Sciences Press, Inc.
233 Spring Street
New York, NY 10013-1578
Phone: 212-807-1047
Fax: 212-463-0742
www.cyc-net.org

Children and Youth Services Review
Elsevier Science, Inc.
360 Park Avenue South
New York, NY 10010-1710
Phone: 212-633-3730
Fax: 212-633-3680
www.elsevier.com

Children's Health Care
Lawrence Erlbaum Associates
10 Industrial Avenue
Mahwah, NJ 07430
Phone: 201-258-2200
www.erlbaum.com

Early Child Research Quarterly
Ablex Publishing Corp.
355 Chestnut Street
Norwood, NJ 07648
Phone: 201-767-8450
Fax: 201-767-6717

Gifted Child Quarterly
National Association for Gifted Children
1707 L Street NW, Suite 550
Washington, DC 20036
Phone: 202-785-4268
www.nagc.org

Journal of Abnormal Child Psychology
Kluwer Academic Publishers
P.O. Box 358
Accord Station
Hingham, MA 02108-0358
Phone: 781-871-6600
Fax: 781-681-9045
www.kluweronline.com

Journal of the American Academy of Child and Adolescent Psychiatry
Williams & Wilkins
351 West Camden Street
Baltimore, MD 21201
Phone: 410-528-4000
Fax: 410-528-4312
www.jaacap.com

Journal of Child and Adolescent Group Therapy
Kluwer Academic Publishers
P.O. Box 358
Accord Station
Hingham, MA 02108-0358
Phone: 781-871-6600
Fax: 781-681-9045
www.kluweronline.com

Journal of Child and Youth Care (formerly *Journal of Child Care*)
Department of Human Services
Malaspina University-College
900 Fifth Street
Nanaimo, British Columbia V9R5S5, Canada
Phone: 250-753-3245
www.uofcpress.com

Journal of Child Psychology and Psychiatry and Allied Disciplines
Blackwell Publishing
350 Main Street
Malden, MA 02148
Phone: 781-388-8200
Fax: 781-388-8210
www.blackwellpublishing.com

Journal of Clinical Child Psychology
Lawrence Erlbaum Associates
10 Industrial Avenue
Mahwah, NJ 07430
Phone: 201-258-2200
www.jccap.net

Psychoanalytic Study of the Child
Yale University Press
P.O. Box 209040
New Haven, CT 06520-9040
Phone: 203-432-0960
Fax: 203-432-0948
www.yale.edu/yup/books/083718.htm

Training Programs and Certifications

PLAY THERAPY

A comprehensive directory of play therapy training programs may be obtained for a fee from the Center for Play Therapy, Denton, TX 76203. The programs listed here represent a small selection of those available in different parts of the United States.

Boston University
Advanced Child and Adolescent Psychotherapy: Treatment of Children and Adolescents on the Front Line
Candace Saunders, L.I.C.S.W., Director
School of Social Work
264 Bay State Road
Boston, MA 02215
617-353-3756

California School of Professional Psychology
Dr. Kevin O'Connor
5130 East Clinton Way
Fresno, CA 93721-2014
559-456-2777

Center for Play Therapy
Dr. Gary Landreth, Director
P.O. Box 311337
University of North Texas
Denton, TX 76203
940-565-3864

The Play Therapy Training Institute
Dr. Charles Schaefer
P.O. Box 1435
Hightstown, NJ 08520
609-448-2145

Postmaster's Certificate Program in Child and Adolescent Therapy
Dr. Nancy Boyd Webb, Director
Fordham University
Graduate School of Social Service
Tarrytown, NY 10591
914-332-6000

Reiss-Davis Child Study Center
Director of Training
3200 Motor Avenue
Los Angeles, CA 90034
310-836-1223

The Theraplay Institute
3330 Old Glenview Road, Suite 8
Wilmette, IL 60091
847-256-7334

GRIEF COUNSELING

Association for Death Education and Counseling
342 North Main Street
West Hartford, CT 06117-2507
860-586-7503

Certification courses for grief counselors and death educators. Offered during the 2 days preceding the annual National Conference in March of each year. Contact ADEC Central Office for details.

National Center for Death Education
Judith Harding, Director
Mount Ida College
777 Dedham Street
Newton Centre, MA 02459
617-928-4649

Offers 1-day workshops (spring) and week-long institutes (summer) to train professional caregivers. A Certificate of Thanatology will be awarded following completion of necessary requirements.

TRAUMA/CRISIS COUNSELING

American Association of Suicidology
4201 Connecticut Avenue, NW
Washington, DC 20008
202-237-2280

Conducts an examination for Crisis Worker Certification prior to the annual meetings in April. Course work and relevant counseling experience must be verified to determine eligibility to take the exam.

American Academy of Experts in Traumatic Stress
368 Veterans Memorial Highway
Commack, NY 11725
631-543-2217

Endorses training programs to certify persons engaged in the field of trauma counseling. For further information, contact the IATC office.

ANIMAL-ASSISTED THERAPY

Delta Society
580 Naches Avenue SW
Suite 101
Renton, WA 98055-2297
425-226-7357

Mercy College
555 Broadway
Dobbs Ferry, NY 10522
914-693-7600

Special program in animal-assisted therapy.

People, Animals, Nature, Inc.
1820 Princeton Circle
Napierville, IL 60565
630-369-8328
www.pan-inc.org

E-learning course in animal-assisted therapy.

Suppliers of Play Materials

Chaselle, Inc.
9645 Gerwig Lane
Columbia, MD 21046
800-492-7840

Childcraft, Inc.
P.O. Box 3239
Lancaster, PA 17604
800-631-5652

Childswork Childsplay
135 Dupont Street
P.O. Box 760
Plainview, NY 11803-0760
800-962-1141

U.S. Toy Company
Constructive Playthings
13201 Arrington Road
Grandview, MO 64030
800-225-6124

Kidsrights
8902 Otis Avenue
Indianapolis, IN 46216
800-892-5437

Learn & Play
Troll Associates
100 Corporate Drive
Mahwah, NJ 07498
800-247-6106

Play Therapy Associates, LLC
1750 25th Avenue, Suite 200
Greeley, CO 80634-4945
800-542-9723

Toys to Grow On
2695 East Dominguez Street
Carson, CA 90810
800-874-4242

Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, CA 92005-1251
800-648-8857

Bereavement Resources

Compassion Books
477 Hannah Branch Road
Burnsville, NC 28714
704-675-5909

Lists books, films, and tapes for purchase related to bereavement in general, including many focused on children.

The Good Grief Program
1 Boston Medical Center Plaza, MAT 5
Boston, MA 02118
617-414-4005

Offers consultation to schools and community groups to help children when a friend is terminally ill or dies. Maintains a resource library of films, books, and materials that may be borrowed or purchased.

National Center for Death Education
Judith Harding, Director
Mount Ida College
777 Dedham Street
Newton Centre, MA 02459
617-928-4649

Maintains a collection of print and audiovisual materials on all aspects of dying, death, and bereavement. Some may be borrowed on interlibrary loan. For information, contact coordinator of Resources.

The Centering Corporation and Grief Digest
P.O. Box 4600
Omaha, NE 68104
402-553-1200

Since 1977, has provided resources for bereaved individuals and the professionals who help them.

Forms for Assessment of the Bereaved Child

TABLE A1. Individual Factors in Childhood Bereavement

1. Age _____ years _____ months

   Date of birth _______
   Date of assessment ________

   a. Developmental stage:
      Freud ___________
      Erikson __________

   b. Cognitive level:
      Piaget ____________

   c. Temperamental characteristics:
      Thomas and Chess ________

2. Past coping/adjustment
   a. Home (as reported by parents): Good _____ Fair _____ Poor _____
   b. School (as reported by parents and teachers): Good _____ Fair _____ Poor _____
   c. Interpersonal/peers: Good _____ Fair _____ Poor _____
   d. Hobbies/interests (list) ______________________________

3. Global Assessment of Functioning: DSM-IV-TR, Axis V
   Current __________________ Past year __________________

4. Medical history (as reported by parents and pediatrician)—describe serious illnesses, operations, and injuries since birth, with dates and outcome ______________
   ____
   ____
   ____

5. Past experience with death/loss—give details with dates and outcome *or* complete Wolfelt's Loss Inventory
   ____
   ____
   ____

Note. This form is one part of the three-part assessment of the bereaved child, which also includes an assessment of death-related factors (Table A2) and family/social/religious/cultural factors (Table A4). From Webb (1993, p. 31). Copyright 1993 by The Guilford Press. Reprinted in *Social Work Practice with Children* (2nd ed., 2003) by Nancy Boyd Webb. Permission to photocopy this form is granted to purchasers of this book for personal use only (see copyright page for details).

