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**WHEN REUNIFICATION WORKS: A FAMILY STRENGTHS PERSPECTIVE**

by

**Antonia Cordero**

**A dissertation submitted to the Graduate Faculty in Social Welfare  
in partial fulfillment of the requirements for the degree of Doctor  
of Social Welfare, the City University of New York**

**2000**

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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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**Abstract****WHEN REUNIFICATION WORKS: A FAMILY STRENGTHS PERSPECTIVE****by****Antonia Cordero****Adviser: Professor Irwin Epstein**

**This qualitative research study examines the successful casework reunification efforts conducted at a voluntary agency. Interventions described are intended to promote and support the psychosocial strengths of families; that is, the Family Strengths Perspective. The study is based on an exploratory retrospective analysis of 18 foster/kinship records (9 foster and 9 kinship case records). The psychosocial stages of the helping process (exploration, assessment, intervention and termination) are used as a heuristic framework to identify patterns of family characteristics and casework efforts that were decisive in the reunification process of families, in which substance abuse, neglect or domestic violence were identified as reasons for placement by the court. A comparative examination of the helping process of the study's mandated subgroups yields a profile of similar and disparate reunification client and case characteristics.**

**Documented similarities among foster care and kinship care records during the stages of the reunification process included: 1) exploration of the placement precipitant, engagement efforts, maternal relations and dysfunctional behavioral family patterns; 2) assessment of the various family coping strengths (family bonds, supportive kinship/foster parent relations, therapy compliance); as well as, assessment of**

reunification barriers (compromised parental-child relations, placement separation anxiety, unplanned pregnancy/drug relapse patterns); 3) interventions designed to address the identified reunification barriers (repairing compromised parental-child relations, allaying placement separation anxiety, challenging domestic violence barriers, interrupting unplanned pregnancy patterns and disrupting inconsistent substance abuse recovery); 4) termination characterized by reunification ambivalence and documented reviews of each family's reunification course during their final reunification stage.

The documented differences in client and case characteristics among the foster care and kinship care families included the extent to which children from the different mandated subgroups: 1) manifested placement separation anxiety and reunification ambivalence 2) the degree to which extended family members were included in the casework assessment and intervention process 3) the quality of case recording during the termination phase.

Overall, this study demonstrates that a qualitative retrospective analysis of successful foster care case records has the potential of identifying agency practices that promote client progress and family reunification.

## Acknowledgments

This dissertation project is dedicated to the indomitable spirit of love and commitment of those families who successfully meet the challenges of the family reunification process. In addition, I would like to commend agencies, such as the Talbot Perkins' children Services, for the skill and dedication they provide during the reunification of these families.

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## **CHAPTER 1: INTRODUCTION**

Foster care is one of the oldest fields of child welfare practice. It is also one in which social work has been principally responsible for its operations. A review of foster care literature suggest, however, that primary emphasis has been placed on the failures and flaws of the child welfare system; more specifically, the failure of the system to swiftly move children from the impermanence of foster care to the security of a safe and stable permanent family. By contrast, little attention has been paid to determining what programmatic efforts and practice elements have been effective in reuniting foster care children with their biological families.

"After more than a decade of child welfare practice conducted according to the federal Permanency Planning philosophy and legislation, concerns are voiced with increasing frequency on how well and efficient the system is working for children and families it is supposed to serve. Heated public debate in recent years have focused more on the child welfare system's shortcomings than successes. Calls for action and service system changes, however, should not be based only on a few sensational cases, as often happens with debates in the public press, but rather on a systematic examination of what happens to larger groups of children and their families as they move through the foster care system" Davis et al., 1995).

During the late 1980's and the early 1990's foster care placement in the city had almost tripled, going from under seventeen thousand (17,000) to fifty thousand (50,000) in just five years (Report of the Mayor's Commission for the Foster Care of Children, 1993). In November of 1992, the Mayor's Commission for the Foster Care Children convened a Foster Care Committee to examine undercare service in the current foster care system and to recommend improvements. The Committee's recommendations reflected a

commitment to the guiding principles of family preservation; sensitivity to individual needs; flexibility of services and options; and integration of foster care services with other available supports. In particular, it recommended that the Child Welfare Agency, the State, and voluntary providers must engage in ongoing joint planning to improve coordination of services and to develop new methods but conceded that this system is limited in measuring quality of service delivery:

"...quality of care should be judged more on the basis of the actual tasks and processes of case workers and behavioral outcomes of clients, and less on certain paper work assignments in the time frame stipulated by state regulations...The system should encourage case workers to meet differential needs of families and children on a case-by-case basis" (Report of the Mayor's Commission for the Foster Care of Children, 1993, p.35).

However, if casework in foster care is to be effective in re-defining quality services and standardizing it into objective, measurable, reimbursable service criteria, it is paramount that we understand and describe the elements of successful delivery of permanency planning casework services.

A review of the literature on family preservation and family reunification services supports the need for studies that examine the strengths or empowerment of families. At the time of this review, there were no such reunification studies. It is the intention of this study to describe foster care reunification efforts that promote and support the psychosocial strengths of biological families.

## **PERMANENCY PLANNING: HISTORY AND CONTEXT**

In 1990, it was estimated that in the U.S. there was approximately 400,000 children in foster care (Center for the Study of Social Policy, 1990). In 1995, 3.1 million children were reported as abused or neglected, an increase of more than 50% since 1985 (National Committee to Prevent Child Abuse, 1996). Nearly 500,000 children currently reside in some form of foster care. By 1995, the number had increased by 65% (Barbell, 1996). More recently, increases in the incidence of AIDS, drug-exposed newborn, and homeless families have further contributed to the number of children needing out-of-home placement. The U. S. General Accounting Office (1994) estimates that parental abuse of alcohol and drugs is a factor in the placement of more than 75% of all children in care.

In response, the child welfare system provides three types of out-of-home care, foster care, group care, and kinship care. The Adoption Assistance and Child Welfare Act (P.L. 96-272) mandates that child welfare agencies place children in need of out-of-home care in the least restrictive environment, this sometimes translates into placing a child with the extended family. However, of the three types of out-of-home care, kinship care has received the least attention from researchers, and little information has been published on how children fare in this arrangement (Dubowitz, Feigelman, Zuravin, 1993).

Child welfare and its practice of foster care have always had a place in the story of the human family. Modern child welfare practices can be traced to the middle of the

nineteenth century, when the movement originated "to seek out and to rescue" children who were neglected or cruelly treated (Anderson, 1989). Agencies devoted to the rescue of children were modeled after the animal rescue societies, and a common outcome of the investigation of complaints was placement in an institution (Hancock & Pelton, 1989). From these institutions, and from almshouses and orphanages, children were often placed with surrogate families who could use their labor or to whom they were indentured. The first choice for placement was a rural, preferably farm families, which provided free care for the children (Jones, 1989).

By the 1920's, however, with the changing social and economic conditions (the relative decrease in farm families, an increasing divorce rate and larger numbers of women working outside the home), the use of the "boarding homes" was replacing the free foster family care that had previously existed (Anderson, 1989). By the time of the Depression, free foster family care was a thing of the past, and orphanages and similar institutions had to pay board for the youngsters in their care if they were to be placed with a family. Moreover, the Social Security Act of 1935, with its supports to families with dependent children, weakened the economic necessity taking children from their parents. By this time, the growth of social casework and the influence of psychoanalytical theory led to the expectation that parents could be rehabilitated to care for their children appropriately, and the perception of foster care as child rearing by substitute family on a temporary basis gradually evolved (Fein & Maluccio, 1992).

By the 1970's, following earlier research findings describing the "drift" or chronic long-term placement of children in foster care (Mass & Engler, 1959), a movement

emerged to provide permanence for foster care children coming to the attention of the child welfare systems. The Oregon project demonstrated various strategies for attaining permanence. With institutionalization of the permanency planning movement in the 1980 Adoption Assistance and Child Welfare Act, and the consequent emphasis on maintaining children with their own families or in another permanent family through adoption, foster care came into dispute (Lahti et al. 1978). Although in the early 1980's up to 40 percent of the children in care had been there for 2 years or more, foster care was no longer officially viewed as a viable long-term alternative for children who were removed from their biological families. Initial outcomes studies supported the belief that the Permanency Planning movement has had some success in its prevention and reunification impetus, except for their most difficult youngsters in care (Gershenson, 1984-86); typically those who are older, who display multiple behavioral, developmental, and other problems and needs (Pecora, J., Whittaker, J. & Maluccio [in press]). In 1997, national child welfare policy shifted towards greater safeguards on child safety, a tightening of timelines for families to resume responsibility for their children, a greater emphasis on earlier termination of parental rights and adoption when families fail to meet timelines (Cross, 2000). These policies were embodied in the Adoption and Safe Families Act of 1997 (PL:105-89). In addition, recognition has grown that service systems are not as responsive as they should be to the special needs and qualities of minority children and families, who are disproportionately represented in the child welfare system (Wulczyn, Brunner, Goerge, 1999; Kellam, 1999; Waldfogel, 1998; Fein & Maluccio, 1992). This issue will be discussed further in later sections of this chapter.

For more than the last two decades, state and local child welfare agencies have been powerfully influenced by the "permanency planning" perspective. This perspective espouses the development of a substitute care system that induces workers to discharge children from care as quickly as possible. Effective and efficient permanency planning is based on a belief that, whether discharge is to the biological family or to an adoptive family, it results the child's perception that the family situation is stable, secure and thus improves child adjustment (Lahti, 1982; Sosin, 1987).

Successful permanency planning involves implementing at least two sets of procedures, a series of administrative mechanisms that ensures that workers attend to the needs of the children in care and a series of worker behaviors that either enables the biological family to regain custody or lays the groundwork for adoption. Nonetheless, not enough is known about foster care casework skills (eg. assessment, interventions or service planning). Few studies document how such services are delivered (Special Child Welfare Advisory Panel, 2000; Walton et al., 1993; Fein & Staff, 1993, 1991; Hess, Folaron & Jefferson 1992; Hess & Folaron, 1991; Barth & Berry, 1987), and research has not successfully addressed the most important analytical question: whether their delivery actually affects the extent to which children spend long periods in substitute care (Wulczyn, 1991; Sosin, 1987).

The assumption by child welfare advocates and researchers that the delivery of casework services may help to speed placements from temporary to permanent care, emerged in part from early studies that looked at the time spent in care in local child welfare systems. On the basis of comparisons of long and short-term cases in a system or

descriptive analyses of the frequencies of delivering particular services in systems with low discharge rates, they concluded that shorter stays might occur if workers were highly involved in three service delivery activities: 1) exploring the viability of various permanent plans, 2) involving the biological family in the planning process to ease the return of the child, and 3) delivering supports to the family that might help resolve crises and improve family functioning (Mass & Engler, 1959; Mass, 1969; Sherman, Neuman & Shyne, 1973; Fanshel, 1976). Other supporting data came from series of well-publicized experiments that included the delivery of at least some of the three service types, along with administrative controls. In these projects children placed in the experimental group and receiving these services were indeed discharged from care more quickly than were the controls (Pike, 1976; Stein & Gambrill, 1977; Lahti et al., 1978; Pearson, Curtin & Crymes, 1982; Fein & Staff, 1993, 1991; Hess & Folaron, 1992).

Despite this evidence, the proper role of service delivery remains controversial. Some critics question whether delivering the permanency-oriented services (or even instituting administrative devices) will ever be beneficial when applied by local agencies that do not garner special resources. They speculate that it may take so much additional worker time to deliver services that the time investment may take the attention of busy workers away from carrying out the administrative procedures that are needed to actually make placements. Therefore, the length of stay in foster care may not be reduced by increased service effort. It has even been suggested that, given pressures to achieve permanence, workers may be forced to deliver fewer and poorer quality services in order to place children quickly. In short, not only is the place of services in doubt, but critics

occasionally imply that workers may be impelled to trade-off between the delivery of appropriate discharge follow-up services, (necessary to reduce placement recidivism) and greater efficiency; thus, reducing the length of stay in substitute care (Maluccio, Fein, Hamilton, Klier, & Ward 1980; Lindsey, 1983; Rooney, 1982).

### **Demographic Characteristics of Foster Children**

As previously stated, since 1985 the characteristics of children in substitute care has changed. Increases in the incidence of AIDS and drug-exposed newborn children have caused infants to remain in care longer than other age groups and children under four to be the fastest growing population in need of foster care (Greenblatt, 2000). Nationally, children entering care today are likely to be younger than their 1980's counterparts, more likely to be poor, homeless, and ill; more likely to be a ethnic minority, especially African-American (64% of foster care placements and remain the longest in care); and more likely to have multiple placements in the systems (Permanency Planning Today, 1998b; Tatara, 1992; Albers, Reilly, Rittner, 1993).

**Ethnicity and Race** The presence of greater numbers of ethnic minority children in the child welfare system has been an ongoing concern since the 1980's (Greenblatt, 1998b; Barbell, 1996; Close, 1983; English, 1990). Children of color are over-represented in the foster care system by a margin of 2-1. As of 1996, children of color comprise 64% of the foster care population and remain longer in care than any other ethnic group (Barbell, 1996; Tatara, 1992). Seaburg and Trolley (1986), reporting on national probability sample of children receiving public assistance, found that these

children were likely to spend more time in foster care, particularly when adoption services were provided, or when they had been abandoned. Further, their study indicated that length of services increased for males, older children, African-Americans, and for physically and mentally impaired.

These findings were consistent with a large agency sample study conducted by Jenkins, Flanzraich, Gibson, Hendricks, and Marshood (1983), who found that ethnic differences affected the length of time children remain in foster care. They concluded that ethnic minority children, particularly African Americans children, remained in foster care significantly longer than European Americans. Likewise, in a longitudinal study of children in foster care children Testa (1985) reported that the median stay for African-American was significantly longer than for European American in the more Urban Chicago area. While ethnically diverse children are more likely to come into the system (Greenblatt, 2000; Wulczyn et al. 1999; Barbell, 1996; Fein & Kluger, 1990; McMurtry, Young & Lie, 1992; Close, 1983; English, 1990), they are less likely to be discharged (Greenblatt, 2000; Wulczyn et al. 1999; Barbell, 1996; Hancock & Pelton, 1989; Benedict, White, Stallings, & Cornely, 1989; Fein, Maluccio, & Kluger, 1990; Chestang, 1978; Hogan & Sau-Fong, 1988; Olsen, 1982). Moreover, in situations indicative of higher levels of risk for physical harm, ethnic minority children appear more likely to be placed with relatives (regardless of risk) than their European-American counterparts. Thus, African-American children are more likely to be placed in foster care when relatives cannot be located (English, 1990).

Similarly, Fein, Maluccio, & Kruger's (1990) study of children in long-term foster family care offered findings concerning the greater vulnerability of ethnic minority children and families: Black children and youth had fewer contacts with their biological families than White youngsters; Latino and Black children were more likely to be placed in transracial foster homes than White children; and ethnic minority children were more likely to enter care at a younger age and stay longer. Apparently, minority status bestows greater risk for biological families as well. Compared to White biological families, ethnic minority families had greater need for services and visited their children less often. Ethnic minority families were poorer and more in need of public housing and public assistance. Despite this, they were less likely to receive concrete services.