TABLE A2. Death-Related Factors in Childhood Bereavement

1. Type of death
   Anticipated: Yes ______ No ______ If yes, how long? ______ or sudden ______
   "Timeliness" of death: Age of the deceased ______
   Perception of preventability:
   Definitely preventable ______ Maybe ______ Not ______
   Degree of pain associated with death:
   None ______ Some ______ Much ______
   Presence of violence/trauma: Yes ______ No ______
   If yes, describe, indicating whether the child witnessed, heard about, or was present and experienced the trauma personally. ______________________________
   ____
   ____
   Element of stigma: Yes ______ No ______
   If yes, describe, indicating nature of death, and degree of openness of family in discussing. ______________________________
   ____
   ____
2. Contact with deceased
   Present at moment of death? Yes ______ No ______
   If yes, describe circumstances, including who else was present and whether the deceased said anything specifically to the child. ______________________________
   ____
   ____
   Did the child view the dead body? Yes ______ No ______
   If yes, describe circumstances, including reactions of the child and others who were present. ______________________________
   Did the child attend funeral/memorial service/graveside service?
   Yes ______ No ______ Which? ______________________
   Child's reactions ______________________________
   ____
   Has the child visited grave/mausoleum since the death? Yes ______ No ______
   If yes, describe circumstances. ______________________________
   ____
   ____
3. Did the child make any expression of "goodbye" to the deceased, either spontaneous or suggested? Yes ______ No ______
   If yes, describe. ______________________________
   ____
   ____

Note. This form is one part of the three-part assessment of the bereaved child, which also includes an assessment of individual factors (Table A1) and family/social/religious/cultural factors (Table A4). From Webb (1993, p. 35). Copyright 1993 by The Guilford Press. Reprinted in *Social Work Practice with Children* (2nd ed., 2003) by Nancy Boyd Webb. Permission to photocopy this form is granted to purchasers of this book for personal use only (see copyright page for details).

TABLE A3. Recording Form for Childhood Grief Reactions

Age of child _____ years _____ months

Date of birth _______________
Date of assessment ___________

See the form "Individual Factors in Childhood Bereavement" [Table A1] for recording of personal history factors.

Date of death _______________

Relationship to deceased _______________

Favorite activities shared with deceased _______________

What the child will miss the most _______________

If the child could see the deceased again for 1 hour, what would he/she like to do or say? _______________

____

____

Nature of grief reactions (describe) _______________

____

Signs of the following feelings? Y = Yes; N = No

Sadness _____ Anger _____ Confusion _____ Guilt _____ Relief _____

Other _______________

Source of information on which this form has been completed

_____ Parent _____ Observation _____ Other

Note. This form is an extension of "Death-Related Factors in Childhood Bereavement" (Table A2), focusing specifically on the nature of the child's grief. From Webb (1993, p. 38). Copyright 1993 by The Guilford Press. Reprinted in *Social Work Practice with Children* (2nd ed., 2003) by Nancy Boyd Webb. Permission to photocopy this form is granted to purchasers of this book for personal use only (see copyright page for details).

TABLE A4. Family/Social/Religious/Cultural Factors in Childhood Bereavement

1. Family influences

   Nuclear family: How responding to death? Describe in terms of relative degree of openness of response.

   Very expressive ______ Moderately expressive ______ Very guarded ______

   To what extend is child included in family discussions/rituals related to the deceased?

   Some ______ A great deal ______ Not at all ______

   Extended family: How responding to death? Describe, as above, in terms of relative degree of openness of response.

   Very expressive ______ Moderately expressive ______ Very guarded ______

   To what extend do the views of the extended family differ or agree with those of the nuclear family with regard to the planning of rituals and inclusion of child?

   Very different ______ Very similar ______

   If different, describe the nature of the disagreement ______________________________

   ____

2. School/peer influences

   Child's grade in school ____________

   Did any of the child's friends/peers attend the funeral/memorial services?

   Yes ______ No ______

   Was teacher informed of death? Yes ______ No ______

   Did child receive condolence messages from friends/peers? Yes ______ No ______

   Does child know anyone his/her age who has been bereaved? Yes _____ No _____

   If yes, has child spoken to this person since the death? Yes ______ No ______

   Does child express feelings about wanting or not wanting peers/friends to know about the death? Yes ______ No ______

   If yes, what has the child said? ____

3. Religious/cultural influences

   What is the child's religion? __________________

   Has he/she been observant? Yes ______ No ______

   What are the beliefs of the child's religion regarding death? ____________________

   ____

   What about life after death? ____

   Has child expressed any thoughts/feelings about this? ___________________________

   ____

Note. This form is one part of the three-part assessment of the bereaved child, which also includes an assessment of individual factors (Table A1) and death-related factors (Table A2). From Webb (1993, p. 39). Copyright 1993 by The Guilford Press. Reprinted in *Social Work Practice with Children* (2nd ed., 2003) by Nancy Boyd Webb. Permission to photocopy this form is granted to purchasers of this book for personal use only (see copyright page for details).

Forms for Assessment of the Child in Crisis

TABLE A5. Crisis Situation Rating Form

1. Psychosocial and environmental problems: DSM-IV-TR, Axis IV
   List problems ____
   ____
2. Anticipated _____ or sudden _____ crisis (check where appropriate)
   Amount of preparation _____
3. Single _____ or recurring _____ crisis events
   (list discrete crisis events)
   a. ____________________ c. ____________________
   b. ____________________ d. ____________________
4. Solitary _____ or shared _____ crisis experience
   Number of other individuals involved _____
5. Presence of loss factor
   a. Separation from family members (list relationship and length of separation) _____
   ____
   ____
   b. Death of family members (list relationship and cause of death) _____
   ____
   ____
   c. Loss of familiar environment (describe) _____
   ____
   ____
   d. Loss of familiar role/status (describe; temporary or permanent? _____
   ____
   ____
   e. Loss of body part or function (describe, with prognosis) _____
   ____
   ____
6. Physical injury or pain (describe, with prognosis) _____
   ____
   ____
7. Presence of violence: verbal and/or physical
   a. Witnessed _____ Verbal _____ Physical _____
   b. Experienced _____ Verbal _____ Physical _____
8. Degree of life threat
   a. Personal (describe) _____
   ____
   ____
   b. To family members (describe, identifying relationship) _____
   ____
   ____
   c. To others (describe) _____
   ____
   ____
9. Other components of the crisis situation _____
   ____
   ____

Note. This form is one part of a three-part crisis assessment, which also includes an assessment of individual and support system factors. Adapted from Webb (1991, p. 11). Copyright 1991 by The Guilford Press. Reprinted in *Social Work Practice with Children* (2nd ed., 2003) by Nancy Boyd Webb. Permission to photocopy this form is granted to purchasers of this book for personal use only (see copyright page for details).

TABLE A6. Individual Factors in the Assessment of the Child in Crisis

1. Age ______ years ______ months
   Date of birth________
   Date of assessment _______
   a. Developmental stage:
      Freud ______
      Erikson ______
   b. Cognitive level:
      Piaget ______
   c. Moral development:
      Kohlberg ______
   d. Temperamental characteristics:
      Thomas and Chess ______
2. Precrisis adjustment
   a. Home (as reported by parents): Good ______ Fair ______ Poor ______
   b. School (as reported by parents and teachers): Good ______ Fair ______ Poor ______
   c. Interpersonal/peers: Good ______ Fair ______ Poor ______
   d. Medical (as reported by parents/and pediatrician)—describe serious illnesses, operations, and injuries since birth, with dates and outcome ______________________

      Past or current use of medications ______________________
3. Coping style/ego assessment (as reported by parents and observed in interviews with child)
   a. Degree of anxiety: High ______ Moderate ______ Low ______
   b. Ability to separate from parent: High anxiety ______ Some anxiety ______ No anxiety ______
   c. Child's ability to discuss "the problem/crisis situation": Good ______ Fair ______ None ______
   d. Presence of symptoms (describe, including the extent to which these bind the anxiety) ______________________
   e. Defenses (list, indicating appropriateness) ______________________
4. Child's past experience with crises ______________________
   a. Previous losses (list, giving age) ______________________
   b. Major life transitions/adjustments (list, giving age) ______________________
   c. Past experience with violence ______________________
   d. Other (describe) ______________________
5. Global Assessment of Functioning: DSM IV-TR, Axis V
   Current __________________ Past year __________________
6. Specific meaning of crisis to the child: Why is this crisis situation so difficult for *this* child at *this* time? (describe) ______________________

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Author Index

Achenbach, T. M., 4, 8, 10, 89, 90
Ainsworth, M. D. S., 28
Ajdukovic, D., 345, 346
Ajdukovic, M., 345, 346
Albert, V., 225
Alessi, J. J., 337
Alexander, D. W., 332
Allen-Meares, P., 190, 192, 193, 238, 342, 345, 352
Amenta, C. A., 211
Anderson, G., 225
Angelou, M., 42
Anthony, E. J., 7, 29, 83, 109
Aponte, H., 128
Armstrong, M. I., 192
Ashford, J. B., 11, 352
Atherton, C. R., 216
Aust, P. H., 228
Axline, V., 120, 121, 156, 157, 170

Backhaus, K., 228
Bank, S. P., 272, 273
Baris, M. A., 238, 255
Barker, P., 89, 131
Barkley, R. A., 132, 193, 350
Barnard, C. P., 290
Barth, R., 225
Bassuk, E. L., 51, 109
Bauer, S. K., 318, 326
Bean, N., 225, 231
Beck, A. T., 48
Begleiter, H., 298, 299
Bell, C. C., 16, 326, 340, 350
Bell, J. E., 121
Belsky, J., 291
Beneson, W. A., 339
Bepko, C., 297
Bergman, A., 28
Berliner, L., 169
Bernier, J. C., 131, 132, 133
Berrick, J., 225
Besharov, D. J., 290
Bevin, T., 158, 174, 327, 345
Birch, H. G., 12, 37
Bishop, K. K., 24, 352
Black, R., 290, 291, 314
Blakeslee, S., 241, 244, 245, 258
Blanchard, P., 121
Bloch, D. A., 120
Block, J., 171, 341
Bloom, M., 356
Bloomquist, M. L., 170
Boland, M. G., 343
Bonecutter, F., 224
Booth, C., 51, 352
Boulanger, M. D., 171
Bowker, J. P., 356
Bowlby, J., 27, 272
Boyd-Franklin, N., 343
Boyle, M. H., 10
Bradley, R., 90, 277, 332
Brandler, S., 169
Brieland, D., 216, 217, 224, 344
Broadhurst, D. D., 322
Bronfenbrenner, U., 12
Browne, A., 48
Bruni, F., 320, 322, 328, 340
Brunner, B., 217, 235

Bryson, K. R., 217, 225
Burge, D., 225
Burns, R. C., 128, 321

Caldwell, B., 90
Call, D. A., 171
Cameron, M., 316
Canino, I., 128
Caplan, G., 356
Carey, L. J., 121
Carlson, B. E., 318
Carrillo, D. F., 24
Carter, E. A., 30
Casper, L. M., 217, 225
Caywood, J. C., 9
Chadiha, L., 25
Char, W. F., 120
Chasin, R., 120, 126
Chess, S., 12, 37, 268, 350, 370, 377
Chethik, M., 157
Choi, N. G., 44, 48, 51, 102, 109
Cohen, D., 317
Cohler, B. J., 7, 29, 83, 109
Coleman, C., 291
Combrinck-Graham, L., 101
Congress, E. P., 24, 25, 74, 86
Conners, C. K., 4, 90
Copans, S., 290, 296
Corr, C. A., 316
Corr, D. M., 316
Costello, E. J., 10
Costin, L. B., 192, 193, 196, 216
Courtney, M., 225
Crawford-Brown, C., 345
Cross, T., 11
Cumella, S., 44

Dane, B. O., 171, 279
Dane, E., 132, 133
Daro, D., 290
Davies, B., 11, 27, 82, 83, 103, 168, 272, 273, 351
Davies, D., 10, 11, 27, 74, 82, 83, 103, 167, 168, 351
Dawson, G., 211
DeChillo, N., 44
DeJong, P., 351
Depta, J. L., 171, 279
deRidder, N. F., 171
Deutsch, C., 298
Devore, W., 24
DiLeo, J. H., 90, 151
Dillard, H. K., 203
Docker-Drysdale, B., 332
Doka, K. J., 218, 233, 237, 272
Dolgoff, R., 21, 22
Donenberg, B., 203
Dore, M. M., 46, 48
Doster, G., 171
Doyle, J. S., 174, 229, 318, 326
Dozois, D. J., 10
Dubrow, N., 316
Duenwald, M., 245
Duncan, G. J., 4
Dupper, D. R., 50
Duvall, E., 30

Edelbrock, C. E., 8, 89
Edelman, M. W., 341
Edelstein, S. B., 225
Emery, G., 48
English, A., 86, 207, 208, 295, 346, 348
Enzer, N. B., 277
Erikson, E. H., 12, 26, 36, 268, 275, 370, 377
Eth, S., 28, 174, 182, 317, 318, 326, 327
Evans, M. D., 258
Ewing, C. P., 7

Fallon, B. J., 344
Feig, L., 288, 290
Feigelman, B., 299
Feigelman, W., 299
Feinberg, F., 291, 292, 297
Ficaro, R., 299, 300
Fick, A. C., 317
Fink, M., 190
Finkelhor, D., 169
Fishman, H. C., 30, 129
Fletcher, K. E., 326, 327, 340
Fox, N. A., 318
Fox, R., 52, 84
Franklin, C., 195, 197, 343
Fraser, M. W., 11, 30, 83, 84, 351
Freud, A., 28, 36, 144, 155, 268, 370, 377
Friedman, R. M., 10
Friesen, B. J., 11, 12, 351
Furman, E., 272, 276

Gallo-Lopez, L., 171
Garbarino, J., 3, 12, 316, 338, 346, 350
Gardner, R. A., 272
Garfinkel, P., 131
Garland, J. A., 168
Garmezy, N., 83, 87
Garrett, K. J., 200
Garrity, C. B., 238, 255
Gelles, R. J., 316
Gentry, D. B., 339
George, H., 299, 332
Germain, C. B., 12, 103
Gerson, R., 74, 85
Gewirtz, B., 293, 294
Ghahramanlou, M., 171
Gibbs, J. T., 342

Gibelman, M., 15, 24
Gil, E., 121, 319, 326, 327
Gilliland, B. E., 218, 316
Ginott, H. G., 170
Ginsburg, E. H., 198
Ginsburg, G. S., 171
Gitterman, A., 12, 83, 171
Gittler, J., 288
Gleeson, J., 224
Glickman, H., 203
Goldberg, M. E., 292, 297
Goldberg, S. B., 272
Goldman, J., 90, 255
Goldstein, E., 290
Goleman, D., 8, 9, 10
Gonzales-Ramos, G., 290
Goodwin, D. W., 298
Gould, P., 90, 151
Graham, E. H., 101, 171
Green, J. W., 24
Gregory, P., 329, 330
Grollman, E., 272
Groves, B. M., 352
Guerney, B., 121
Guerney, L. F., 121
Guerry, S., 90, 255
Guidubaldi, J., 244
Guterman, N., 316
Guze, S. B., 298