### **Poverty**

In recent years, there has been significant policy research on the effect that poverty has on the growing number of foster care children (Barbell, 1996; Courtney, 1994; Close, 1983; Dileonardi, 1980; English, 1990; Hutchinson, 1993). Studies have demonstrated that lower income children come into the system, and that once in the system, they are more likely to be placed in foster care (Courtney, 1994; English, 1990). Not clear from this body of research is whether neglect and abuse are more prevalent in poor neighborhoods, or whether the measures being used to determine the existence of neglect and abuse are more likely to be evident in poor households (Wells, Stein, Fluke, & Downing, 1989). However, several studies show that poverty is closely correlated with child maltreatment and foster placement (National Center for Children in Poverty, 1991).

According to the Final Report of the National Commission on Children (APWA, 1991), "a recent analysis of the factors that place children at risk of maltreatment suggests that only family income is consistently related to all categories of abuse and neglect" (p. 284); supporting the link of social and economic factors to higher abuse rates among minorities.

In addition, recent attention has been given to the "Feminization of Poverty" and the concomitant increase in childhood poverty, often as a factor in neglect (Pearce, 1978). Predictably, an inverse relationship exists between family income and levels of neglect, with the most at risk families subsisting below the poverty level, regardless of family size. For many years the most heavily represented in children's protective service system have been single parents, parents who are socially isolated and who suffer from a major mental illness, parents who have substance abuse problem, and parents who are living below the poverty line (Barbell, 1996; Hansen, Conway, & Christopher, 1990; Murphy, Jellinek, Quinn, Smith, Poitras & Gosko, 1991; Rosenthal, 1988; Stuart, Rutman, & Jones, 1979).

### **Length of Stay**

Not all studies point to race and ethnicity as having a major influence on the length of time children spend in foster care. In fact, Benedict and White (1991) and Benedict, White and Stallings (1987), found no differences in length of stay between African-American and European-American children in a large sample study in Maryland. In both of these studies, the average stay foster care between the groups was approximately the same. Likewise, in a longitudinal study of 165 foster children, Lauder,

Poulin, and Andrews (1986) were not able to establish a link between either age or ethnicity and length of stay in foster care.

More recently, Goerge (1990) found that children placed with relatives had fewer placements than other children, and found that Black children were more likely than Whites to be placed with relatives; contributing to a slower move back to the parent or adoption (Barbell, 1996; Barth, 1994; Wulczyn & Goerge, 1992). The longer children were in placement, the less likely they were to be reunited with biological parents. A variety of placements also reduces the chances for reunification (Finch, Fanshel, & Grundy, 1986; Wulczyn, 1991). Finally, Goerge (1990) found that when children are in kinship foster care, their families, parents and workers did not feel the same need to reunite the child with a biological parent as they did with non-relative placements.

Studies of children who had longer stays in care had mothers who had characteristics or problems which effected the parent-child relationship, and their stay appeared to impair the parent's ability to perform minimum levels of acceptable child rearing (Jones, 1993). Parent's child caring ability was affected by physical/mental health difficulties or substance abuse problems (Barbell, 1996; Benedict and White, 1991; Goerge, 1990; Lauder et al., 1986), having some sort of family crisis, or bearing a child out of wedlock (Fanshel & Shinn, 1978). Probably the most frequent indicator used by the worker, of a desire to regain custody of the child (Benedict and White, 1991) was whether the parent was cooperative, and complied with the service plan.

### **Kinship Care: An Overview**

Despite its prevalence, kinship care and the role of the state in monitoring children in this type of care has been controversial. (Task Force for Permanency Planning, 1990). There are several reasons why keeping the children within the family appears preferable to placement with strangers and consistent with the pervasive philosophy of family preservation (Center for Study of Social Policy, 1990a). Proponents argue that blood is thicker than water, and the natural ties among kin engender a special commitment. It also seems reasonable to spare the child the trauma of placement with total strangers. In addition, placement with relatives might facilitate ongoing contact with parents, which is thought to be desirable for most maltreated children. Given that foster placement is intended to be a temporary, help-giving interventions, a suitable relative could be an effective role model for the parent, and allow a degree of supervised parenting. Furthermore, having families care for their kin has a long tradition, particularly in the African-American community (Stack, 1974).

A contrasting view is less optimistic. Placement of a child in the same family that reared a parent who is now deemed unable to care for the child can be a major concern. In addition, boundaries and role responsibility might be difficult to negotiate within some families. For example, it might be awkward for a grandmother to restrain her daughter from assuming responsibility for her child, even if this places the child at serious risk. This concern is exacerbated by a less stringent screening of relatives compared to unrelated foster families. The support and monitoring of kinship care arrangements have also been substantially less than that given to foster families (National Commission on Family Foster Care, 1991).

## **Kinship Care Demographics**

Nationally, foster care agencies have recruited 125,000 kinship homes (Barbell, 1994). Although national demographic studies of kinship care are limited, Dubowitz, Feigelman, & Zuravin (1993) reported data from several state and local jurisdictions. The data suggested that placement with relatives was a frequent practice, at least in large urban areas. For example, in 1990, 8,205 (46%) of foster care children in Illinois were placed with relatives (Illinois Department of Children and Family Services, 1990), almost half of the 5,000 foster children in New York were placed in kinship homes (Task Force on Permanency Planning 1990), and 550 or 20% of foster children in Baltimore, Maryland. Dubowitz, Feigelman, & Zuravin (1993) reported on several aspects of kinship care from the above mentioned studies that included child and caregivers characteristics, long-term planning, casework interventions, service provisions.

## **Kinship Children**

### **Ethnicity:**

Most of the children were of African-American, and just over half were females. Ninety percent were African Americans in this study, compared to 70% in a similar kinship study of children in Baltimore (National Center on Child Abuse and Neglect, 1988). Another study found the ethnic representation of children in kinship to be similar to that of the children in foster care (Task Force on Permanency Planning, 1990); similarly, another study found that African American and Latino children were more

likely to be placed in foster care (Wulczyn, Brunner and Goerge, 1999; Waldfogel, 1998; Barbell, 1996; Lindsey, 1994; Wulczyn and Goerge, 1990).

**Age:**

Children in this kinship study were placed at a younger age than foster care children in Maryland or elsewhere (Maryland Foster Care Review Board, 1991; National Black Child Development Institute, 1989; American Public Welfare Association, 1990). They had been first placed in care at a median age of approximately five years. Age distribution was even younger for a New York City kinship sample, where more than half the children were five years of age and only 15% were ten years or older. (Task Force on Permanency, 1990).

**Reason for Removal:**

Neglect was the most common reason for removal. In general, however, the reasons for placement in kinship care are similar to those leading to foster care, neglect being the most common problem (National Committee to Prevent Child Abuse, 1996; Maryland Foster Care Review Board, 1991; National Black Child Development Institute, 1990; Task Force on Permanency Planning, 1990). By contrast, in the New York City study (Task Force on Permanency Planning, 1990) almost half of the children were primarily placed because of prenatal drug exposure, and most of the families had a member with a drug problem; suggesting that reasons for placement may vary by location (Greenblatt, 1998b).

## **The Kinship Caregiver**

### **Shared Child-rearing Responsibilities:**

In the Maryland study almost half the children were placed with a grandmother; many of the others were with an aunt; a finding similar to the findings of the New York City study of kinship care (Task Force on Permanency Planning, 1990). The acceptance of these children into their homes reflect a explicit tradition in African American families of shared responsibility for child-rearing (Stack, 1974). It appears that the majority of the children in kinship care, and to a lesser extent in foster care, enjoy rather stable arrangements with their caregivers (American Public Welfare Association, 1990). Nevertheless, Zuravin et al. (1993) found abuse to be 2.4 times more likely in regular foster homes than in kinship homes.

### **Caregiver Characteristics:**

Fewer than half the caregivers in the Maryland study had completed high school and more than half were not employed; reflecting the low-income, inner city population. The median age of caregivers was 48 years; and 20% were age 60 or older. Nearly half the care givers were employed, three-fourths of these were full-time. Most of the caregivers reported being in good health. One-third of the caregivers were married, 22% were separated or divorced, 22% were widowed. Over half the children were cared for in a household with a single adult; household had a median of three children.

**Long-term Planning:**

Caregivers and the caseworkers differed in their understanding of the long-term plan concerning the child placement. Thirty-five percent of the caregivers were unsure of the plan, compared to 7% of the caseworkers. In addition, 39% of the caregivers thought the long-term plan was for the child to remain with them, compared to 58% of the caseworkers, although 93% of the relatives indicated that they would care for the child as long as necessary. Overall, relatively few of the children in kinship care were expected to return to their parents, and few, compared to those in foster care in the same city, were expected to be adopted (Maryland Foster Care Review Board, 1991). One explanation for this is that caseworkers may have viewed kinship care as satisfactory long-term with less need to find alternative care. This is supported by one study of kinship care, where the permanency planning goals for 88% of the children was remaining in kinship care, 10% were to be adopted, and only 1% were to return to their parents (Thornton, 1991). Another study on kinship care found, however, that the plan for most of the children was to return to their parents, and only 15% were expected to remain with their relatives (Task Force on Permanency Planning, 1990); the difference was likely due to the fact that most of the children in the latter study were infants who were placed with kinship parents following their mother's drug exposure. Overall, a striking discrepancy in the long-term planning perspectives of the caseworkers and caregivers suggests important, practice-relevant differences in how kinship care is viewed by each of these groups.

**Caseworkers/Interventions****Contact with Worker:**

Seventy-six percent of the children in the Maryland study had been moved a single time (from their parent to a caregiver); relatively few had moved more than twice. Most caseworkers (81%) had worked with the child and family for less than a year. Twenty-nine percent of the caregivers had no contacted the caseworkers at all in the year preceding the study; 19% had made contact more than five times. One-fourth of the workers reported seeing the child fewer than four times in the year preceding the study; whereas 31% had seen the child more than six times.

**Service Provisions:**

In the Maryland study, both the caseworkers and the relatives were asked what services had been provided. Contact between worker and children in kinship care was generally infrequent. Despite a court order for bi-monthly visits, one fourth of the caseworkers had seen the child fewer than four times the previous year. In addition, a large proportion of the caregivers did not initiate contact with the workers. The degree of monitoring and support that should be provided to children in kinship care and their families is the subject of much debate. One view holds that the approach to these children should be the same as for foster children, or at least no less stringent (Task Force on Permanency Planning, 1990). Others argue that kinship care is a better arrangement than foster care and less agency involvement is needed. This debate has been based on strongly held beliefs, but with a paucity of data (Dubowitz et al., 1990). In the Maryland

study, substantially fewer relatives than caseworkers reported having received such services as AFDC, medical assistance, caseworker services, and therapy/counseling. The caseworkers and the relatives were asked what additional services they thought were needed. By far the most frequent need reported by both groups was for more money; casework services were seldom reported as necessary by caregivers, and even less frequently by caseworkers.

### **Foster Care Reunification: Outcome Data**

Little data has been gathered on child welfare service outcomes since the implementation of permanency planning statutes (Davis, English & Landsverk, 1995; Barth & Berry, 1987). However, Boyd (1979) found that children provided with intensive direct services spent one third less time in foster care and their rate of return home doubled. Fanshel & Shinn (1978) also demonstrated that highly intensive casework activity as a contributor to reunification. Gibson, Tracy, & DeBoard (1984) indicate the parents who had early and intensive services were reunited with their children sooner. The signing of service agreements were associated with reunification in the Alameda Project (Stein, Gambrill, & Witse, 1978). Fein, Maluccio, Hamilton, & Ward (1983) found that reunification was more common for children placed for reasons of neglect whereas placement in permanent foster homes or pre-adoptive or adoptive homes was more often a result of mother's unwillingness to take care of the child. Other investigations underscore the difficulty of explaining the outcomes; Jones, Neuman, and Shyne (1976) conclude "clearly no single item was of great value predicting what kind of

case with what kind and amount of service would do well" (Davis, English & Landsverk, 1995, p. 110).

### **Length of Stay**

Benedict & White (1991) assert that the impact of the potentially negative foster care experience and outcomes of services for children and their families may be directly related to length of stay in care. Recommending that documentation of factors related to varying foster care stays also holds significant usefulness in individual case planning. Factors they found associated in predicting length of stay were the children's physical health and their school performance; that is, children with health/development/school problems make up an important portion of the agencies' continuing caseloads, and may require a more expanded and intensified constellation of services than has been available in the past. At the same time, they found that, in contrast to previous studies, there was no significant association with length of stay for children with mental health and behavior problems. The type of placement setting was however associated with length of stay. Children placed with relatives, that is, family members who received foster care reimbursement (10.2% of the total sample), had significantly longer length of stay than children placed in pre-approved agency homes and group or institutional settings. This finding could be expected, since extended family members could be perceived as a permanent placement for these children. The last significant finding in their study was that for a majority of the children and families, at least in the study's metropolitan population, foster care was a short-term, crisis-oriented service with the probable need for

a different approach to service for those families than is needed than for the 25% who will remain for two years or longer.

Gibson et al. (1984) investigated casework service factors in a sample of 48 foster children who entered foster care in Louisiana between 1974 and 1976. They identified a critical number of contacts needed between the agency and the biological family, to reduce length of stay. In a longitudinal survey of 185 Pennsylvania foster children placed in 1978-79, Lauder et al. (1986), found six factors significantly associated with length of stay. Using correlations between predictor variables and dispositional status, the factors identified were frequency of visits, child's behavior problems, family crisis, parental mental health problems, parent neglect, and teenage status. Milner (1987) studied 75 children discharged from foster care in 1983-84 in Alabama after varying lengths stay. He found a high degree of correlation between visiting patterns and length of stay, with positively oriented visiting associated with short-term placement. He did not find that children's characteristics, circumstances of parent-child separation, characteristics of the social workers and their supervisors, quality of the foster care placement, or conflicts, were associated with length of stay.

There has been little consensus on direction or importance of many of these factors across studies. For example, minority race or ethnic origin has been associated with longer los in some studies (Jenkins et al., 1983; Jenkins & Diamond, 1985; Testa 1985; Seaburg & Trolley, 1986) whereas other investigations have found no relationship between race and los (Lauder et al., 1986; Milner, 1987). The only factor on which there is consistent agreement across studies is the importance of parental visiting, with shorter

foster care stay related to regular and frequent visiting; indicating the importance of understanding and assessing biological family attachment relations; as well as assessing and intervening in ambivalent parental acting out (e.g. inconsistent visiting, non-compliance with court-ordered mandates or lack of follow-up with case management service referrals).

### **Foster Care Recidivism Data**

The likelihood of successful reunification or permanent out of home placement can also be estimated from research on failed attempts to reunify children. Many reunifications fail after years spent in foster care. Researchers have reported that from 20 to 40 percent of those children who return home will be placed again in out-of-home care (Barth, 1995; Courtney, 1995; Maluccio, Krieger & Pine, 1988; Rzepnicki, 1987; Tatara, 1992; Wulczyn, 1991). Block & Libowitz's (1983) study of reunification efforts that resulted in return to foster care noted parent's inability to cope in 86% of the disrupted cases. Lahti, Green, Emlen, Clarkson, Kuehnel, & Casciato (1978) found that children returned to foster care after unsuccessful reunification were older and had fewer visits from parents while in foster care. Turner (1984) concluded that recidivists had more parental problems per case and received less post-reunification, case management, and referral to community services than parents who were able to keep their children at home.