Haapala, D. A., 51, 352
Haley, J., 30
Hall, K. B., 216, 361
Hallowell, E. M., 133
Halter, A. P., 50
Hancock, B. L., 192, 196, 201
Hann, D. M., 317
Harper-Dorton, K. V., 236, 290
Hartley, E., 187
Hartman, A., 4, 19, 74, 85
Hearn, K., 337
Heegaard, M., 258, 277, 282, 283, 329
Hepworth, D. H., 92, 102, 103, 125, 126, 196
Herbert, M., 236, 290
Herman, J. L., 28, 318
Hermansen, S. B., 298
Hershorn, M., 317
Hess, P. M., 354
Hewlett, S. A., 8, 341
Hickey, L. O., 171, 279
Hodges, V. G., 217
Hoffman, J., 171
Holzhalb, C. M., 24
Homeyer, L. E., 171
Hooker, C. E., 48
Howell, C. T., 4, 8
Huang, L. N., 13, 342
Hudgins, L., 225
Hudson, B. L., 317, 336
Hunt, K., 42, 53, 75, 81, 92, 93, 96, 112, 113, 114

Inhelder, B., 37, 265
Ismond, D. R., 87

Jackson, K., 44
Jacobsen, H. E., 171
James, B., 28, 158, 318, 323, 326
James, C. B., 338
James, R. K., 218
Jang, M., 15, 342
Jenkins, E. J., 16, 326, 340, 350
Jenson, J. M., 290
Johnson, H. C., 11, 12, 87, 350, 351
Johnson, J. H., 157, 168, 169
Johnson, M. E., 289, 290
Johnston, B., 217
Jordan, J. V., 318
Joslin, H., 272, 273

Kadushin, A., 14
Kadushin, G., 92
Kagan, R. M., 37, 51
Kahn, M., 272, 273
Kalter, N., 171, 177
Kamen, B., 293, 294
Kaplan, C. P., 272, 273
Karr-Morse, R., 7, 350
Kastenbaum, R. J., 265, 316
Katz-Leavy, J., 48
Kaufman, S. H., 128
Kazdin, A. E., 156
Keane, T. M., 28
Keith-Spiegel, P., 247
Kelly, J., 239, 245
Kendall, P. C., 158
Kight, M., 186
Kinard, E. M., 216
Kinney, J. M., 51, 352
Kirby, L. D., 83, 84
Kirk, R. S., 224
Klebanov, P. K., 4
Klein, M., 155
Kliman, G., 276
Knitzer, J., 8
Kolodny, R. L., 168
Koocher, C., 247
Korr, W., 344
Kostelny, K., 316, 350
Kovacs, M., 90
Krestan, J., 297
Kronenfeld, D., 44
Kurtines, W. S., 171

Lamont, E. R., 90
Landon, P. S., 33
Landreth, G. L., 120, 157, 364
Langevin, C., 171
LaPerriere, K., 120
Larsen, J. A., 92, 102, 103, 125, 126, 196
Lavin, C., 202
Leavitt, L. A., 318
LeCroy, C. W., 8, 11, 352
LeProhn, N. S., 90
Levine, C., 216, 343
LeVine, E. S., 157, 158, 237, 353, 356
Levinson, B. M., 332
Lewis, J. M., 244, 245
Lidz, T., 30
Lieberman, A. F., 24, 25
Lieberman, F., 12
Lindy, J., 182
Linsk, N., 224
Lorion, R., 316
Lourie, I. S., 48
Lowe, C. B., 4
Lowenberg, F. M., 21, 22
Lukas, S., 319, 322
Lum, D., 24
Lynn, M., 171, 173, 316

Mahler, M., 28
Main, M., 27, 361, 364, 366
Malchiodi, K., 74, 90, 151
Malekoff, A., 169
Maluccio, A. N., 32
Mannes, M., 32, 216, 226, 322, 352
Marans, S., 317
Margolin, G., 316
Margolis, J., 171
Marsiglia, F. F., 225
Mash, E. J., 10, 193, 350
Maslow, A., 100
Mason, S., 224
Mayer, J., 290, 291
McAllister, E., 225
McCurdy, K. L., 290
McDermott, J. F., 120
McElroy, C. Q., 171
McFarlane, A. C., 185, 326
McGoldrick, M., 30, 74, 85, 272, 273
McGonagle, E., 171, 178
McNamara, M., 121
McPartland, J., 211
McPherson, M., 288
Meyer, C. H., 59, 103
Michaels, D., 216, 343
Middleton-Jeter, V., 44
Millay, E. St. V., 265
Miller, D., 317
Miller, S. D., 351
Miller, W. M., 130
Miller-Cribbs, J., 25
Minuchin, P., 294
Minuchin, S., 30, 126, 129
Mishne, J. M., 157, 217
Moe, J., 306
Molnar, J., 4
Moreno, D. C., 9
Morgan, L. J., 217
Moustakas, C., 157
Mullen, E. J., 354
Murphy, L., 338

Nabe, C. M., 316
Nadel, M., 299
Nelson, K. E., 351
Newton-Logston, G., 192
Nierenberg, A., 171
Nisivoccia, D., 171, 173, 316
Norman, E., 30, 83
Northen, H., 60
Nuñez, R. D. C., 50

Oaklander, V., 151
Offord, D. R., 10
Olshansky, S., 203
Osofsky, J. D., 8, 317
Oster, G. D., 90, 151
Ozonoff, S., 211

Palombo, J., 34, 35
Papell, C. P., 168, 171
Pardo, C., 316
Paret, I. H., 12, 216, 225, 347
Parnell, M., 102, 110
Patterson, S. L., 225
Pecora, P. J., 90, 224
Pelcovitz, D., 169
Pelzer, D., 227, 228
Perlman, H. H., 52
Perry, B., 7, 350
Petitti, D. B., 291
Petyr, C., 56
Pfeffer, C. R., 90
Phillips, M. H., 44
Piaget, J., 37, 265, 268, 370, 377
Pinderhughes, E., 225
Pine, F., 28
Polombo, J., 132
Pope, L., 57
Pynoos, R. S., 28, 174, 182, 317, 318, 326, 327, 338

Quay, H. C., 4

Rafaelle, L., 171
Rando, T. A., 276, 328

Raphael, B., 272, 274, 276
Rapoport, J. L., 87
Rasbury, W. C., 157, 168
Ratey, J. J., 133
Rattray, M., 345
Reamer, F. G., 22
Redl, F., 170
Reed-Ashcraft, K., 224
Reid, S., 152
Remkus, J., 28, 347
Reysa, A., 171
Rhodes, J. E., 109
Rice, D. G., 246
Rice, J. K., 246
Richmond, M., 14
Roberts, A. R., 171
Roberts, B. S., 171
Rogers, C., 52
Rogers, P., 171
Roman, C. P., 169
Ronnau, J. P., 217, 351
Rooney, R. H., 49, 92, 102, 103
Rose, S. D., 167, 170, 171
Rosen, H., 272, 273, 276
Rosenbaum, A., 317
Rosenberg, E., 275
Rothman, B., 168, 171
Rothschild, M., 203
Rounds, K. A., 24, 25, 352
Rubin, L., 109
Rudolph, L. B., 143, 173
Rush, A. J., 48
Rutter, M., 10, 83, 109
Ryan, L. G., 8
Rynearson, E., 328

Sabatino, C. A., 82
Saleebey, D., 351
Sallee, A. L., 157, 158, 237, 341, 353, 356
Saltzman, W., 316
Sandau-Beckler, P., 32, 226, 352
Sarnoff, C. A., 167
Sarton, M., 315
Satir, V., 14, 130
Saxe, L., 11
Schaefer, C. E., 121, 152, 171
Schervish, P., 15, 24
Schiffer, M., 167, 170
Schlesinger, E. G., 24
Schlosberg, S. B., 51
Schowalter, J. E., 272
Schreier, S., 171, 177
Schteingart, J. S., 4
Schuckit, M. A., 298, 299
Schulsinger, F., 298
Schwab, F., 320
Schwartz, W., 171, 173
Sedlak, A. J., 322
Shahinfar, A., 318
Shapiro, J. R., 12, 216, 225, 347
Shapiro, V. B., 12, 216, 217, 225, 347
Shaw, B. F., 48
Sheafor, B. W., 33
Shennum, W. A., 9
Shinagawa, L. H., 15, 342
Shulman, L., 171
Siegel, D. H., 131, 132, 133
Siegel, D. J., 350
Siegel, L. J., 157, 168
Silver, S. E., 10
Silverman, N., 11
Silverman, P., 237
Silverman, W. K., 171
Slavson, S. R., 169, 170
Smith, R. S., 41, 43, 44, 45, 46, 48, 49, 53, 58, 59, 66, 75, 78, 80, 81, 82, 85, 86, 92, 93, 95, 96, 97, 98, 99, 100, 101, 102, 103, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 343
Snyder, N. G., 44, 48, 51, 102, 109, 314
Solomon, J., 27
Spielberger, C. D., 90
Sroufe, L. A., 28
Stahlman, S. D., 284
Stark, K. D., 171, 177
Steele, W., 328
Stein, C. L'E., 90, 255
Steiner, G. L., 343
Stern, D., 12
Stoop, D., 174, 229
Stott, F. M., 3
Strand, V. C., 158
Straughan, J. H., 122
Straussner, S. L. A., 81, 288, 289, 290, 294, 297, 298, 299
Suarez, Z. E., 128
Sullivan, D. F., 172
Sweeney, D. S., 171