The most powerful predictors of case outcomes in Turner's study were, however, problems at the time of placement. Johnson & D'Esperance (1984) showed that families with children who were physically abused and in which reabuse was reported had briefer

services, less parent-child contact time, mothers with less reasonable expectations of the child, and less use of agency resources. Berkley Planning Associates (1983) concluded that parents with substance abuse problems were least likely of all families to make progress toward reunification. Research comparing populations of children receiving services at home with children placed in out-of-home care found that reabuse rates for children remaining home were higher (Barth & Berry, 1987). In regards to stability of living conditions thirty two percent of reunified children were found to re-enter foster care in the study by Fein et al. (1983).

Nationally, from 55 percent to 73 percent of children in substitute care are returned to their families annually (Tatara, 1989). Services to help a family maintain its functioning after reunification, however, typically last less than 6 months and exist as special intensive programs in only 37 states (Barth & Berry, 1990). The lack of maintenance programs is an unfortunate correlate of the increasing number of children reentering foster care each year (Festinger, 1996; Wulczyn & Goerge, 1990). Maluccio, et al. (1994) note that research on the links between reunification and service delivery variables have established the importance of services to children and their families before and after discharge. A study of county agencies in Utah (Walton, 1991, Walton, et al., 1993) demonstrated that after a 90-day period, 93% of families in the experimental group, who received intensive family-focused reunification services, were reunited compared to 28% of the families receiving conventional services. Group differences persisted at least one year after the end of treatment. Likewise, foster care reentry was reduced to 10

percent for reunified families referred to a private agency offering comprehensive family-centered services in New England (Fein & Staff, 1993).

### **Employing Reunification Case Reviews**

Gershenson (1987) asserts when a former foster child "reappears at the agency the system has the responsibility to examine in sufficient detail not only the reason for deciding again to place the child in foster care but the factors that lead to this traumatic repetition" (p.1). In that regard, Hess & Folaron (1992) propose the use of the Professional Review Action Group (PRAG) model for reviewing cases of disrupted (reentry) family reunification. The PRAG model provides for care reviews, periodic reporting of review findings (a feedback mechanism for the agency and community), and recommendations for and documentation of corrective action. Hess & Folaron (1992) conducted a study using PRAG to review cases of disruptive family reunification in an eight-county area in Indiana. The findings suggest that the most frequent predictor of placement reentry was nonresolution of the parent problem that precipitated placement. Multiple service delivery system problems, including high caseloads size, staff turnover, and insufficient regulations of reunification practice, interacted with the serious nature of families' problems to reduce the likelihood of successful reunification.

### **Permanency Planning Critique**

According to Katz (1990) Mass and Engler shocked the social work profession of the 60's with their documented portrait of what has come to be called "foster care drift"

(chronic long-term placement of children in foster care). Currently, while nationally 40% of the children who are placed in some form of foster care are returned in less than one year, 10-15% remain in care for five years or more (Permanency Planning Today, 1998, p.6). Kellam (1999) reports that while African American children constitute only 15% of the U.S. child population, they represent 49% of the foster care population nationwide and a higher percentage in large urban areas. Factors that place children at risk of longer stays include residing in an urban area, being placed as an infant, lack of services, and being African American (Wulczyn, Brunner & Goerge, 1999). It is estimated that 50% of the children in substitute care nationally experience between two and five placements . As many as 40% of foster parents stop providing care within the first year, 10-15% remain in care for five years or more (Permanency Planning Today, 1998, p.6). 64% of foster parents who left the foster care system attributed it to agency-related problems; such as poor communication with the foster care worker, insensitivity, to the needs of the foster parents, and lack of essential supports like respite care, day care and training (Barbell, 1995).

Permanency planning critics maintain that the permanency planning movement has failed to meet its mandated family preservation goal (Pelton, 1991; Stein & Gambrill, 1985). Concern is growing that permanency planning is still not fulfilling its promise because of mechanistic imposition of the desirable options mandated by the federal legislation. The "spirit" of permanency planning, it is feared, has been ignored as states have institutionalized the concept, a phenomenon analogous to what occurred in the past when the reform movement of moral treatment for the mentally ill was transformed into

the state hospital system (Wells, 1991). In spite of the permanency planning practices of goal-directed, timely decision making to move youngsters back to their biological families or into adoption as quickly as possible, the efficacy of these practices is being strained by the troubled youngsters and families coming into the child welfare system (Fein & Maluccio 1992). The lack of federal leadership in promoting professional standards of practice and effective policy initiatives has permitted 50 separate states "system" to operate. Services to children and families are fragmentary, the promise of funding for adequate preventive services has never been fulfilled, and the press of substance abuse and housing problems is forcing child welfare into overwhelming crisis (Ooms, 1990). Children's agencies in each state are overwhelmed by the number of cases, caseworkers are inadequately trained and responsible for too many children, and the resources for assisting families (such as public housing, prenatal care, and drug-treatment programs) are insufficient for the demand (Kammerman & Kahn, 1989). Thus, permanency planning is a limited response to a complex set of systematic problems in such areas as employment, housing, health, and education (Fein & Maluccio, 1992). The imposition of statutory time limits and mandated services intensify the importance of providing for equitable and efficient allocation of agency-resources. Without much guidance from research on permanency planning, workers must make decisions that rely on their theoretical estimates of the likely case outcomes. In depth study of reunification services is vital if fallacies and hopes are to be separated from realities; and if effective program planning and implementation are to occur.

Most recently, The Special Child Welfare Advisory Panel (March, 2000), a panel of national experts advising New York City's Administration for Children's Services on improving the City's child welfare system, issued its "Advisory Report on Front Line and Supervisory Practice." Some of the reports practice findings were:

Too many front line workers (caseworkers) are insufficiently skilled at assessing family and child needs and in engaging clients to seek and accept help, with sufficient follow-up.

Service planning is too rarely tailored to individual needs, and the implementation of service plans is too often limited to making referrals.

Many workers lack the necessary knowledge about such key issues as domestic violence, how to work with relatives of children in care, the special needs of adolescents and their families, and how to access other systems to get help for families and children.

Current practices regarding visiting between parents and children too often impede, rather than further, permanency (March 2000, p.7).

Jones (1993) and others suggests that child welfare workers a need common set of Case work indicators that have been empirically verified. This would reduce workers' subjectivity, increase reliability in decision making, and provide for more accountable practice by facilitating internal supervision to aid in decision-making (Stein & Rezepiniki, 1984; Dalgheish and Drew, 1989; Wald & Woolverton, 1990). Currently little data is available on the service characteristics of service decision making. Few permanency planning studies have examined client characteristics and their linkage to casework interventions (Davis et al., 1995; Albers et al., 1993; Benedict & White, 1991; Tatara et al., 1989; Milner, 1987; and even fewer have examined their association with

reunification outcomes (Walton et al., 1993; Fein & Staff, 1993, 1991; Barth & Berry, 1987).

The purpose of this study is to examine the practice components of successful reunification. This investigation will focus on documented practices in successful reunification cases; as well as the body of research knowledge already available. Such a study has the potential for adding to the knowledge base about reunification services and supplying information for policy and practice utilization.

The following chapters describe the research methodology that was employed, the descriptions of successful reunification characteristics and practices and conclude with a discussion of the study's findings and practice implications.

## **CHAPTER 2: STUDY PURPOSE AND METHODOLOGY**

**The purpose of this study is to identify and describe successful casework reunification efforts conducted that are intended to promote and support the psycho-social strengths of biological families; that is, utilizing the Family Strengths Perspective (Early and GlenMaye, 2000; Laird, 1996, Ronnau and Poertner, 1993). Accordingly, this study employed Maluccio, Warsh & Pine's (1993) definition of family reunification as the planned process of reconnecting children in out-of-home care with their families, so as to help them achieve and maintain their optimal level of reconnection. Maluccio, Abramczyk and Thomlison (1996) point out that this emphasis on an optimal level of reconnection between children in placement and their families reflects renewed recognition in the field of child and family services of the importance of family preservation and permanency planning for children and youth in out-of-home care or at risk of such placement; that is, an understanding of the significance of the family in a child's development; a conviction of the family as the preferred child rearing unit whenever possible; and a belief in the potential of most families to care for their children, as long as they receive appropriate societal supports.**

**By developing a profile based on successful reunification client and intervention characteristics, agency caseworkers need not rely solely on their direct practice experience to evaluate permanency planning options. Although mindful that these elements cannot be used as prescriptive criteria for permanency planning decision-making, such knowledge can be utilized as guides for assessment and case planning. In**

addition, the findings of this study can be utilized for training purposes. New workers can be trained to utilize this information to intervene more effectively and efficiently with clients; thereby, improving their service delivery and increasing the likelihood of reunification as an outcome. Although the scope of this study is limited to this particular voluntary foster care agency, the findings can contribute to a general understanding efforts to improve reunification services.

### **The Agency**

Talbot Perkins' Children Services is a well-established private New York City, non-sectarian child welfare agency. At the time of the study, Talbot Perkins' Children Services was serving 500 children and 1,000 families in foster and kinship care. Talbot Perkins' Children Services' client base was comprised, primarily, of low-income African-Americans (73%) and Latino (23%) families. The staff was comprised of 14 administrators, 61 direct service workers and 30 support staff. A noted distinction of this agency was the prominence that the social work profession played in the agency. For instance, both the Executive and Associative Executive Directors, half of the administrative staff, all of the direct service supervisory and approximately 5 caseworkers are graduate social workers; in addition, the agency's training and staff development curriculum employed a social work practice model that was, also, led by a Social Work Director of Training. Other distinctive agency features were: provision of on-site primary medical/mental health services and parent education services; community-based family preservation services to newly reunified families and to the families of children at risk for placement. Talbot

Perkins' Children Services' major funding source was local public funding; the remaining sources were public/private child welfare grants and donations derived from fundraising activities. Utilizing a social work practice model that emphasized a "family strength perspective" (Early and GlenMaye, 2000), Talbot Perkins' Children Services offered a range of child welfare placement and community-based prevention services.

### **Methodology: Rationale and Design**

Epstein (1999) defines Practice-Based Research as "the use of research-inspired principles, designs and information gathering techniques within existing forms of practice to answer questions that emerge from practice in ways that inform practice" (Epstein, 1999, p 4.) Encouraging social work practitioners to conduct research on their own clinical case records, he comments:

"Social workers in health and mental health settings routinely collect and record enormous quantities of psycho-social information about clients characteristics and presenting problems, social worker interventions and client responses to these interventions. This information is intended primarily for clinical, supervisory, administrative and accountability purposes...This approach to practice-research integration is more naturalistic, heuristic and/or reflective in that is done in natural practice settings, where it seeks to provide practitioners with a greater understanding of their own practice through strategies of inquiry that integrate practice and research requirements. These strategies give primacy to currently accepted social work practice principles and organizationally embedded program theories" (Epstein, 1990 p.1-4).

In this study, utilization of practice-based research approach involved the design of a qualitative retrospective case review. The intention of this review was to systematically uncover and articulate successful casework reunification efforts at a

voluntary agency that were intended to fortify the psycho-social strengths of biological families.

Specifically, the research questions examined were:

1. What are the demographic profiles of successfully reunified families and are there differences between family subgroups based upon reasons for placement?
2. Are there differences in client behaviors/characteristics in successful kinship vs. foster care cases?
3. What are the family behavioral characteristics and casework practices that are attendant in successful reunification?
4. Do casework practices in successful reunification cases differ based upon mandated reasons for placements?

### **Definition of Terms**

The terms utilized in this study have been defined in various ways through the literature. The study will employ the following definitions for each of the following terms:

*Child Abuse* will refer to the physical and/or sexual trauma inflicted on children by their biological/surrogate parental guardian(s).

*Child Neglect and Child Maltreatment* will be used interchangeably and will refer to the physical, emotional and educational negligence of children by their biological/surrogate parental guardian(s).

*Domestic Violence and Domestic Abuse* will be used interchangeably and will refer refer to a complex set of socialized, often intergenerational, behavioral patterns that exist among violent families.

*Drug Abuse and Substance Abuse* will be used interchangeably and will refer to the abuse of and addiction to alcohol and other drugs.

### **Case Selection**

Due to the amount of data recorded within each case record, (placement stays for the study's families ranged between 2-10 years), the study was limited to 18 case records of families who were successfully reunified during the years of 1991 to 1996. The central units of analysis were the child in care, the reunified family and the caseworkers' interventions. For the purpose of the study, the reunified family was defined as the child(ren) who have been returned to either their natural parent(s) or kinship family. A minimum of one year in care was used to secure greater likelihood of including families who have been reunited as a result of casework services rather than court mandate. Family subgroups were arranged by placement category (foster care or kinship care) and placement precipitant (neglect, domestic violence or substance abuse) (see table I).

**Table I**  
**Study Subgroups**  
*N = 18*

<b>Families</b>	<b>Placement Precipitants</b>		
	<b>Neglect</b>	<b>Domestic Abuse</b>	<b>Substance Abuse</b>
<b>Foster Care</b>	2	3	4
<b>Kinship Care</b>	2	2	5

To ensure an unbiased sampling, the 18 records (9 kinship and 9 foster care records) were systematically retrieved by selecting every fifth record until the desired number of cases records were collected. The researcher, (a former agency social worker) protected confidentiality by being the sole data collector. To insure unbiased data analysis of the study group, data were transcribed and analyzed from coded data forms; thereby, securing a blind review of the records. The researcher stored the master list of the actual names after data collection (with their corresponding coded identification numbers) in a locked cabinet file. After completion of the data analysis, the master list was destroyed. Thereby, assuring client/caseworker confidentiality.

### **Data Extraction**

The study began deductively with an articulated conceptual framework, so as to organize and focus the initial data and promote validity in the retrieval of reunification characteristics and practice elements. Hess' & Folaron's. (1992) PRAG model for reviewing foster care case activities (referred to in the previous chapter) was employed as a template to identify successful reunification family characteristics/casework efforts. Accordingly, Hess & Folaron (1992) identified the following case activities as essential to achieving family reunification:

- 1) **Accurately and assessing, with the family, the problems and needs that required placement to protect the child.**
- 2) **Developing case plans that reflect accurate assessment, changes required for the child to safe with the parents, agency and parent responsibilities, the permanency planning goal, and services to support achievement of the goal.**

- 3) Engaging family members in appropriate services that specifically target identified problems and needs.
- 4) Coordinate the multiple services provided to all family members, including foster family care and parent-child visiting.
- 5) Monitoring and assessing the family's adherence to the service plan and the degree of actual changes achieved.
- 6) Assessing whether and when reunification should occur.
- 7) Preparing all family members for the transition process of the child's return home, including the development of a specific plan for the child's protection.
- 8) Coordination of services to support family members following reunification has stabilized.
- 9) Closely monitoring the child's safety in the home until reunification has stabilized.

In order to secure uniformity and reliability of the extracted data for this study, Hess' & Folaron's. (1992) criteria of case reunification activities were transformed into a data collection format. In addition, as Holbrook (1995) prescribes, the researcher drew upon her own prior practice experience to identify other potentially relevant practice characteristics not included in Hess' & Folaron's criteria (see data form in Appendix A).