Tait, D. C., 171, 279
Terr, L. C., 157, 326, 347
Thomas, A., 12, 37, 78, 268, 350, 370, 377
Thompson, C. L., 143, 173
Thyer, B. A., 24
Timberlake, E. M., 82
Tonning, L. M., 216, 225, 230, 231
Tormes, Y. M., 290
Tracy, E. M., 48, 51, 290, 292, 293, 295
Turkel, D., 190
Turner, F. J., 193
Tyson, K., 56

Vail, P. L., 132
Vaillant, G., 298

Vallianatos, C., 224
Vanderkloot, J., 102, 110
vanderKolk, B. A., 28, 182
Vastola, J., 171
Vinter, R., 171
Vostanis, P., 44

Wachtel, E. F., 29, 31, 56, 120, 121, 126, 159
Wallerstein, J., 239, 241, 244, 245
Walsh, F., 272, 273
Walton, E., 32, 226
Washington, R. O., 36, 190, 238, 342, 363, 366
Waterman, J., 225
Waters, E., 28
Webb, N. B., 11, 12, 13, 15, 17, 24, 25, 32, 35, 55, 61, 68, 69, 70, 71, 74, 86, 122, 124, 125, 130, 148, 151, 174, 186, 218, 222, 228, 233, 240, 250, 265, 266, 267, 268, 269, 270, 271, 276, 277, 323, 324, 325, 326, 333, 345, 353, 364, 370, 371, 372, 373, 376, 377
Wegscheider, S., 299
Weick, A., 57
Weil, M., 24, 352
Welsh, B. L., 190, 238, 342
Werner, E. E., 109
Wertz, R., 290
Wetherbee, K. M., 90
Wewers, S., 317
White, T. B., 120, 126
Whittaker, J. K., 48, 224
Wiley, M. S., 7, 350
Wilkerson, I., 4, 7
Wilson, J. P., 28, 352
Winnicott, D. W., 151, 250
Winokur, G., 298
Winters, K., 290
Wolfenstein, M., 276
Wolin, S., 83
Woltmann, A. G., 152
Worden, J. W., 237
Wu, S. J., 13, 345

Yalom, I., 174
Youngstrom, N., 291

Zalba, S., 173
Zayas, L. H., 128
Zevon, M., 300
Zilbach, J. J., 30

Subject Index

Abandonment
intervention options, 229–230
out of home placement and, 216, 234
Abuse
see also Physical abuse; Sexual abuse
affect of, 317–318
assessment of, 319–320, 321*t*, 322–324, 323*t*
case example, 227–228, 230–231
description, 316, 339–340
group work and, 337–338
intervention options, 337–338
mandatory reporting of, 296
one-to-one work with the child, 146–147, 148
out of home placement and, 216–217, 218, 219*f*, 226–227
psychodynamic child therapy and, 158
in substance abusing families, 290–291
Abuse, physical
see also Abuse
case example, 5–7, 320, 322
indicators of, 320, 321*t*
making referrals as a result of, 32
witness to, 6, 7, 317–318
Abuse, sexual
see also Abuse
"Good Touches/Bad Touches" curriculum, 190
indicators of, 322–323*t*
making referrals as a result of, 32
psychodynamic child therapy and, 158
in substance abusing families, 290–291
Academic functioning, single-parent homes and, 238
Administrators, school, 201–202
Adoption Assistance and Child Welfare Reform Act (P.L. 96-272)
see also Permanency planning; Placement, out of home
description, 224
working with substance abusing families and, 293
Adoption of refugee children
case example, 347–349
losses experienced by, 345, 346*t*
Advocacy
AIDS and, 343
merging goals with clinicians, 343–344
in school-based intervention, 211–212
Aggression, 9
see also Behavioral problems
AIDS
see also HIV
and the need for services, 343
out of home placement and, 216, 233
Amendments to Education of the Handicapped Act, 352
Anger
nontraditional families and, 244
teaching skills to manage, 339
Animal-assisted therapy
case example, 334–336
description, 332–333*f*, 336
programs and certifications for, 366

Anxiety
see also Emotional problems
crisis intervention and, 181–182
description, 9–10
divorce and, 244–245
one-to-one work with the child and, 148
as a result of trauma, 16
Archway Program, 300–303, 301*f*, 302*f*
see also Substance abuse/dependence
Art therapy
see also Interventions; Play therapy
in Banana Splits group, 179–180*f*
Body Map of Feelings exercise, 277–278
in crisis intervention group, 183*f*
description, 150–151
family violence and, 328–330*f*, 329*f*
materials, 54–56, 55*f*
working with substance abusing families and, 300–302*f*, 303*f*
Assessment
biopsychosocial, 59–99
case example, 75, 77–78, 80–82, 92–96, 134–135*f*, 136*f*
in child welfare system, 232
collateral information, 63
culturagram use, 86–87
of cultural sensitivity, 25
description, 59–61
determining who/what, 61–63, 62*f*
developmental history form, 74–75, 76*t*–77*t*
drawings during, 90–91
DSM-IV-TR use, 87–88
eco-map use, 85–86
of family violence, 319–320, 321*t*, 322–325*t*, 323*t*
feedback/review process of, 97–98
genogram use, 84–85
guidelines for contacts with parents, 64–67
guidelines for contacts with the child, 67–73*f*
identifying risk and protective factors, 82–84*t*, 351
impact of family circumstances, 239–240
making referrals as a result of, 32
order of, 64
placement into a group and, 172–173
posttraumatic stress disorder, 324, 326–328
process of, 61
projective questions during, 91
sample biopsychosocial assessment, 92–96
school-based intervention and, 201, 203–204*f*, 205*f*
summarizing the data from, 91–92
testing, 89–90
tripartite forms, 75, 78*t*–80*t*
Attachment
see also Development
animal-assisted therapy and, 332–333*f*
case example, 347
effects of violence on, 318
object loss, 237
out of home placement and, 226–227
role of in development, 27–28
Attention-deficit/hyperactivity disorder
case example, 134–137*f*, 138*f*, 139–141, 206–211
etiology of, 350–351
working with, 131–133, 352
Attention problems
see also Emotional problems
description, 9
noting during assessment, 72, 73*t*
Autism, case example, 206–211

Banana Splits groups, 178–179, 180*f*, 181*f*
see also Divorce; Group work
Behavior modification
interventions with ADHD children, 132–133, 137, 138–142, 138*f*
in sleep disorders, 162–163, 165–166
Behavioral problems
cognitive-behavioral treatment of, 158–159
etiology of, 350–351
increased rates of, 8–11
recognizing, 28–29
residential treatment placement and, 225–226
in substance abusing families, 291
testing and, 89–90
Bereavement
see also Grief work
case examples, 259–265*f*, 279–285*f*
forms for, 370–377
intervention options, 276–279
resources, 368
sibling death and, 272–276
tripartite assessment, 266–268*t*, 269*t*–270*t*, 271*t*–272
Best interest of the child
beliefs regarding, 215–217
in custody disputes, 247
Biological predisposition, role of, 350–351
Biopsychosocial assessment; *see* Assessment
Blended family. *see* Reconstituted family
Board games
see also Play therapy
case example, 280, 284

description, 152–153
examples of, 55*f*
family violence and, 332
use of in grief work, 277
Body Map of Feelings exercise
see also Art therapy
case example, 282, 283*f*
description, 277–278
family violence and, 329–330*f*
Bonding, role of in development, 27–28
see also Development
Books for children
regarding divorce, 244, 258
using in situations of family violence, 331*f*
using with substance abusing families, 303–304
Boundaries
in nontraditional families, 241, 243
in single-parent homes, 238
in substance abusing families, 290–291

Card games
description, 152–153
examples of, 55*f*
family violence and, 332
Storytelling Card Game, 277
Case examples
ADHD and family work (Tim), 134–137*f*, 138*f*, 139–141
affected by illness and death (Sabrina), 259–265*f*
animal-assisted therapy (Marta), 334–336
assessment (Barbie), 75, 77–78, 80–82, 86–87, 88–89, 92–96
custody dispute (Malcolm), 247–255, 250*f*, 251*f*, 253*f*
death as a result of abuse (Elisa), 320, 322
eco-map (Barbie), 47*f*
effects of environment (Jacob and Damien), 4–8
engagement (Barbie), 100–103
foster care (Dave Pelzer), 227–228
foster child who is HIV positive (Maria), 228
goal setting (Barbie), 105–108, 106*f*
homelessness (Barbie), 42–44, 43*f*
identification for services (Barbie), 44–46
intervention options (Barbie), 108–110
intervention options (Sabrina), 279–285, 280*f*, 281*f*, 283*f*
kinship care (Kayla), 231–232
kinship care (Ricky), 230–231
one-to-one with the child (Linda), 159–163*f*, 164*f*, 165–166
refugee adoption (Alexa), 345–349
school-based intervention (Eli), 206–211
school-based intervention (Johnny), 199
separation anxiety (Anna), 144
sibling death (Sabrina), 273–276
substance abusing family (Vanessa and Vernon), 304–307*f*, 308*f*–310*f*, 311*f*
team approach to treatment (José), 18–21, 20*f*
tripartite assessment (Sabrina), 268*t*, 269*t*–270*t*, 271*t*–272
update on Barbie, 112–115
use of puppets in individual work (Tammy), 145–146
World Trade Center attacks, 184–186, 186–188
Case management
in child welfare, 232–233
commitment to, 51–52
coordination of services, 51–52
in homeless family, 42–44, 43*f*
Child Abuse Prevention and Treatment Act (P.L. 93-247), 319–320
Child Behavioral Checklist, 89–90
see also Assessment
Child-centered therapy
description, 156–157
exclusion of parents from, 120–121
integrating with family therapy, 353–354
Child welfare
see also Role of social worker
history of, 13–14
research, 354–355
Children of alcoholics and addicts (COA) group, 304–307*f*, 308*f*–310*f*, 311*f*
Children of color
kinship care and, 225
orphaned by AIDS, 343
out of home placement and, 216–217
poverty and, 342
Children's Apperception test, 89
see also Assessment
Clay
see also Play therapy
description, 151
use of in grief work, 277
Cognitive-behavioral treatment, 158–159, 355
Collaboration, interagency
commitment to, 51–52
description, 110–111, 351–352
following assessment, 97–98
group work and, 176
issues in, 198–199
need for, 48–52
relationships in, 56–57
between school, home and community, 190–191

Communication
in school-based intervention, 200–201
with schools, 191
via play, 54–56, 55*f*, 143, 155
Community violence
see also Violence
description, 317, 339–340
group work and, 337–338
preventive approaches to, 338–339
Conduct disorders, as a result of trauma, 16
Confidentiality
see also Ethics
in family work, 122–123, 131
in group work, 177*f*–178
in interagency collaboration, 56–57
issues of, 22–23
in school-based intervention, 200
in working with nontraditional families, 255–257
in working with substance abusing families, 294–296
Conflict management skills, teaching, 339
Consent to treatment, 23
see also Ethics; Resistance
Convention on the Rights of the Child, 344–345
Coping skills
see also Resilience
description, 29–30
identifying in crisis interventions, 186
Countertransference in family work, 130
Crisis
family, 31–32
out of home placement as, 218–219
Crisis intervention
see also Interventions; Trauma
animal-assisted therapy and, 333*f*
case examples, 184–186, 186–188, 334–336
debriefing group, 174, 188–189
group work as, 181–184*f*
psychodynamic child therapy and, 157–158
training in, 16
Culturagram, 25, 86–87
see also Assessment
Cultural curiosity, 15
Culturally sensitive practice
description, 24–26, 352–353
in family work, 128–129
need for, 342
one-to-one work with the child and, 148
providing, 15
Custody disputes
see also Divorce
case example, 247–255, 250*f*, 251*f*, 253*f*
description, 245–247, 246*f*
ethical challenges in working with, 255–257
stresses related to, 238–239

Death
case example, 259–265, 262*f*, 263*f*, 264*f*
developmental ability to understand, 265–266*t*
as a result of domestic violence, 316, 327–328
of sibling, 272–276
tripartite assessment, 266–268*t*, 269*t*–270*t*, 271*t*–272
Debriefing, group, after disaster
case example, 184–186, 186–188
description, 181–184
Delinquency, 9
see also Behavioral problems
Denial
description, 292
treatment and, 296–297
Depression
see also Emotional problems
description, 9–10
as a result of trauma, 16
testing and, 90
Detoxification programs, 297
see also Substance abuse/dependence
Development
ability to understand death and, 265–266*t*, 273
assessment and, 60, 65–66, 72, 73*t*
developmental history form, 74–75, 76*t*–77*t*
of the family, 30
family identity and, 230
family violence and, 324
out of home placement and, 226–227
understanding, 11, 27–30
Diagnosis
DSM-IV-TR classifications of, 87–88
substance use disorders, 287–288
Disability
classification of, 193, 194*t*–195*t*, 203–204*f*
parents of children with, 203
terminology, 202–203
Disenfranchised grief
see also Placement, out of home
description, 218
in nontraditional families, 237
understanding, 233
Divorce
see also Custody disputes; Reconstituted family; Single-parent homes
Banana Splits groups for children of, 178–179, 180*f*, 181*f*

case example, 247–255, *250f*, *251f*, *253f*
custody battles, 238–239, 245–247, *246f*
ethical challenges in working with, 255–257
intervention goals, 240–241, 243–245, 257
issue of loss in, 236–238
stresses related to, 236, 238–239

Dolls
see also Play therapy
case example, 262–263
description, 151–152
materials, *55f*

Domestic violence
see also Violence
assessment of, 319–320, *321t*, *322–325t*, *323t*
child's exposure to, 317–318
description, 316, 339–340
group work and, 337–338
preventive approaches to, 338–339

Draw-A-Family technique, *68–70f*, *71f*, 150–151
see also Art therapy

Draw-A-Person technique, *68–70f*, *71f*, 150–151
see also Art therapy

Drawing exercises. *see* Art therapy

DSM-IV-TR, 87–88, 287–288
see also Assessment

Eco-map
see also Assessment
in assessment, 324
case example, 19, *20f*, 46, *47f*
description, 85–86

Ecological perspective
assessment and, 61
case example, 4–8
description, *5f*
on etiology, 11–13
need for, 4
training and, 32–33

Education for All Handicapped Children Act (P.L. 94-142), 192–193
see also School-based interventions

Education, providing to homeless children, 50–51

Emotional problems
etiology of, 350–351
increased rates of, 8–11
recognizing, 28–29
residential treatment placement and, 225–226
testing and, 89–90

Engaging potential clients
description, 48–50, 100–103
effects of violence on, 318

Ethics
confidentiality issues, 22–23
consent to treatment issues, 23
description, 21–22
in family work, 130–131
in school-based intervention, 200
substance abuse/disorder and, 292–296
in working with nontraditional families, 255–257

Ethnic sensitivity
see also Culturally sensitive practice
description, 24–26
need for, 342

Etiology
of attention-deficit/hyperactivity disorder, 131–132
ecological perspective of, 11–13
interacting factors of, 350–351

Evaluation. *see* Assessment

Family
see also Kinship placement; Reconstituted family; Single-parent homes
attention-deficit/hyperactivity disorder and, 133
beliefs regarding, 215–217
crisis within, 31–32
development of, 30
factors precipitating placement, 221
homeless, 42–44, *43f*, 50–51, 102–103
identity, 230
involvement in treatment, 122–130
reciprocity of, 31
roles in substance abusing families, 299–300
structures of, 235–236, 257
substance abusing, 288–292
violence within, 316; *see also* Abuse; Domestic violence