The pertinent data from each selected case record were entered and coded by their identification number onto the data form. In preparation for qualitative data analysis, the data form entries were transcribed into the computer in WordPerfect format and organized into two data sets. The first set was a transcription of the collected data according to each family case record. The second set was a transcription of all the data by reunification characteristics and case activities. Face validity and reliability of data collection were reviewed with the dissertation committee chair. Although statistical

assessment of these are not possible in a qualitative study, the reader can judge the appropriateness and consistency of interpretation of quoted case citations throughout the study.

### **Data Analysis**

Holbrook (1995) proposes personal document research, (e.g. case records) as an alternative research that includes the voice and experience of the research participant. In other words, "personal document research bridges the gap between practitioner and researcher by offering a research method more in line with social work's traditional clinical values and social activist concerns" (Holbrook, p. 146). Accordingly, the study employed Meyer's & Palleja's delineation of the psychosocial stages of the helping process (exploration, assessment intervention, and termination) as the framework for the data analysis.

Meyer & Palleja (1995) credit Richmond's Social diagnosis (1917) as the first codification of a casework approach to helping people. This conceptualization contributed to the professionalization of social work because it defined the purpose and process of the profession. Although there are varying practice approaches employed by social workers, the psychosocial approach (Hamilton, 1951; Hollis, 1964) is the oldest social work model in continuous use. The study employed the psychosocial phases of the helping process as a combined deductive-inductive framework to identify and describe the "reunification" helping process. In addition, intervention patterns were analyzed

according to placement category (kinship or foster care) and placement precipitant (i.e. neglect, domestic violence or substance abuse).

### **Methodological Strengths and Limitations**

A particular strength of the study's method was its unobtrusiveness. Analysis of available case records does not intrude into the practice situation and, consequently, does not produce reactive effects which changed or disturbed the variables under study (Grinnell, 1993). With this method, what was being studied had already taken place. Grinnell (1993) also points out that an analysis of available clinical information may be the most economical and time-efficient data collection method; a distinct advantage for meeting the resource and time-limitations of a dissertation project. A particular limitation of this method is that the data are limited to case record entries that are embedded in the day-to-day practice variations and constraints of the agency. As Rapp & Poertner (1983) point out, child welfare agencies are often constrained by structural service delivery limitations (e.g., high crisis-oriented service demands vs. fixed staff resources), at times, prioritizing provision of crisis service over service documentation; affecting the integrity of service recording and, in turn, the validity of study findings. Another possible limitation is the lack of generalizability to the general foster care population as the cases are all from a single voluntary agency. Although the agency is typical of a private non-sectarian contracted agency, its service delivery system, staffing patterns and training services differ from other private agencies and large public agencies. So, for example, due to its small size and ideology, the agency's service delivery is more centralized by

**department units; has proportionately more MSW staff members; and provides more individualized in-service training services than a typical public agency.**

**Consequently, the study's findings can be employed formatively by the agency under study; as well as serve as an exploratory research effort for generating hypotheses that can be expanded and tested quantitatively; in turn, and utilized as a more inclusive representative foster care sample population to define quality casework services and standardize them into objective measurable, reimbursable service criteria.**

**In the next three chapters there will be an examination of the stages of the helping process with successfully reunified families. Each chapter will provide a literature review, describe characteristics and casework practices that are particular to the study's family subgroups, based upon placement reason (neglect, domestic violence or substance abuse) and placement category (kinship vs. non-kinship).**

## **CHAPTER 3: CHILD NEGLECT**

### **Literature Review**

According to Nelson, Saunders & Landsman (1993) although considerable resources have been devoted to the study of child physical abuse, and child sexual abuse, historically there has been a lack of attention given to families in which child neglect is a significant problem. Even less attention has been paid to families in which child neglect is long-standing or chronic, indicated by prior foster placements (Nelson, Saunders & Landsman, 1993; Wolock & Horowitz, 1984). With regard to parenting behavior, neglecting families are characterized by single mothers with high incidence of poverty, large families, inadequate living arrangements for children, environmental problems such as poor housing and deteriorated neighborhoods (Nelson et. al, 1993; Martin & Walters, 1982; Wolock & Horowitz, 1984; Giovannoni & Billingsley, 1970). In terms of interactional patterns, neglecting mothers have been found to interact less with their children, are more negative and less positive in their interactions, and are more controlling of their children during child-directed play. Herrenkohl et al. (1983) found that poor parenting skills were a significant predictor of neglect. In a study comparing chronically neglecting families with newly identified neglecting families, chronically neglecting families were found to have more child abuse and neglect problems, more out of home placements, more adult problems, more child problems, and more resource problems (Nelson et al., 1993).

The multiplicity of problems facing chronically neglecting caregivers suggests interventions that are comprehensive, in home, and long term. Moreover, family therapy has been shown to be effective in establishing generational boundaries and improving extended family relationships among neglectful families (Daro, 1988; Howing, et al.,1989). Family planning services may also be an important resource in reducing neglect (Zuravin, 1988).

### **Attachment Theory: Its Impact on Child Welfare Policy and Practice**

According to Grigsby (1994) in the past 20 years, knowledge concerning personality development has grown steadily, and with it has come a clearer awareness of the psychological devastation that occurs when children grow up without permanent parental figures. The importance of constancy in the caregiver-child relationship has been documented in the literature on social-attachment theory (Bowlby, 1988a;1980;1973;1969; Ainsworth, 1988; 1985; Goldstein, Freud, Solnit & Goldstein, 1986; Goldstein, Freud & Solnit, 1979;1973; Littner, 1967). Attachment behavior is any form of instinctual behavior that results in a person attaining or retaining proximity to another individual. Attachment behavior leads to the development of affectional bonds between parent and child, and later adult and adult. Many intense emotions are aroused during the formation, maintenance and disruption of the emotional bond. Conversely, the maintenance of the bond is experienced as a source of security, and the renewal of a bond is often a source of joy. In most families, the child's initial attachment relationships are with the biological parents. In adoption situations, children adopted immediately after

birth form attachment relationships with caregivers who become their "psychological parents." In other families, children who do not experience reliable parental care, may develop of strong sibling bonds and enjoy mutual influence in formulating their own identities (Bank & Kahn, 1982).

In the child welfare field, parent-child attachment is the conceptual foundation in permanency planning policy; thereby, supplying the rationale behind the mandated goal of providing services to facilitate a child's return to their parent; or with another caretaker if the child cannot return to their parent. Wasserman & Rosenfeld (1986) applied this theory in relation to child abuse and neglect; attributing abuse and neglect as a failure or aberration of the normal parent-child bond; as well as, recommending that an assessment of this bond serve as a guide for decision making in child neglect cases. Ainsworth (1985) argues that a child's attachment to parents may persist throughout the lifespan and can also be applied to other affectional bonds (Ainsworth, 1989). Consequently, because continuity of care is viewed as essential to a child's healthy development, it follows that child welfare policy and practice has reflected the theoretical basis of social-attachment theory. In cases in which children must be removed from the care of their parents, efforts are mandated to facilitate and strengthen the parent-child relationship through the provision of supportive services. Alternatively, various authors have discussed the importance of parental visitations (Hess, 1982;1988; Stone & Stone, 1983; Murray, 1984). Hess (1982) discusses frequent, regular parent visitation of children in foster care as crucial in maintaining the attachment relationship of the parent and child. Still other authors have discussed the importance of maintaining the attachment of siblings

(Aldridge & Cautley, 1976; Banks & Kahn, 1982; Ward, 1984; Hegar, 1988a, 1988b). Even in cases in which children have received life-threatening injuries or in which the parent-child bond does not exist, policy and practice attention to principle of attachment, directs children to be removed from their parents and legal measures should be taken to terminate parental rights so that the child can be placed with parents and provisions of the necessary services to facilitate healthy parent-child attachments.

### **Intergenerational Attachment And Separation Problems**

McMillen & Rideout (1996) suggest that, upon completion of social work assessments, patterns of intergenerational dysfunction often dominate genograms and social histories. Physical abuse, sexual abuse, alcohol and drug abuse, depression, out-of-home placements, teen pregnancy, divorce and severe poverty are but some of the problems that persists in certain families from one generation to the next. As a result, social workers are often asked to intervene in these families in an effort to stop the cycle.

Although researchers and theorist have been interested in intergenerational family phenomena for several decades, knowledge development has proceeded slowly. For example there are studies on intergenerational alcoholism but few on intergenerational foster care (McMillen & Rideout 1996). Attachment Theory proposes that family problems are perpetuated intergenerationally through views of self and others developed in childhood and imposed on subsequent relationships, including those with one's children (Egeland, Jacobvitz & Sroufe, 1988).

According to Attachment Theory, the intergenerational transmission process follows three basic propositions. First, children who experience childhood trauma are prone to develop negative views of self and others, becoming at risk of insecure attachment patterns with their parents. Second, these views of self and others are carried into subsequent relationships, often resulting in relationship problems. Third, parents' attachment styles affect their children's development. That is, adults who have developed insecure styles of relating are most likely to parent inadequately and create conditions favoring the development of insecure relationship styles in their own children. In addition, studies assessing parents' relationship with their own parents, and their children's attachment styles, have found a relationship between parents' childhood attachment experiences and their children's attachment to them. (Zeanah et al., 1993; Martin, Kaplan, Cassidy, 1985). In theory, breaking the cycle of intergenerational parenting problems occurs when a child or adult develops secure patterns of relating to others, despite adverse childhood experiences (McMillen & Rideout, 1996). The proposition that the cycle can be broken through supportive relationships with others has been supported in studies that have examined intergenerational child maltreatment and alcoholism (Zuravin et al, 1996; Egeland, Jacobvitz & Sroufe, 1988; McCauley & Hesselbrock, 1993).

Accordingly, Attachment Theory in child welfare practice raises our of the trauma of separation and placement; thereby, dictating that the decision to remove a potential at-risk child from their family be weighed against the possibility of causing unnecessary separation trauma (Littner, 1967). Accordingly, Stone and Stone (1983) caution

protective service workers "to act with utmost caution in placing children, as interruption of the parent-child attachment relationship through separation of the child from his or her parents could be only the first in a series of painful separations that child will face" (p.15). Littner (1967) also points out that, while foster placements are used as a possible solution to the problem of abuse, placement itself is often accompanied by a new set of problems that usually require intervention. In fact, placement problems may result in lasting psychological damage unless "we have the courage to tolerate and help, rather than to cover over, the upset feelings of the child, of his own parents, and of his new parents" (Littner, 1967, p.32). As early as 1962, Mandelbaum warned that of all the problems social workers have to address with parents and children, none were more central to all life experiences than separation. Leader (1978) maintained the importance of treating unresolved intergenerational abandonment issues and separation anxiety.

"Those (adults) feeling abandoned, as they marry and become parents, find themselves, sometimes to their own surprise, psychologically abandoning each other or their children... Among families engaged in family treatment, what stands out... is the fear of abandonment as a deep underlying current that has destructive consequences on intergenerational family interactions... Forced separations, are, of course, sometimes unavoidable and necessary, but they leave a trail of bitterness that results in fractured relations from one generation to another... in the majority of families seeking help, the intergenerational theme of abandonment flows like a deep underground stream" (Leader, 1978, p.139-141).

### **Ambivalence: A Factor in the Permanency Planning**

A key element in permanency planning lies in assessing and working with the history and relative intensity of parental ambivalence in the parent-child relationship, as acted out

in the placement experience (Hess & Falaron, 1991). Although some element of parental ambivalence may take place during the reunification process, Hess and Falaron (1991) found persistent and sustained levels of parental ambivalence in their study of 40 unsuccessful reunifications. In most of these, persistent ambivalence about the parent role and family reunification was identified as characteristic of the custodial parents; the parent's ambivalent attitude was found to contribute specifically and directly to placement reentry. Numerous personal and social forces appeared to have interacted before placement, during placement, and after the child's return home to both contribute to and reinforce the parents' ambivalence. Similarly, Hess & Falaron (1991) found unresolved ambivalence as a frequent contributor to placement reentry. In approximately sixty-six percent of the 41 reentry cases they reviewed, persistent ambivalence about the parental role and family reunification was identified as a characteristic of the custodial parent. Ambivalent parents were found to be more likely to have requested a child's placement before the disrupted reunification and again at reentry; to refuse at least one service; and to be inconsistent in attendance in court, visits with their children, and participation in services. In 35 percent of the cases, the parents' ambivalence directly contributed to placement reentry.

Family ambivalence may exist about the return of the children due to a new equilibrium attained during the child's absence; as well as the crisis of imminent removal no longer being a motivation for parental compliance to court-mandated behaviors (Fein & Staff, 1991; Hess & Folaron, 1991). Other researchers have also noted parents' ambivalent attitudes about their children's return home (Maluccio et al, 1986; Pike et al., 1976; Ward, 1984). Ward (1984) found that parents expressed interest in reunification, but acted in ways

inconsistent with their statements, such as visiting irregularly or taking no actions to facilitate return. The implications of these findings link ambivalent parental acting out to the quality of parental-child attachment relations; suggesting that an assessment of these acting out behaviors may indicate poor parental-child attachment relations. However, situational or characterological factors (e.g., poor parenting/coping skills, chronic history of poor social/family supports or reactive emotional disorders) are equally plausible causes for ambivalent parental acting out behaviors. Consequently, assessing and addressing ambivalent behavioral cues would aid biological parents' to either reconcile their conflictual feelings and become more committed to reunification or clearer about their parenting inability/unwillingness; thereby, facilitating the reunification process or the process towards another permanency planning option. In short, assessment of the nature and degree of ambivalence related to parenting is essential to effective protection, placement and permanency planning (Hess & Folaron, 1991).

## **THE EXPLORATION STAGE**

### **Families Mandated for Neglect: Exploring their Stories**

According to the case records reviewed in this study, 4 out of 18 families were mandated into care because of maternal child neglect. As expected, when examining the study's case records, there was documented evidence of child neglect in all of the case records. However, the chapter will present findings on the helping process with the families mandated into care for neglect. As suggested in the literature review, the cause of child neglect is frequently a failure or aberration of normal parent-child bonds. The proceeding case excerpts document chronic neglect and placement reentries among both kinship and non-kinship families.

### **Placement Precipitant: Compromised Attachment Bonds**

As expected compromised attachment bonds were a major placement precipitant. That is, among the four families referred for neglect there was documented evidence that neglect eroded the affectional bonds between the parent and child. In the following kinship scenario, despite the mother's ability to have 3 children (previously placed for neglect) returned to her care, her insufficient attachment to the oldest child compels her to voluntarily place the child with the maternal grandparents. It appears that the biological mother's conflictual-dependent relationship with the maternal kinship grandparents, and their particular investment in the welfare of this oldest child, was the contributing factor to this mother's lack of bonding with her oldest child.

Child and sibs were placed as a result of BM's (biological mother) hospitalization. She left children in neighbor's care, who turned them over to authorities. During the time of the placement hearing, BM was able to prove that she had not abandoned her children but was unable to plan for them due to lack of a stable income and housing. Upon completion of the service plan, children were permanently discharged to BM. Shortly afterwards BM approached her mother and asked if she would consider caring for the oldest female child, as she had no desire to do so. Upon MGM (maternal grandmother) agreement to become the family resource for the child, BM voluntarily placed the child in foster care. BM expressed difficulty with finances and lack of bonding with child as reason for voluntary placing child with MGPs (maternal grandparents)...MGM made it clear that she blames herself for much of BM's behavior. She felt that by having [this oldest child] placed in her home, perhaps BM would soon realize what a mistake she had made and want her child returned to her...MGPs are eager to accept responsibility for [this oldest] child and often advocate for her educational, personal needs and progress. They provide thoughtful and loving caretaking.

Evident in the succeeding kinship case excerpt is the affect that the biological mother's mental illness had on compromising her care and, in turn, her affectional bonds towards her children.

Kinship parents provided brief history of BM's difficulties and the children's placement history. Kps had custody of children once before for five months because of BM's breakdown but report she had another breakdown, where children were returned to KPs' care. BM confirmed this history when CW met with her.

As previously stated, when contrasting the kinship and non-kinship families, while compromised attachment bonds are evident in all the cases, the lack of environmental resources (e.g., inadequate family bonds/support, financial resources, shelter, etc.) appears to exacerbate non-kinship mothers' deficient parenting and extend the children's placement stay. The following non-kinship case scenarios are a noted examples.

BM was first pregnant when she was a teenager and has had 8 children and several abortions since then. Three of those children have already been adopted. BM has 2 other children in care was attempting to maintain remaining 3 children in her care but lost the apt.; she was living and was staying in one small room of a friend's apt - that was deemed unsafe for her children...BM was unable to keep clothes or bedding clean. There was minimal food in house...She agreed to sign voluntary placement until she could get adequate housing and settle herself again. Children were voluntarily placed for 4 yrs, but due to mother's inconsistent visits and failure to adequately plan, agency filed for neglect and children's status was changed to mandated placement.

Two youngest children were placed with 4 older sibs due to BM's neglect. They were found, left unattended in their welfare hotel room. Placement was precipitated when the youngest child had to be hospitalized for lead poisoning. At that time mother was referred for preventive services but failed to follow through on recommended service referrals or even begin to provide adequate care and supervision for her six children. When children were placed initially mother responded well and had 3 older children returned but during trial discharge for next 2 children she left them alone and children were re-entered into care.

### **Engagement Efforts**

As suggested in the literature, the worker's initial goal is to maintain and/or enhance the parents'/family members' bond with the child by promoting family reunions (visitation of the child). Evidence of workers' engagement efforts were charted in both kinship and non-kinship cases; and while there were a range of efforts, there were no appreciable differences in documented engagement efforts among the kinship and non-kinship cases. Instead there appeared to be a common effort to engage the family members in reunion activities for the additional purposes of family assessment and planning. The proceeding excerpts document this process.

Contact has taken place in the (kinship) foster home and at the agency...Caseworker has focused on gaining a relationship with each member, and caseworker has not attended visits between the BM and the her children yet. A schedule for caseworker to attend these visits will be made with KM (kinship mother) and BM...I (caseworker) talked with BM about the planning that would need to occur before we can make a decision about the children's return home. BM was agreeable to my visiting her home and having her and the children in the agency together for visits...BM has met with CW (caseworker) at agency three times...Interviews have focused on helping her understand that regular attendance in a (psychiatric) day treatment program is required and that ongoing assessment of her level of ability is necessary before a recommendation for the return of her children can be made.

The following is a striking example of a kinship worker's understanding of the importance of the parental-child attachment. Despite the biological mother expressed plan to voluntarily free her 6 year old daughter for adoption to the maternal grandparents, note the child's separation reaction. Prompting the worker's continued efforts to encourage the biological mother's visits.

In dealing with [this child] MGM admits to feeling overwhelmed. Since the child has been placed in her home, there has been a deterioration in the child's behavior. MGM is at a loss to curb the child's temper tantrums...BM has not visited child since she was placed in kinship care. BM didn't come to agency appointment. Worker will invite BM to agency again. CW will continue to encourage visitation between BM and child. Agency to pursue plan to free child for adoption by MGPs (BM had previously expressed interest in adoption of child by MGPs).

In the next excerpt, the non-kinship worker's assessment of the parents' relationship leads to attempts to increase the father's participation in planning and reunions.

It appears that the demands of BF (biological father) makes on BM aren't unrealistic but he has to develop better communication skills. Worker also

explained the importance of BF being involved in reunions, since he will be part of the family when the children return.

The following non-kinship case scenario highlights the worker efforts at utilizing family reunions to engage, assess and enhance the mother's relationship with her children.

When mother appears at the reunion, her contact with children is a minimal one. Worker attempts to encourage mother to interact with the children, to no avail...BM brought the children candy. Her interaction with the children was around the candy she bought for the children...Worker attempted to conduct an interview with BM who was accompanied by her cousin; however, to no avail. BM said she had things that she had to take care of...Worker explained the point that she has to be able to work with her to plan for the children's return. The mother made no response to worker's statement....Mother fails to keep all schedule reunion appointments...Worker explained (to mother) that the children are disappointed when their mother doesn't keep the reunion appointment. The children feel rejected by their mother. BM stated that she wants the children to be discharged. Worker explained to the mother that she observes that she has difficulty relating to her children. BM stated that she had completed a parenting program. Worker explained that maybe she needs to attend a more intensive program. BM was in agreement to attend another program.

### **Maternal Family Relations**

Attachment theory maintains that although the child's primary attachment is to their biological parents, attachment to other reliable caregivers can enhance or substitute for faulty or compromised parental bonds. The proceeding kinship case recordings demonstrate attempts by kinship guardians to support or strengthen the child-maternal bond.

MGM reports she is currently caring for child because BM does not wish to care for child and has asked MGPs to care for child. MGPs admit to feeling overwhelmed by the child's behavior. They describe tantrums, hyperactivity and a general refusal on the child's part to listen. MGM attributes this to child's separation from her BM...MGM is at a loss to curb the child's temper

tantrums. She often resorts to attempting to establish visits between the child and BM. It was explained that these visits should not be forced on either mother or child. However, MGM believes that it is in child's best interest and that it might calm her.

BM has been living with her father, and consideration is being given to returning the children to their MGF's (maternal grandfather's) care, so they could be living with their mother. Further assessment of the family is needed over a longer period of time...BM lives with her father who functions as a support to her. BM's father has agreed to provide support to BM in taking care of the children. The children know and love their grandfather, as he has been involved in their caretaking over the years...Kinship father (maternal uncle) acknowledged that BM would not be able to handle the children alone - he agreed with her poor judgement. He said that he believes his father is quite capable of providing for the care of the children (if they were discharged to mother's and grandfather's care)...He also said that he and his three brothers would always be around to help.

Unlike the above recordings, the following non-kinship recording demonstrates how, sometimes, maternal family relations can compromise the maternal-child bond.

The purpose of this conference was to discuss the possibility of MC (maternal cousin) being a resource for BM and baby. MC told worker that she knows BM her whole life. She explained that her mother (BM's maternal aunt) raised BM. MC demonstrated a good understanding of BM's problems and the dependency she has on people...MC ventilated her anger to worker towards her mother in regards to being a big cause of the way BM is now. MC told worker that her mother also raised her daughter because MC was working and when she displayed parental interest, her mother would become possessive of MC's daughter and intimidated MC to not take an active part in her parental role...Since MC's mother's death...MC beginning to start to form a true mother-daughter relationship.

### **Dysfunctional Intergenerational Family Patterns**

As suggested in the child neglect literature, both characterological and situational family factors, at times, negatively effect intergenerational attachment patterns. When reviewing case records, there was evidence of a common pattern of dysfunctional

intergenerational attachments among neglecting parents. For instance, the proceeding kinship case scenario documents how the cultural separation crisis, created by the maternal grandparents immigrating to the U.S., appears to have been a factor affecting the biological mother's affectional bond with the maternal grandparents; this in turn, appears to have disrupted the biological mother's ability to form an affectional attachment with her oldest child.

MGM experienced culture shock once she arrived in New York. She found herself missing her simple country lifestyle and its people...Like their mother, (MGM's children) experienced cultural shock upon entering the U.S...Because of their ages, (MGM's children) had difficulty adjusting to their new environment. BM was 19 yrs...They (biological mother and sibs) spoke no English. Subsequently, they lost interest in their studies and stopped attending school. The older children reacted adversely to the change trust upon them (being moved from Santo Domingo)...BM eloped with her boyfriend...According to MGM, BM had met boy in the Dominican Republic. Their relationship only lasted a few months. BM then met another man...She had 3 children with this man...MGM has been greatly affected by the change in her children upon their arrival in the U.S. When being interviewed, she became saddened over the fact that her 3 older children (BM and her two sibs) had failed to take advantage of the opportunities (educationally) available to them in the U.S. She is aware that it was due to the cultural shock experience. At this time she places many hopes on her 2 younger children. She is very proud of their accomplishments thus far and want them to succeed. MGM feels that they have a better chance as they do not face the language barrier that their older siblings encountered, and having been born here in the U.S. Both children did not experience cultural shock...MGP are interested in the care of their dtrs. and kinship granddaughter (biological mother's oldest daughter). They want to get the adoption process completed...They both want to move back to the Dominican Republic so that their children will live in a better environment.

As with the kinship case records, the non-kinship records also demonstrate the affects of dysfunctional intergenerational family relations on parental attachment patterns. In the next case scenario, the biological parents' abusive experience with their parents appear to impact on their relationship with their children and others.

BM told me some of her history...Up to the age of three BM lived with her mother and father. When her mother died, BM stayed with her father until 5 or 6 years of age, and remembers being beaten by her father and uncle; father abandoned her. She was then adopted by her maternal aunt and uncle...BM began to having conflict with her stepmother (maternal aunt) at 18. BM gave birth at 18. Her stepmother encouraged her to leave home. Subsequently, BM gave up this child to be reared by the housekeeper...BF was in foster care from 9-13...It seems that from previous conversations that natural father doesn't want to surrender child due to unresolved feelings about foster parents (whom are his god parents) It seems that when he was a youth, his foster parents were about to adopt him, but his natural parents were against plan always instilling in him, "children belong with their parents."..As meeting progressed, natural father reminisced about his experience in foster care, the need for children to be with their parents, particularly with their mother. He also degraded foster mother (his godmother) for the care she had given children. Worker reminded him that he had chosen foster mother and requested through the courts that children be placed in this particular home.

The succeeding case excerpt displays how a non-kinship mother's poor attachment experiences as a child affected her negative sense of self and others, resulting in inadequate parenting skills.

According to BM, her parents were never married, nor did they live together. BM has nine siblings, for the most part, living in the NYC area. BM is not close with any of them...BM claims she has never felt in control of her life or decisions, even growing up. She was not allowed to make her own decisions or choices, or go out and socialize. She was often left with the job of parenting her younger siblings while MGM worked as a nurse; or (maternal grandmother) felt unable to deal with her children. BM met the children's father when she was 16 years old. She stated that he has been the only man in her life...At this time, BM also dropped out of the 10th grade and started to have babies. BM reports that her mother was angered by her behavior; unable to control her and she eventual placed her in a group home.

## **Summary**

The impact of intergenerational dysfunctional family patterns on the biological parents' ability to adequately bond and care for their children was evident among kinship

and non-kinship neglecting parents. In response, workers' designed reunion activities that supported or enhanced family relations and afforded them opportunities to assess family interactional/behavioral patterns. However, one significant difference between the kinship and non-kinship families during this phase appeared to be the workers' ability, among children placed with kinship families, to expedite the reunification process through their collaboration with kinship members. The length of placement stay of each of these groups substantiated this difference. That is, neglected kinship children averaged 2-4 years in placement; whereas, non-kinship neglected children averaged 6-10 years in placement. Indicating that family kinship involvement has a positive contribution towards family reunification.

## **THE ASSESSMENT STAGE**

### **Families Mandated for Neglect: Understanding their Stories**

During the permanency planning process, assessment is the critical stage that determines whether family reunification is a viable permanency goal. It questions whether there are enough coping strengths, and capacity to change, to warrant planning for the children's return to the family. The following section profiles workers' assessment of the neglecting families' coping strengths and limitations.

### **Family Strengths: Parental-Child Bonds**

The quality of the parent-child attachment is a key factor guiding permanency planning. Despite the many parenting problems evident amongst the study's neglecting families, often there was documented evidence of sound parent or parent-surrogate bonds with the children in care. The following case excerpts demonstrates the workers' assessments of the strength of these bonds among several families.

**BM is consistent in reunion visits. Both girls are active and friendly, and demonstrate strong attachment to their mother and other family members. Both have stated a strong wish to live with their mother while maintaining contact with their (kinship) uncle and other extended family members.**

**In the proceeding case, despite the biological mother's poor attachment to the child, the maternal grandmother's attachment to the biological mother appears to have fostered her bond with her kinship grandchild.**

**MGM has shared that BM does visit the home; however, the child and BM do not demonstrate bonding. MGM stated that child calls BM by her first name and that BM will not make any effort to engage child...Child has adopted well with her kinship family (maternal grandparents). She addresses**

her grandmother as mommy, and relates appropriately with the rest of the family. Child does not relate with BM, and often does not acknowledge her presence when she visits the (maternal grandparents) home.

As with the kinship families, non-kinship families demonstrated strength in their parental-child attachments.

At the conclusion of conversation, worker inquired as to why BPs were crying at the last reunion. BM stated that she was very attached to oldest son, since he is the only child she kept for any length of time...(During a subsequent reunion the worker records), the children appeared very excited and happy upon seeing BM at agency. All of the children and BM hugged and kissed one another...Children played happily with each other in the playroom...Interaction between children and BM was excellent. There is a strong sense of family bonding.

Children (in care) appear very close to BM and siblings (residing at home). They are anxious to spend reunions visits with BM, and eager to discuss school, recreational activities etc. with her. They verbalize their love for BM and inquire when they will be returning home. BM is attentive to children during contact and reciprocates affection. BM is warm and appropriate in her interaction with children and has consistently expressed her desire to have them returned to her care.

### **Sibling Bonds**

As suggested by attachment theorists, maintaining sibling bonds are also important in families where reliable parental care is unavailable. The following two case examples substantiate the importance of siblings relations, in the absence of biological parental bonds.

Child is a 6-1/2 yr. Dominican-American female, with a ready smile for everyone. She is an outgoing, energetic and friendly child who charms adults and interacts with peers easily. She continues to have a very close relationship with (kinship) MGP's. She maintains a positive relationship with the other children in the home who are her playmates. They look forward to child's final adoption. The kinship family continues to demonstrate a strong attachment to child...As a result, child is secure in this family. She is

surrounded by people who love and care for her, and has developed into a friendly child with lots of energy.

As with the kinship siblings, workers' recorded assessment of non-kinship sibling bonds. Evident, in the succeeding entry, is the influence that the sibling bond has on mitigating the youngest sib's foster placement separation anxiety.

Sibling visits are monthly and the children appear to enjoy each other and have a good relationship. They are having supervised visits in the BM home and expressed a strong interest in being returned to BM. Youngest sib appears ambivalent about being returned but enjoys being with sibs.