Family-child influences, understanding, 30–32

Family Educational Rights and Privacy Act (P.L. 93-380), 22–23, 200
see also Confidentiality

Family therapy
see also Integrated child and family model
bereavement, 278–279
description, 125–130
ethical challenges in, 130–131
exclusion of children from, 119–120
historical perspective, 14
integrating with child therapy, 353–354
with substance abusing families, 297–298

Feelings Faces exercise
  see also Art therapy
  case example, 280–281*f*
  description, 277–278
  family violence and, 329*f*–330
Feelings-in-the-Bottle activity
  see also Art therapy; Substance abuse/dependence
  case example, 306–307*f*, 308*f*–310*f*
  description, 300–302*f*, 301*f*
Feelings-in-the-Drug-Syringe activity, 300, 303*f*
  see also Art therapy; Substance abuse/dependence
Fetal alcohol syndrome, 291
  see also Substance abuse/dependence
Foster care placement
  see also Placement, out of home
  case example, 227–228
  description, 224, 234
  interventions with the foster parents, 232
  purpose of, 294

Games, board
  see also Play therapy
  case example, 280, 284
  description, 152–153
  examples of, 55*f*
  family violence and, 332
  "Operation" game, 277, 280, 284
  "Talking, Feeling and Doing" Game, 55*f*, 153, 332
  use of in grief work, 277
Games, card
  description, 152–153
  examples of, 55*f*
  family violence and, 332
  Storytelling Card Game, 277
Genogram, 84–85
  see also Assessment
Goals
  of clinicians and advocates, 343–344
  setting, 104–108, 106*f*
  in working with nontraditional families, 240–241, 243–245
"Good Touches/Bad Touches" curriculum, 190
"Goodness of fit," 12
Grandparent custody; *see* Kinship placement
Grief work
  see also bereavement
  case example, 259–265*f*, 279–285*f*
  forms for assessment, 370–377
  intervention options, 276–279
  out of home placement and, 228–230*f*, 234
  tripartite assessment of bereaved child, 266–268*t*, 269*t*–270*t*, 271*t*–272
Group work
  for abused children, 337–338
  Banana Splits example of, 178–179, 180*f*, 181*f*
  with bereavement, 278–279
  case examples, 184–186, 186–188, 304–307*f*, 308*f*–310*f*, 311*f*
  confidentiality issues in, 177–178
  as crisis intervention, 181–184*f*
  description, 188–189
  format and structure, 175–176
  leadership of, 176
  membership determination, 172–174
  rationale for, 167–169
  rules for, 176–177
  in substance abusing families, 300–303, 301*f*, 302*f*
  types of, 169–172
Guardian *ad litem*
  see also Divorce
  case example, 247–255, 250*f*, 251*f*, 253*f*
  description, 246–247
  ethical challenges in working with, 256–257

History of social work with children
  description, 13–14
  group work, 169–170
  play therapy, 155–156
  research, 354–355
HIV
  see also AIDS
  case example, 228
  and the need for services, 343
  out of home placement and, 233
Homelessness
  case example, 42–44, 43*f*
  engaging clients and, 102–103
  and the need for services, 342–343
  school-based service model and, 50–51
Homogeneity in groups, 173–174
  see also Group work

Illness, case example, 259–265*f*
Immigrant children
  case example, 345, 347–349
  losses experienced by, 346*t*
  rights of, 345
Individualized education program, 192–193
Individuals with Disabilities Education Act (P.L. 101-416), 193, 202
Integrated child and family model
  see also Family therapy
  bereavement work, 278–279
  description, 121–122, 141–142

Integrated model of group work, 171–172, 188–189
see also Group work
Intervention, crisis
see also Interventions; Trauma
animal-assisted therapy and, 333*f*
case examples, 184–186, 186–188, 334–336
debriefing group, 174, 188–189
group work as, 181–184*f*
psychodynamic child therapy and, 157–158
training in, 16
Interventions
see also Art therapy; Family therapy; Group work; Play therapy; School-based interventions
attention-deficit/hyperactivity disorder and, 132–133, 140*t*
for bereaved children, 276–283*f*, 280*f*, 281*f*
case example, 136–137, 139
with the family, 122–130
focus of, 103–104
with foster parents, 232
guided by research, 354–355
involving parents in, 352
need for, 342–343
one-to-one with the child, 146–148
options, 108–110
out of home placement and, 227, 228–230*f*
progress tracking, 111–112
selecting, 15
setting goals for, 104–108, 106*f*
substance abuse/dependence, 296–300
trends in, 349–350
in working with nontraditional families, 240–241, 243–245
Interventions, school-based
with bereavement, 279
case example, 199, 206–211, 345, 347–349
communication and, 200–201
comprehensive evaluation and, 203–204*f*, 205*f*
ethical challenges in, 200
legislation and, 191–193
out of home placement and, 227
regarding violence, 337–338, 339
role of social worker in, 193, 195–198, 211–212
substance abuse/dependence prevention in, 312

Job training, 50–51
"Joining" process, 126

Kinship placement
see also Placement, out of home
case examples, 230–231, 231–232
description, 216–217, 224–225, 234

Learning disability
classification of, 193, 194*t*–195*t*, 203–204*f*
parents of children with, 203
terminology, 202–203
Legislation
Adoption Assistance and Child Welfare Reform Act (P.L. 96-272), 224, 293
Amendment to Education of the Handicapped Act, 352
Child Abuse Prevention and Treatment Act (P.L. 93-247), 319–320
disability classifications, 194*t*–195*t*
Education for All Handicapped Children Act (P.L. 94-142), 192–193
Family Educational Rights and Privacy Act (P.L. 93-380), 22–23, 200
Individuals with Disabilities Education Act (P.L. 101-416), 193, 202
and schools, 191–193
Lifebook
case example, 248
description, 228–229
Loss
case example, 259–265, 262*f*, 263*f*, 264*f*
due to AIDS, 233
group membership and, 174
intervention options, 229–230
in nontraditional families, 236–238, 244, 257
out of home placement and, 227
by refugee children, 345, 346*t*, 347–349
in substance abusing families, 291–292

Maltreatment. *see* Abuse
Mandatory reporting
Child Abuse Prevention and Treatment Act (P.L. 93-247) and, 319–320
impact of, 294
Marital relationship, historical perspective, 14
see also Family
Mental disorders
DSM-IV-TR classifications of, 87–88
etiology of, 350–351
recognizing, 28–29
testing and, 89–90
Meta House, 297
see also Substance abuse/dependence

National Association of Social Workers, 22
see also Ethics

Neglect
see also Abuse
case example, 231–232
out of home placement and, 219*f*
in substance abusing families, 290–291

One-parent family; *see* Single-parent homes
Out of home placement
see also Foster care placement; Kinship placement
case example, 295
description, 216–217
determining need for, 217–219*f*, 220*f*–221*f*, 222*f*–223*f*
intervention options, 228–230*f*
issues for children in, 226–227
levels of, 223–226
permanency planning and, 216, 224
as a result of substance abuse, 291–292
working with substance abusing families and, 293–294

Parenting special needs children, 203
Peer pressure, 168–169
Permanency planning
see also Placement, out of home
Adoption Assistance and Child Welfare Reform Act (P.L. 96-272), 224
failure of, 216
Physical abuse
see also Abuse
case example, 320, 322
indicators of, 320, 321*t*
making referrals as a result of, 32
Pitfalls in work with children, avoiding, 33–34
Placement, out of home
see also Foster care placement; Kinship placement
case example, 295
description, 216–217
determining need for, 217–219*f*, 220*f*–221*f*, 222*f*–223*f*
intervention options, 228–230*f*
issues for children in, 226–227
levels of, 223–226
permanency planning and, 216, 224
as a result of substance abuse, 291–292
working with substance abusing families and, 293–294
Play
see also Play therapy
during the assessment, 67–72*f*
as communication, 54–56, 55*f*, 155
in family work, 127–128
therapeutic, 153–155
in working with children, 54–56, 55*f*
Play-Doh, 55*f*, 151
see also Play therapy
Play therapy
see also Art therapy; Interventions
approaches, 155–159
bereavement, 276–278
description, 143, 153–155
historical perspective, 14
materials, 54–56, 55*f*
one-to-one with the child, 146–148
suppliers of materials for, 367
techniques, 149–153
themes in, 72, 73*t*, 154
training programs, 365–366
Posttraumatic stress disorder
see also Trauma
assessment of, 324
case example, 206–211
components of, 326–327
group membership and, 174
prevention of, 182–183
working with, 16
Poverty
engaging clients and, 101–102
impact on children, 15
kinship care and, 225
meeting the needs of children within, 3–4
and the need for services, 342
in nontraditional families, 238
Prevention, levels of, 356–357
Projective questioning, 91
see also Assessment
Protective factors
assessment of, 83–84*t*
description, 351
Psychodynamic child therapy, 157–158
Psychosocial component, 60
see also Assessment
Puppets
see also Play therapy
case example, 145–146
description, 55*f*, 152