### **Kinship/Foster Guardianship Bonds**

As previously noted, involvement by extended family members tended to facilitate and support the maternal-child bond. However, these involvements were not without their problems. In the succeeding kinship excerpt, the worker's assesses the strengths and limitations of maternal family involvement on the children's relationship with their parents.

The children see their mother weekly, usually on weekends during family gatherings - there are two more MUs (maternal uncles) they see regularly. The children know their mother. They call their foster parents "aunt" and "uncle."..This is notable, given the children are ages 5 and 6, and have lived with their uncle for three years. The children have maintained a connection with their mother throughout the placement...BM's family is hoping to provide her with financial support to prepare her for the return of the children...The legal husband and natural father in this situation has not appeared. The degree to which this family has "pushed him away"-- his actual interest in participating in the care of the girls is still unknown but should be explored.

As with kinship guardian care, the non-kinship worker must support, while assessing, the child's relationship with the foster parent and the feasibility of the

reunification goal. Evident in the two preceding case scenarios are the non-kinship workers' attempt to balance supporting the respective foster care relationships while safeguarding the integrity of the reunification process.

FM reports that child is acting out in terms of her behavior. FM stated that the child developed an attitude that the foster mother is not her real mother and that she can do what she wants to do. FM stated that she explained to child that she knows she is not her mother. She is the person caring for her and therefore respect has to be given. Worker stressed the importance of giving the child a lot of attention and affection, as well as using positive reinforcement with the child. (After subsequent visits the worker records), FM (foster mother) has been involved in the development of this plan and is in full agreement...Both girls have adjusted well to life in the foster home and have a very close relationship with FM...FM is confident that BM is prepared for girl's return; however, if this plan is somehow not carried through, she has agreed to adopt children.

FM continues to receive counseling as to her role as FM, as opposed to adoptive parent. FM is quite anxious to adopt children, but also needs to be reminded of the (permanency planning) court process. CW will continue to provide counseling on a regular basis around this issue.

### **Family Therapy Compliance**

As asserted by Daro (1988) and Howing et al. (1989) Family therapy has proven effective in improving parental and extended families relations among neglectful families. Although treatment courses varied in their length and focus, the study found that, in both kinship and non-kinship cases, the families mandated into care for neglect had documented evidence of sustained participation and treatment gains.

BM has agreed to accept a (therapy) referral from CW. Goals of parenting would be: issues of discipline, providing adequate supervision of children and time management...BM and children continue to be seen for weekly collateral therapy. Therapist reports that the family has made great progress since they began. Therapist feels that they are highly committed to the therapeutic process...Family therapist feels that progress has definitely been made with

the family, in terms of reunification. She feels that with continued collateral therapy (with mother and children) their prognosis is very positive

Not unexpectedly, a common feature among kinship and non-kinship biological mothers' was their initial resistance to therapy. In the following kinship case excerpt, the worker's assessment, of the mother's need to be empowered in her treatment regime, facilitates her compliance with treatment.

BM has not been involved with psychiatric community clinic for the past year. According to psychiatric nurse, she has not participated fully in the program and sometimes fails to receive her prescribed dosage of medication...BM's ability to follow through...will be monitored and a report from psychiatrist will be retained before a recommendation of return be made...BM said she is unhappy with the services provided by the community clinic, she has sought the psychiatric services of a private psychiatrist. She has also informed this CW that she will begin day treatment at a local hospital mental health clinic...BM has continued to have regular bi-weekly appointments with her psychiatrist. He has been prescribing and monitoring her medications to treat her schizophrenia...BM has responded well to decreased medication as reported by psychiatrist and observed by caseworker...As of this month medication has been discontinued completely, and BM has remained stabilized with no sign of relapse. It is the psychiatrist opinion and agency that BM does not require hospitalization or medication.

The use of directive confrontation and limit setting was also employed to reduce treatment resistance, as apparent with this non-kinship mother.

Worker explored with BM her resistance to therapy. BM told worker although she knows she is a very dependent person who doesn't follow through with anything, she wants to handle it herself and doesn't want to go therapy... Worker pointed out that BM has not followed through with anything in our contract and that if she continues not to do anything, her parental rights will be terminated as part of the contract agreement. BM appeared unemotional and said she knew worker was right... (In subsequent entries the worker noted), BM appeared cooperative and enthusiastic. BM stated that her parenting skills and therapy have been going well...BM remains in treatment, which provides great support and insight in planning for her children...Therapist stated that he is continuing his work with BM on issues of limit setting and intervention (about children). SW (social worker) feels that BM still has a long way to go. SW feels that trial discharge may be

premature (for all 4 children in care) yet agreed on plan of staggered trial discharge.

### **Family Limitations: Barriers to Reunification**

Despite the above listed strengths, workers' found coping limitations, common among both kinship and non-kinship neglecting families, that served as barriers to the family reunification process. Among these barriers were compromised parental-child relations, placement separation anxiety, domestic violence and unplanned pregnancies.

### **Compromised Parental-Child Relations**

The succeeding kinship case entry demonstrates the worker's keen assessment of how a maternal grandfather's dysfunctional relationship with his daughter began to compromise his parenting of his kinship granddaughter.

MGF regrets bringing BM to the U.S., he feels she would have done better much better in their homeland (Santo Domingo). MGF feels bitter over BM's behavior as it only caused grief and sorrow for MGM. On account, there have been several confrontations between MGF and BM, which is why he avoids contact with her...According to MGF, once BM ran off with her boyfriend years ago he disowned her...According to MGF, BM was "bad" from the day she was born, and will not change...When discussing kinship child, it was difficult at times for worker to differentiate whether MGF was referring to child or BM. He compared the child to BM stating she has the same temperament and many of the same characteristics. Although the child is very young, MGF spoke pessimistically of her; stating that he doubted she could be saved; believing that in all probability the child will follow her mother's footsteps.

Non-kinship workers, also, documented how biological parental early childhood experiences served as impediments in their parenting relations.

BM does not provide appropriate supervision and children can become out of control during their play. BM does not attempt to calm the children down...BM appears to be emotionally removed and distant from her own life and that of her children. She is a poor information resource and reporter. The background and developmental information she can provide about the children is extremely vague and incomplete. It is as if there was a total lack of information with her own children, and really has no ideas as to who they are. All these characteristics may have stemmed partially from the fact that she was imposed upon adult responsibilities too prematurely...BM is in great need to parenting skills training, as well as psychotherapy to help her deal with her own intrapsychic conflicts surrounding her subconscious desire to be responsibility free and how this has impacted upon the children...BM has not maintained a consistent relationship with children in care. Her rights to her youngest child...have been terminated and he is in the process of being adopted, due to BM's lack of planning.

### **Placement Separation Anxiety**

As suggested by attachment theorists, the initial foster placement is, often, the first in a series of painful separations for the children in care and their family. The study found, in both kinship and non-kinship records, evidence of different forms of placement separation anxiety reactions affecting the reunification process. The proceeding is an example of a kinship child's initial placement separation reaction.

Child has been receiving weekly (play) therapy. The therapist stated that child has insomnia, severe depression and anxiety. The therapy's long range goals are to help child address feelings of separation and loss, and enhance feelings of belonging.

The succeeding non-kinship case scenario documents how a biological mother's inconsistent visitation serves to extend her child's separation fears.

The children had some difficulty being separated from BM and adjusting to care. Initially children were bed-wetting nightly...infant seemed to experience the most difficulty. His behavior is unpredictable - sometimes cooperative and well behaved and other times not. Although he is extremely attached to FM, he has been constantly testing her...FM stated that during her trip to the agency, the child was sad throughout the entire trip, not knowing

if her mother will appear or not. FM tried to allay the child's fears. FM stated that she is running out of excuses to tell the child. FM said she was glad to see BM keep reunion appointment.

Also evident, in both kinship and non-kinship records, was documented evidence of poor parental separation reactions. The following kinship entry records a mother's fragility in coping with an administrative discharge planning delay.

BM has been feeling increased anxiety in recent months about the prolonged separation from her daughters and the number of arrangements to be made for their return. She began receiving medication last year for anxiety, insomnia, and "flight of ideas."..She also has little insight into her illness, her abusive marriage, or into how and why her children were placed in the care of her brother. The psychiatrist noted that the nature of BM's illness is chronic and there is a real possibility of exacerbations and remissions.

Similarly, as a result of a mother's inconsistent visitation and permanency planning, the children's and their mother's subsequent separation reaction is noted.

BM, FM and all the children were present. The mother has minimal interaction with the children. We (caseworker and mother) tried to engage the children in talking about school, friends, what they like to do. However, they spoke very little to their mother. The mother was unable to carry on a substantial interaction with her children. FM informed worker that BM was very paranoid because when worker met with children alone, BM stated (to foster mother) she wondered if worker was turning them against her...FM phoned worker to inform her that after the reunion oldest child inquired if he could call FM by her name instead of Mom. Initially child wouldn't inform FM why but after a while he stated because my BM asked me to. FM and child have strong bond and BM is attempting to separate them. She fears losing children.

### **Domestic Violence**

There was recorded evidence that domestic violence served as a reunification barrier for 2 out of the 4 mandated neglecting families. The succeeding kinship recording

describes the worker's assessment of the biological mother poor judgement about the risks to the children associated with her husband's violent behavior.

BM said she left her husband a little over two years ago and took her children to her parents home, where she would leave them to return periodically to her husband...MU said BM would often leave for weeks or months at a time and was suffering from an abusive relationship with her husband, MU said BF is a "convicted felon" and had repeatedly assaulted BM during their marriage. During this time, while the children were staying at their MGPs, a CPS report was filed for neglect due to BM's repeated absences and emotional state. BM is quote dependent on her father and brothers for emotional as well as financial support...BM's judgement is impaired, and family members help her with making decisions, and following through on tasks, such as keeping appointments ...children's schooling, and decisions about contact with her husband who according to the family was a drug abuser and battered BM...BM has stated that she wouldn't mind if he visited children, and said she thinks he was very attached to them. BM's account of her husband - her apparent belief that he is doing better now without a basis for that belief, and her apparent minimization of the extent of his problematic behavior seems to indicate some poor judgement on her part.

As with the above kinship recording, the following non-kinship recording highlights the effects that domestic violence has on this family's reunification process.

It was reported by FM that BPs had a fight over the weekend and BF had given BM a bloodied nose. Throughout the reunion meeting BF degraded BM and gave her order on how she should raise the children...Throughout the meeting he emphasized that BM was an unfit parent and that he was interested in getting custody of children. BM was withdrawn and rolled her eyes...Workers impression is that BM lacks self confidence...Her image of self is very poor. It appears that BF thrives on making BM feel inadequate. Although BM complains about the relationship she appears unable to break the emotional bonds...BF has always dominated natural mother's life and seems to fear that he is losing control as natural mother is showing independence..."I'm a little lazy but he doesn't have to make me feel I am less than a person all the time..."..Although BM isn't happy in the relationship, she is emotionally bonded through the children and her own dependency...BM told worker she doesn't like when BF tells her what to do and tries to be her "father." Yet natural mother admitted at different parts of the conversation to "needing BF in order to survive."

## **Unplanned Pregnancy Pattern**

As indicated in the literature, despite the poor interactional patterns of neglecting mothers' with their children, they tend to have many unplanned pregnancies and large families. In 3 out of the 4 mandated neglecting families, there was evidence of a pattern of unplanned pregnancies serving as barriers to reunification. Assessments of this pattern is illustrated in the following kinship and non-kinship case examples.

BM lives with her four yr. son and her new 8th month old baby; BM has not planned for child (in care) and has made no attempt to get her back. BF's whereabouts are unknown. (The kinship) MGM has shared that BM does visit the home; however, the child and BM do not demonstrate bonding. MGM stated that child calls BM by her first name and that BM will not make any effort to engage child.

BM informed (non-kinship) worker she was pregnant and planned to keep the baby...Worker asked BM if she felt by having baby that BF would change. BM insisted that the baby would mature BF. worker tried to have BM gain insight to the fact that BF is a father to other children and that he's not responsible towards them. BM insisted that she was different...It should be noted that worker again asked BM why she had denied being pregnant in the past. BM stated she was afraid of losing all her children, that was how she lost her two sons at another agency. Worker inquired as to BM's plans in regard to the expected baby. She expressed interest in putting child up for adoption. Although this is the plan expressed by BPs, most likely BM will not follow through. This child represents the children she has lost and assist her in feeling attached to BF...Worker spoke with her about family planning. She seems to have a fear of contraceptives and refuses to use them. She depends on BF for protection. Worker will continue to explore this issue...Natural mother is presently contemplating having an "abortion" and getting (uterus) tubes tied...Overall BM has poor self image and is dealing with a lot of guilt feelings around children....Due to being pushed into role of a mother at an early age, she didn't move through the stages of adolescence, which has affected her development in adulthood.

Evident in this last recording is the worker's assessment of a non-kinships mother's denial of responsibility for her unplanned pregnancies and risk for future pregnancies.

**BM's denial and failure to take responsibility and control for herself, her life and her youngsters, appears to be consistent pattern in her functioning regardless of the situation it is always..."somebody else's fault", or something that BM felt she had no control over, (such as having six children by the age of 25..."It the birth control that failed", or something are just meant to be.."BM stated she does not wish to have more children, "has been discussing birth control with her doctor"; but is presently using none, and has "several boyfriends, no one specific, you might say."**

### **Summary**

**During this phase, case reviews documented more commonalities than differences among the kinship and non-kinship neglecting families. For instance, kinship and non-kinship, workers' routinely recorded evidence of family/foster bonds observed during agency or home visits, while also charting the liabilities of these bonds. Therapy resistance, compliance and treatment gains were, also, documented among both groups. Similarly, documented recordings of the impact of family limitations on the reunification process was also evident among kinship and non-kinship records.**

## **THE INTERVENTION STAGE**

### **Families Mandated for Neglect: Changing their Stories**

Even during evaluation of the assessment phase there was a conspicuous need for workers' to support neglecting parents coping strengths, while, also, developing interventive strategies to address their reunification barriers. The interventions documented were congruent with the identified areas of assessed family limitation; that is, compromised parental-child relations, placement separation-anxiety, domestic violence and unplanned pregnancies. Listed below are examples of the workers' efforts at addressing these reunification barriers.

### **Compromised Parental-Child Relations**

Ainsworth (1989) contends that when children must be removed from the care of their parents, permanency planning practice requires attempts at facilitating and strengthening the parental-child relationship. Similarly, unresolved conflictual intergenerational parental-child relations must also be addressed. As a result of an agency pre-adoption homestudy certification, the following kinship case excerpt identifies an unresolved intergenerational family pattern; as well as, documents an interventive plan designed to improve the maternal grandfather's relationship with his kinship granddaughter.

In considering this home for (adoption) certification, there is much resistance on the part of MGF's to child's placement in the home. His disciplinary measures appear extreme and raises concerns for child's emotional and physical well-being. This kinship placement allows the child to maintain ties with extended family members. However, due to the family dynamics observed by the homefinder and "MGF" own experience as a child when he

was a victim of extreme measure of discipline, I am recommending the following: 1) Close monitoring of the kinship home. 2) Homefinder strongly recommends formal therapy for MGF in order to explore his negative feelings towards BM and how these feelings may impact on his treatment of child...3) Therapeutic services should include a parental skills training component...4) CW to continue monthly visits to kinship home so that interactions between child and kinship parents can be monitored prior to final adoption.