Reciprocity of child and family effects, 31
Reconstituted family
see also Divorce; Family
description, 236
ethical challenges in working with, 255–257
intervention goals, 240–241, 243–245, 257
issue of loss in, 236–238
stresses related to, 238–239

Referrals, making, 32
Refugee children
  case example, 347–349
  losses experienced by, 345, 346*t*
Relationships
  with clients, 52–56, 55*f*
  divorce and, 244–245
  with other professionals, 56–57
  with parents, 65
  therapeutic, 154
"Rescue fantasy"
  description, 33–34
  in family work, 130
  working with substance abusing families and, 293
Research, integrating with practice, 354–355
Residential treatment placement, 225–226
  see also Placement, out of home
Resilience
  assessment of, 83–84*t*
  description, 10–11, 29–30, 351
Resistance, 23
Rights of the child, 23, 344–345
Risk factors
  assessment of, 83–84*t*
  description, 351
Role of social worker
  see also Team approach
  case example, 18–21, 20*f*
  in child welfare, 232–233
  in schools, 193, 195–198, 211–212
  in special education, 205–206
  as specified in the Education for All Handicapped Children Act, 192–193
  training and, 32–33
  understanding, 17–18
  in working with substance abusing families, 293

School administrators, 201–202
School-based interventions
  with bereavement, 279
  case example, 199, 206–211, 345, 347–349
  communication and, 200–201
  comprehensive evaluation and, 203–204*f*, 205*f*
  ethical challenges in, 200
  legislation and, 191–193
  out of home placement and, 227
  regarding violence, 337–338, 339
  role of social worker in, 193, 195–198, 211–212
  substance abuse/dependence prevention in, 312
Self-blame among nontraditional families, 244
Self-esteem
  animal-assisted therapy and, 332
  financial issues and, 238
  group work and, 172, 312
  one-to-one work with the child and, 147, 148
Separation anxiety
  case example, 144, 145–146
  in family work, 123–124
  noting during assessment, 72, 73*t*
Sexual abuse
  see also Abuse
  "Good Touches/Bad Touches" curriculum, 190
  indicators of, 322–323*t*
  making referrals as a result of, 32
  psychodynamic child therapy and, 158
  in substance abusing families, 290–291
Siblings
  death of, 272–276
  in family work, 124–125
Single-parent homes
  see also Divorce
  ethical challenges in working with, 255–257
  intervention goals, 240–241, 243–245, 257
  issue of loss in, 236–238
  meeting the needs of children within, 3–4
  stresses related to, 236, 238–239
Social problems, 9
  see also Behavioral problems
Socialization, via group work, 168
Socioeconomic disadvantages. *see* Poverty
Somatization disorders, as a result of trauma, 16
Special education
  see also Disability; School-based interventions
  case example, 206–211
  comprehensive evaluation and, 203–204*f*, 205*f*
  role of social worker in, 205–206
Special needs children
  see also Disability
  parenting, 203
  terminology of, 202–203
Squiggle game
  see also Art therapy
  case example, 250–254, 251*f*, 253*f*
  description, 151
State-Trait Anxiety Inventory, 90
  see also Assessment

Storybooks
regarding divorce, 244, 258
using in situations of family violence, 331*f*
using with substance abusing families, 303–304
Storytelling Card Game, 277
Strengths
description, 351
identifying in crisis interventions, 186
Stress
in nontraditional families, 238–239, 257
of parental substance abuse, 288–291
Substance abuse/dependence
case example, 230–232, 259–265*f*, 304–307*f*, 308*f*–310*f*, 311*f*
contributing factors, 298–300
effects of substances, 289*t*
ethical challenges in, 292–296
exposure to, 287
in family of origin, 288–292, 311–312
group work and, 300–304, 301*f*, 302*f*, 303*f*
impact on children, 15
intervention options, 296–300
out of home placement and, 216
terminology, 287–288
Suicide risk, 90
Supervision of clinical social workers, 34–35

Team approach, 18
see also Role of social worker
Temperament
match between child and parent, 12
role of, 350
Termination, 112
Terminology of special needs, 202–203
see also Disability
Themes in play
see also Play therapy
description, 154
noting during assessment, 72, 73*t*
Therapy, art
see also Interventions; Play therapy
in Banana Splits group, 179–180*f*
Body Map of Feelings exercise, 277–278
in crisis intervention group, 183*f*
description, 150–151
family violence and, 328–330*f*, 329*f*
materials, 54–56, 55*f*
working with substance abusing families and, 300–302*f*, 303*f*
Therapy, family
see also Integrated child and family model
bereavement, 278–279
description, 125–130
ethical challenges in, 130–131
exclusion of children from, 119–120
historical perspective, 14
integrating with child therapy, 353–354
with substance abusing families, 297–298
Therapy, play
see also Art therapy; Interventions
approaches, 155–159
bereavement, 276–278
description, 143, 153–155
historical perspective, 14
materials, 54–56, 55*t*
one-to-one with the child, 146–148
suppliers of materials for, 367
techniques, 149–153
Time line, 229
Toys, 54–56, 55*f*
see also Play therapy
Training of clinical social workers
in child development, 27–30
in crisis intervention, 16
description, 26, 32–33
in play therapy, 149
programs and certifications for, 365–366
in school-based intervention, 197–198
Trauma
see also Crisis intervention; Posttraumatic stress disorder
animal-assisted therapy and, 333*f*
crisis intervention and, 181–182
difference from victimization, 327–328
exposure to, 317–318
group membership and, 174
one-to-one work with the child and, 147, 148
out of home placement as, 218–219
in the preverbal child, 349
psychodynamic child therapy and, 157–158
working with, 16
Tripartite assessment
see also Assessment
of the bereaved child, 266–268*t*, 269*t*–270*t*, 271*t*–272
description, 61–63, 62*f*
of family circumstances, 240, 241*f*, 242*t*–243*t*
of family violence, 323–324, 325*f*
following the World Trade Center attack in 2001, 186–188
forms, 75, 78*t*–80*t*
out of home placement and, 218–219
use of, 31–32

Unmarried mothers; *see* Single-parent homes

Victimization, difference from traumatization, 327–328
Videotapes, use of, 303–304
Violence
see also Community violence; Domestic violence
assessment of, 319–320, 321*t*, 322–325*t*, 323*t*
description, 315, 339–340
exposure to, 317–318
in the family, 316
group membership and, 174
group work and, 337–338
impact on children, 15
intervention options, 328–333, 337–338
one-to-one work with the child and, 147
preventive approaches to, 338–339
psychodynamic child therapy and, 158
Violence, community
see also Violence
description, 317, 339–340
group work and, 337–338
preventive approaches to, 338–339
Violence, domestic
see also Violence
assessment of, 319–320, 321*t*, 322–325*t*, 323*t*
child's exposure to, 317–318
description, 316, 339–340
group work and, 337–338
preventive approaches to, 338–339

Welfare system
see also Placement, out of home
historical perspective, 14
role of social worker in, 232–233
Withdrawn behavior, 9
see also Behavioral problems
Workbooks
family violence and, 331*f*
regarding divorce, 244, 258
use of in grief work, 277–278
working with substance abusing families and, 303–304
World Trade Center attacks
see also Crisis intervention
in 1993, 184–186
in 2001, 186–188, 334–336

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