Among case records reviewed, there was a conspicuous pattern of documented responses to the threat of loss of parental rights. That is, after a number of attempts to engage the non-compliant parents in reunification planning, a change in the permanency planning goal, (from family reunification to adoption), often, resulted in the parents becoming committed to planning for their children's return. The ensuing non-kinship case scenario exemplifies this dynamic.

Periodically, BM will establish contact with the agency and children. Five years ago a trial discharge with her children was requested because BM had kept in constant contact with her children, had completed her parenting skills program and at the time was in family therapy. This trial discharge was halted seven months later by a call requesting the agency readmit children to care due to a charge filed against BM for leaving the children unattended. Children have, for years, been on an emotional roller coaster. At times the children have experienced close and constant contact with their BM, only to have those feelings countered when BM fails to continue such a relationship. Due to BM's lack of planning and inconsistent visits over the course of children's first six years in care youngest sib (placed at another agency) was adopted and our agency moved to have mother's rights terminated...A suspended judgement was granted to BM. BM was given a year to comply with several terms and conditions set forth by the judgement...Based on BM's compliance as well as her and children's strong desire to be returned to BM's care, the agency feels that the goal of adoption is no longer appropriate for this family and is requesting ppg (permanency planning goal) to return to parent.

## **Placement Separation Anxiety**

As referred to in the literature, while placement is used as a temporary solution for addressing child neglect, the placement experience brings with it a new set of problems (eg. separation and abandonment fears) that usually require interventions in their own right. Although, placement separation anxiety was apparent in all the study's neglect case records, interventive efforts in this area were charted primarily in the non-kinship cases. The following recording highlights a worker's differential use of supportive interventions with older and younger sibs.

Worker conducted an interview with older children. Both children stated that they enjoyed their visit with their mother. Both children became emotional in the car on the way back to foster home...Worker explained to children that day visit will continue with their mother...During the visit with his mother, youngest child was constantly referring to his FM. Child stated he didn't want to go with his mother. Worker had to reassure child numerous times that was going back to their foster home.

Note in the succeeding case scenario, the worker's ongoing efforts to mitigate the foster mother separation and abandonment fears.

FM stated that child is doing well in the home. FM states that (the youngest) child does not know his BM and stated his fear before leaving for day visit at BM. FM is very happy with this placement and is experiencing possible separation anxiety. FM was counseled on this matter (by caseworker) ...Plan of day visits, weekends visits and trial discharge was explained and discussed with FM. FM was in agreement yet stated that child appeared slightly traumatized upon returning from last day visit at BM. FM stated that child had referred to his BM by her first name and told FM that he didn't want to leave FH. FM speaks very highly of FC (foster child) and is content with placement. SW to monitor closely and to counsel FM, child and BM on possible separation anxiety...(Youngest) child continues to have split loyalties between BM and FM...FM shared that (oldest) child was very excited about going home again on weekends. She shared she has a bad time with (oldest) child prior to his home visits because he gets out of hand, with excitement and anticipation to go home. He does not listen to her. CW shared to be patient and understand that child has been anticipating going home for quite

some time...Child appears to be in good condition for trial discharge. CW counseled FM on her anxiety over children going home.

### **Domestic Violence**

The following foster care recording illustrates a worker's interventive efforts when addressing family violence.

Worker met with BPs...to give them some insight into their relationship. Worker explained the importance of BF developing better coping mechanisms instead of using verbal and physical abuse. BM was unable to verbalize feelings but seemed to appreciate worker confronting BF about certain issues...Worker assisted BM in understanding her passive aggressive behavior. Worker attempted to assist BPs through role play...Worker explored with BM her current feelings regarding her situation with BF. Although BM shared with worker that BF is always there to meet baby's emotional and financial needs, he is not always there to meet her own needs. She also expressed her continued ambivalence regarding staying with BF. Worker was again supportive of therapy for BM but she continues to be resistive of it...Natural mother admitted to having an urge to hit oldest son when she becomes overwhelmed and angry.

### **Unplanned Pregnancy Pattern**

In the following foster care case, the worker's keen and tireless efforts to interrupt the parents' pattern of repeat unplanned pregnancies.

BM called. She has given birth to boy. I (caseworker) had provided BM a letter stating our compliance with BM's desire to have her tubes tied but although BM has had all of her (four) proceeding children at another hospital, she had this child at a Catholic hospital, who refuses to perform that surgery...It should be noted that worker spoke with BF about family planning. He wasn't susceptible to BM using contraceptives, although he did say he didn't want anymore children...Worker inquired as to whether BM had made any plans about tubal ligation and what type of contraceptive she was using. BM stated she had completed the final form and had 180 days from the date form was signed to make final decision. Also informed worker that she and BF were currently having a sexual relationship...BM called to tell us she gave

birth to a girl. The baby was born at home...As far as the tubal ligation was concerned BM was unable to have this done...BM stated her intention to go to hospital to arrange for procedure...BM focused on issue of abortion, after birth, feelings of rejection and loss after BF approved of abortion plan....It is obvious that BM is very depressed and feeling overwhelmed. It seems that BM is feeling a loss as this is the first time in 7 years that she hasn't been pregnant, also relationship with BF has always been consummated through children and children seem to represent her womanhood...BM informed worker that BF was involved with three other women and was no longer assisting her financially. BM sounded confident and was eager to start life without being dependent on BF...Worker conducted an interview with BM. Worker discussed her plans for when baby will be born. Natural mother stated that her sister-in-law will let her keep baby with them (BM currently lives with boyfriend's sister). Worker discussed with BM if she would like to place baby in foster care until she had her own place to bring home baby....BM stated that she would think about it. Worker reminded BM that sister-in-law was unable to assume responsibility of the baby due to her having three children and living in a two bedroom apt...BM maintained minimal contact with her children during the reunion...Worker stressed the importance to BM of entering therapy and parenting. BM stated that she will wait until she takes care of things for her new baby. BM stated that she wants to keep her baby.

### **Summary**

During this stage there was a range of documented interventions. While the number of kinship and non-kinship neglecting families were insufficient to make a quantitative comparison between both groups, the study found sufficient examples to illustrate workers' interventive efforts in all the areas that posed barriers to reunification. In the area of compromised parental-child relations, documented evidence demonstrated collaborative interventive planning among the agency's units, such as the homefinding and casework units. As well as, a tendency for some non-compliant parents to respond, constructively, to the agency's proposed change from reunification to adoption. The domestic violence case scenario illustrated efforts to mitigate the dynamics of

**intergenerational family violence; and the unplanned pregnancy scenario prominently illustrated, despite interventive efforts, the established pattern of neglecting families to have large unplanned families. A notable finding was the documented attempts, primarily, by non-kinship workers' to mitigate placement separation fears; suggesting that, by its nature, the kinship reunification process may diminish the need for casework intervention of the placement experience.**

## **THE TERMINATION STAGE**

### **Families Mandated for Neglect: Completing their Stories**

During the termination stage, three prominent documentation areas emerged throughout the records of families of neglected children; that is, reunification ambivalence, a summary of the parental-child attachment recovery process and a review of the final stage of reunification.

### **Reunification Ambivalence**

Hess & Falaron (1991) suggest that a key to permanency planning is identifying and working with the normative family reunification ambivalence that exist prior to the return of the children. The signs of parental ambivalence documented, among families of neglected children, were inconsistency court attendance, visits with children and non-compliance with court-mandated referral services. The proceeding case scenarios depicts various aspects of this reunification ambivalence.

BM agreed to sign an application to surrender her parental rights, but BM has not come to the scheduled meeting nor has she contacted CW. BM is suppose to surrender so that MGM can adopt child...Since agency's decision to seek a termination in this case, BM has not cooperated with agency.

During the trial discharge stage, reunification ambivalence was, also, apparent among the foster parents.

FM, who at times can be difficult with giving her full cooperation brought oldest child to agency for this visit...She stated that she will miss youngest child over the x-mas vacation child (was scheduled to have visit with biological family)...FM is very happy with placement. FM shared her concern over child's future. FM stressed that if trial discharge does not work out, she would want to take child...FM again shared her concern over BM not returning his belongings (after his x-mas visit with family)...Worker made

visit to FM's home. Worker discussed with FM how she will be working towards children having day visits with their mother. Worker observed that FM was experiencing difficulty separating from the youngest child... Worker explained to FM that foster care is only a temporary situation and she needs to learn to separate from the child as well as not letting the child feel guilty for leaving her.

### **Parental-Child Attachment Recovery Process**

Hess & Falaron (1991) found, in their study of unsuccessful placement reunification, that unresolved parental ambivalence was a contributing factor to placement reentry, linking ambivalent parental acting out, at times, to poor parental-child relations. In reviewing the charts of neglecting families, there was documented evidence of the workers' attempts to, at times, resolve ambivalent behavioral cues by strengthening the quality of the parental-child relations. The following are examples of the workers' attempts to support the attachment recovery process.

Observing the interaction during reunion visits, it has become quite obvious to this worker that indeed, BM is quite overburdened. When the children begin to get out of had, BM doesn't seem to be able to control or discipline them. She becomes oblivious to the situation. Even more significant, BM appears to lack any type of emotional connection or attachment to the children. She doesn't seem to know how to relate to them with genuine warmth, concern and affection. At every visit, BM brings the children snacks, sugary snacks and drinks. Oftentimes, she will also bring them trinkets and expensive toys. On some level, even BM realizes that having all these children can be overwhelming for her. She finally admitted to the worker "I'm not going to tell them (Special Services for Children) that I feel overwhelmed. I'll never get my kids back."

Subsequent to the above-mentioned mother's admission and her consent to participate in family therapy, the worker charted the proceeding.

BM is highly committed to this therapeutic process, and utilizes these sessions to strengthen her relationship with children and to promote more

open communication between them. Children primarily view these therapy sessions as another opportunity to see BM every week, and often have trouble calming down and participating. BM does an excellent job calming the girls down and explaining how important these sessions are...BM has demonstrated her commitment to the children's return home through her completion of parenting classes and her consistent attendance and participation with individual and family therapy.

Staggering the discharge process was another example of an attempt to insure the integrity of the attachment recovery process.

BM has worked consistently over the past year for the return of her children. She remains in treatment over the past year and has made good progress. BM wishes to have all of her children home...BM hasn't cared for her children in over five years and her therapist stated that she will become overwhelmed if all her children are discharged to her care at one time. The children will make a smooth adjustment with staggered trial discharge....Older children have been trial discharged to BM. Both are making excellent adjustment. Younger children remain in foster care, but plans to be trial discharge are pending the adjustment of the two older children and how BM is managing in caring for them... Youngest child was very excited over going home for the weekend. He who is a very close to his FM has begun to develop a strong bond with his BM. Youngest child was counseled on his sister's trial discharge. Child stated he understood and that he "was next" to go home...Overnight visits at the home of BM have been very instrumental in this development of family bonding.

### **Reviewing of the Final Phase of Reunification**

As Meyer and Palleja (1995) assert, termination is a time where the themes of the case can be recognized and the helping process reviewed. The study found that there was evidence, in all of the case records, of neglect themes related to the discharge plan throughout the termination phase. Also prominent were documented evidence of the workers' efforts to monitor the period of unsupervised visitation and trial discharge. As well as, documented evidence of provision of prevention services to support the quality of

the family's reunification. The following case of a mother referred for neglect due to mental illness, is a striking example of the final stage of the reunification. This excerpt describes the worker's effort to monitor the mother's parental functioning while assessing and providing the family and community resources safety measures designed to monitor her fragile mental health functioning.

BM is able to attend to the children's needs when in the agency. Further assessment of this ability outside of the agency will be made during supervised day visits as part of the preparation for discharge. Planning will include supervised day visits to take place within the next month. Overnight visits will occur contingent upon a positive assessment of the day visits, and eventually, weekend visits will take place before trial discharge occurs...Spoke with foster parents about the planning for child's return to BM. Foster parent agreed it would be good idea to have homemaker in the home during trial discharge period. They also agreed that BM would need the support of the family members as well...Another activity geared towards the facilitation of an eventual discharge has been the initiation of family counseling sessions with BM, her father and children. These sessions focus on preparation for discharge by discussion of issues of the adjustments everyone in the family will make to this change. Their counselor has seen them for a number of sessions and feels positive about BM's ability to assume the responsibility of parenting...BM's therapist and family counselor believe she is functioning very well, and that she is capable of caring for her dtrs. In addition, we believe that the strong support of BM's family will help her resolve any problem that might arise. The entire family understands BM's psychiatric diagnosis of "atypical psychosis in remission," and the necessity to be aware to the possible recurring symptoms...Regular contact with the family has been maintained by this agency during trial discharge. At this time BM is currently functioning very well and appears to be capable of caring for her daughters. and will be referred for (discharge) preventive services.

**Summary**

These findings about the helping process during this final stage affirms Hess & Falaron (1991) suggestion that some form of parental ambivalence frequently takes place during the termination stage. Accordingly, among all of the neglecting families' case records, there was evidence of parental ambivalence prior to reunification; as well as, ambivalent behavioral cues by the children in care and foster/kinship parents. In addition, during this stage there was documented evidence of workers' sustained efforts to support and/or safeguard the parental-child attachment recovery process; suggesting that it is the means by which reunification is achieved for families of neglected children. As anticipated, while there was evidence of a review of the final phase of reunification in all of the respective case records, the recordings varied in length and detail. Nonetheless, among all the recordings, there was a review of the particular discharge issues relative to each family's respective rehabilitation process; as well as, documentation of the workers' efforts to safeguard the family's reunification by the provision of discharge preventive services.

## **CHAPTER 4: DOMESTIC ABUSE**

### **Literature Review**

According to Featherstone and Trinder (1997) domestic violence has always occurred; however, like poverty or sexual abuse, the social and political visibility of domestic violence appears to be cyclical. What appears constant is that a common meaning for "domestic violence" is not a given and that there is always divergence of perspectives on the issue. Fraser (1989) contends that feminist made the phenomenon of violence political rather than personal and private, as well as linking it to male/female power relations rather than individually pathologizing it. Since the seventies such feminist discourse on domestic violence has been relatively successful. Public attitudes have shifted from tolerating wife beating to condemning domestic violence as unacceptable. Historically, domestic violence and child welfare have been seen as largely separate concerns (McKay, 1994). Past research studies that have examined social work intervention have found little evidence of a social work response which recognizes these links and incorporate them into work with families (Maynard, 1985; Farmer & Owen, 1995). However, over the last decade domestic violence has gained a place on social work agendas, partly as a result of linking domestic violence with child protection issues.

The domestic violence-child welfare association had drawn explicitly on a number of bodies of research. Bennett & Lawson (1994) and other researchers contend that there is a relationship between domestic violence and substance abuse (Finklehor, Hotaling & Yllo, 1987; Eberle, 1982; Hamilton & Collins, 1981). Researchers, such as Hester &

Radford (1996), argue against contact of nonresidential fathers in domestic violence cases on the grounds of the risk posed by contact to mother and child. The "overlap" argument (ie. children being abused on contact with violent men, and men using contact to abuse mothers) draws upon research which points to the likelihood that men who are violent to their wives are more likely to also abuse children (Stark & Flitcraft, 1988; Bowker et al., 1988; Kelly, 1994). The "witnessing" argument draws upon a rapidly expanding body of research which indicates that witnessing (not physically experiencing) violence is in itself psychologically damaging to children (Fantuzzo & Lindquist, 1989; Jaffe et al., 1990; Carroll, 1997; NCH Action for Children, 1994 Brandon & Lewis, 1996; Campbell, 1997). In short, the message to welfare professionals is that men's violence puts children as well as women at risk. This is reinforced by the high proportion of children reported, both, to be maltreated by abusive fathers, and reported to be severely affected by witnessing violence (Featherstone & Trinder, 1997). Tutty & Wagar (1994) assert that children who have witnessed their mothers being abused by their fathers learn aggressive or passive methods of dealing with conflict that leave them at risk for responding with violence or being victimized in their adult relationships (Davis & Carlson, 1987; Jaffe et al., 1990; Moore et al., 1989). Research by Hughes (1988) has demonstrated that children who observe interparental abuse commonly exhibit signs of heightened anxiety, depression, low-self esteem, problems at school, self-abuse, aggressiveness, dependency, somatic difficulty and poor sleep habits. Early intervention holds the promise of short-cutting this intergenerational transmissions of violence through teaching alternative means of problem resolution.

Some contemporary family violence researchers offer an alternative perspective of domestic violence. Gelles (1993) charges that although the feminist approach (the gender lens) provides a clear focus on violence towards women, the lens is too narrow; it blurs, obscures or simply excludes other forms of violence within families, including sibling abuse, violence by women and elder abuse. These family violence researchers have argued that the patterns of violence within families are far more complex and varied, and require consideration of interactional dynamics alongside structural and socio-economic factors (Gelles, 1993). In terms of women's violence, Straus (1993) maintains, based on National Family Violence Surveys conducted in the United States, that women initiate and carry out physical assaults on partners as often as men, although female assaults produce fewer physical injuries, are less chronic or repeated, and that there are differences in context and meaning. According to Featherstone and Trinder (1997), the strength of family violence perspective is the attempt to present a more diversified perspective of domestic violence than the unitary feminist vision. In addition, it allows for generational relations and it places women as actors rather than acted upon. However, Featherstone and Trinder, also point out the disadvantage of this "wide-angled-Lens; that is, it produces a picture which is not sharply focused. It typically draws upon large-scale quantitative methods of data collection which precludes consideration of the context within which the domestic violence occurs, or the meaning of violence for the participants. The details is not microscopic enough. Just as significant, the snapshot in time produced by surveys, such as those conducted by Straus (1993), cannot capture the histories and the sequence of events which frame the processes of violence within

families. The picture that women can be as violent as men produced by the wide-angled lens can be misleading.

The question of power and how it should be understood in the context of domestic violence is also important. For feminists writings within these traditions it is important that power or oppression do not disappear in a mishmash of relativism. While Black feminist have increasingly challenged a range of assumptions, including the presumption of the centrality of gender to identities. The assumption that Black women would see men's violence as their primary form of oppression has been strongly contested (hooks, 1984). Featherstone & Trinder assert that families are more complex than the simple dichotomizing of abuser/abused, powerful/powerless. Instead they suggest domestic violence approaches which contextualize men's and women's violence and explore power in a more nuanced way; that is, the relationship between macro-micro power relations. Johnston & Campbell (1993) have produced a more disparate account of domestic violence. Johnston & Campbell's research suggest that domestic violence is not a unitary phenomenon with a single explanatory framework, and with a single prescription for practitioners. If domestic violence can take different forms and follow different patterns, then, it follows that in the context of child welfare, there is a need to consider differential domestic violence assessments that takes into account the context and patterns of violence within each family; and in turn, develop appropriate interventive strategies that include the child's safety and preventive domestic violence discharge services.

## **Treatment Considerations**

According to Stanley (1997) there is a growing body of evidence which testifies to the fact that, both abusive and non-abusive, fathers tend to be excluded from child protection work, leaving mothers to bear the brunt of social work assessment, monitoring and intervention procedures. Farmer & Owen's (1995) work draws attention to the process by which, even when fathers are known to be the perpetrators of child abuse, social work energy focuses on counseling and advising mothers who are, thereby, charged with the responsibility for controlling their behavior. Milner (1993) describes how, in her practice as a child protection worker, despite her awareness of the tendency for men to be excluded from the process, she "ended up working with mothers and systematically dropping father from the system" (p.59). O'Hagan & Dillenburger (1995) draw upon Milner's work and their own practice experience to argue that avoidance of men in child care work and the consequence exposure of mothers to the oppressive scrutiny of the child protection system results in the abuse of women. The majority of direct service workers in child protection are women (Hallett, 1989). Since most caseworkers are women, it is perhaps easier and less threatening to work with clients of the same gender. Men, especially those who are known to be violent, can intimidate female workers both covertly and openly (Milner, 1996). Furthermore, battering men often perceive violence as a family problem rather than an individual one, of they are willing to recognize that there is a problem at all (Peled, et al. 2000). Thus, women offer social workers' a softer target for intervention' (Milner, 1996, p.119). However, as Stanley points out (1997), by structuring the relationship between family and the social services department in this way,

men's abuse remains relatively hidden within the family's private domain rather than exposed to public scrutiny and challenged. In families where the man abuses his partner and their children, mothers' are placed in 'triple jeopardy' of trying to protect their children, appealing the child protection system and coping with their own experience of the abuse the best they can. Stark & Flitcraft (1996) point out that fear of having their child taken into care will prompt mothers to pretend to professionals that they are able to manage men's violence both towards themselves and their child. Consequently, the secrecy which surrounds the abuse is further intensified and the child's need for protection goes unmet. Ultimately, social workers who fail to include abusing fathers in their intervention are unwittingly colluding with the gender stereotyping that places responsibility for caring solely with women.

Stanley (1997) suggest that if social workers are to confront the problem of domestic violence and its relation to child abuse in their practice they will have to be willing to tackle the 'invisible man'. In assessment stages practitioners need to abandon the association of parenting with mothering and to adopt greater clarity as to which parent or care giver represents a risk to the child. Intervention with families needs to be planned in accordance with assessment so that the responsibility of the man and women is identified. Alternatively, in cases where the mother is the identified abuser, domestic violence may provide the context in which the abuse occurs; facilitating an understanding of the neglect or violence as a response to her own experience of abuse (Kelly, 1994).

McKay (1994) suggests what becomes more difficult for some helping professional to accept is the battered woman who becomes physically or emotionally

abusive or neglectful of her children. Battered woman often give their abusers full-time attention in a futile effort to control the level of their partner's violence, or they respond by withdrawing from the family, including children, in an effort to protect themselves. In either scenario, the care of the children is seriously affected (Stacey & Shupe, 1983). It is also important to recognize that battered woman are not a homogeneous group. They range from women of great strength and coping capacity to women who experience a wide spectrum of mental health difficulties. In the context of domestic violence, battered women may view themselves as being more in control of their anger and the level of punishment of their children than their partner. In reality, their frustrations with their situations combines with the stresses of parenthood to set the stage for the physical abuse of children.

For practitioners to work effectively with a battered woman her fears and confusion must be recognized and validated. Her shame about not being able to protect herself and her children must be met with support by the worker (McKay, 1994). Practitioners who can identify and voice their own feelings of frustration may be able to use their these feelings to offer the woman who is living with the daily threat of violence support and validation.

Stanley (1997) cautions social workers attempting to intervene in families where both women and children are being abused may well experience feelings of frustration and impotence, which reflect those of the women in need of support. Feelings of impatience may also be evoked in professionals by women who seem unable to separate from violent men or who, having been assisted by social workers to leave a violent

partner, choose to return. In such cases, using threats to place child or retain child in care, as a primary measure, only serve to subject mother to additional stress. Peled, et al. (2000) suggests that whether the battered spouse is seen as trapped in a violent relationship against their will or as choosing to stay in it, it is commonly assumed that freedom from violence means leaving the abuser. In accordance with the goal of an empowering social work practice (particularly with battered spouses), some domestic violence theorists define empowerment as allowing the clients control over their decision as to whether to stay or leave the abusive relationship (Dutton, 1992; Schechter, 1982; Stark & Flitcraft, 1988; Van Den Bergh & Cooper, 1986). In Peled, et al. (2000) words,

"Women's empowerment entails a shift from self-blame and self perception as victim to self acceptance. It also requires women's realistic assessment of responsibility for the violence, as well as a realistic evaluation of personal resources available for fighting. Women's ability to choose to stay (or to leave) would be further enhanced by being morally, emotionally, and practically supported in their decision, rather than being left alone and isolated...Most important, women...have to incorporate a notion of the reversibility of their decisions; that is, staying does not preclude leaving in the future, just as leaving does not preclude a possible return to the relationship (p. 19).

There has been little study of relationships that have remained intact through the resolution of domestic violence or attention given to ways women have freed themselves of the abuse without leaving their partner. Fewer interventive models exist to support women who wish to stay with their abusive partner. Professional assessments of women's perceptions of their situations are likely to change once the option of staying and trying to stop the violence from within the relationship is legitimized. Consequently, Peled et al. (2000) suggest that social work empowerment practice, with battered woman who stay

with their abusive partner, should include teaching women to assess and act on the degree of lethality in their situation, thus strengthening women's ability to protect themselves and their children. As Mills (1996) advises,

Interventions for battered women, both legal and otherwise...respect the possibility or likelihood of this relational structure [and] provide the time and fluidity for self guided resolution. Such a system should recognize that a true empowerment for battered women is achieved not through obedience to the expectations of legal or social work advocates or models but through acknowledgement of the woman's need to reconsider and reevaluate the meaning of the trauma in a flexible time frame and a supportive environment. (pp. 263-266).

Following this principle of freedom of choice, practitioners need to retain an awareness of the consequences of leaving for women; not only may the family home, income, social networks, social status and community identity be lost, in addition, the woman who leaves a violent partner may be exposed to new risks. Mullender & Moley (1994) identify a number of studies that show how women are particularly vulnerable from their partners when they are in the process of leaving a relationship. So for example, women who have been in this country for less than a year may also be exposed to the treat of deportation when they leave their husbands (Debbonaire, 1994). Research studies that have asked women about the sort of support they and their children need have produced a range of responses. Pahl's (1985) survey found that women with children who had left their violent partners valued information, advice and practical resources. NCH Action for Children's (1994) questionnaire completed by women attending NCH family centers found that nearly three-quarters of those dissatisfied with the services provided thought that counseling would be of benefit to their children.

There is little information that exists on children's perceptions of their mothers' decision to stay or to leave the abuser. The few available studies on the experiences of children of battered women suggest that, on the one hand, they commonly express fear and worries about potential and actual danger to their mother and, on the other hand, often feel trapped in conflicts of attachment and loyalties between their parents (Peled et al. 2000; Peled, 1989). However, Burman and Allen-Meares (1994) assert that interrupting the potential intergenerational cycle of violence is an important objective in the treatment of children who have witnessed domestic violence. Straus, Gelles and Steinmetz (1980) concluded that sons who observed violent fathers have a 1,000 percent greater chance of repeating this abuse with their own future spouses than do sons from nonviolent homes. Rosenberg (1985) reported, "Females who were exposed to their parents' violence as children and were socialized to accept traditional views of women's roles may become trapped should they find themselves in a violent relationship" (p.10). Nevertheless, Burman and Allen-Meares (1994), in their more recent study of the treatment of children who witness parental homicides, maintain that despite the traumas that these families experience, through treatment and community resource involvement, they were able to constructively adapt to their life stresses. This adaptation was, in large part a measure of their strengths, involvement, and fortitude. Stark and Flitcraft's (1996) contend that, since domestic violence is a major context contributing to child abuse, more work needs to be undertaken to examine the nature of this relationship.

## **THE EXPLORATION STAGE**

### **Families Mandated for Domestic Violence: Exploring their Stories**

This chapter will present the findings on the successful process of helping families mandated by domestic violence. Among the present study's case records, 5 out of 18 families were mandated into care because of domestic violence. The study employed the perspective advanced by researchers, (such as Featherstone & Trinder, 1997; Johnston & Campbell, 1993), who, using a multi-lens explanatory frame, view domestic violence as a complex set of socialized behavioral patterns that exist among violent families. In other words, the perspective promotes an eclectic understanding of domestic violence that takes into account the intergenerational context and dynamic patterns of each affected family.

### **Placement Precipitant: The Overlap and Witnessing of Domestic Violence**

As referred to in the domestic violence literature, the study found that there was documented evidence, among all of the study's domestic violence cases, that supported the "overlap" and "witnessing" viewpoint. That is, domestic violence overlap refers to the likelihood that men who are violent with their paramours are more likely to abuse children. Whereas, "witnessing" refers to the effects that viewing family violence has on the children. The following kinship case excerpts support the view that placement was precipitated by both the overlap and witnessing of parental violence.

**Children are in placement as a result of a court finding of neglect against BM, who was unable to protect them from witnessing BF's domestic abuse of her and because of his sexual abuse of his step daughter. BM had argument with**

this paramour...and he stabbed her 14 times on both her arms and body. At that time she was pregnant with twins but they didn't survive...BM said middle daughter's BF (another paramour) also stabbed her in the past when he found out she was with oldest daughter's BF. An Order of Protection was reissued against middle daughter's BF, who repeatedly battered BM in the past. This paramour has verbally threatened to hurt BM since the children have been in care, but has not followed through with threats...BM reports before they met he was in jail for 6 yrs and is an IV drug user...BM states child's learning problems are related to her sexual abuse. BM says child and sibs were placed with MGM because of domestic abuse.

As with the prior domestic violence case the following kinship family shares many of the same features: the biological mother's history of abusive relations, sexual abuse of a child and substance abuse by one of the mother's paramours. The following excerpt supports McKay's (1994) counsel that battered woman can become physically/emotionally neglectful of their children.

Four children came into care because of BM's boyfriend sexual abuse of her youngest son. During contact with worker, BM admitted to not being as involved in children's protection and having difficulty with her intimate relations...She had a relationship with oldest children's BF (who is now in jail) and said she hates him now because he abused her...BM says youngest children's BF is a drug user and now lives and works in New Jersey.

In the proceeding non-kinship case record, the mother's justification of the father's physical/alcohol abuse and fathers' denial is particularly striking.

BF physically abuses BM and children. BM is unable to protect herself and children from abuse. Placement was precipitated by BF trying to choke a sib. BF is a chronic alcoholic who has a history of abusing BM and children...When confronted with BF's history of abuse (alcohol and domestic violence), BM's first reaction was to offer excuses...(According to abuse allegations) father is violent and has been physically abusive of mother when he is under the influence (of alcohol)...BF generally denies family violence and appears to feel that the police have been involved because of nosey neighbors who create problems where there are none. He denies an alcohol problem.

As Straus (1993) advises, women can be as violent and abusive as men. In the following non-kinship case, there was recorded evidence of both spousal/parental physical abuse and denial.

Child and sibs are in placement as a result of neglect and corporal punishment by BPs and well documented history of family violence. BF thinks his brother-in-law "called BCW (Bureau of Child Welfare) and said that my wife and I were fighting"...He does not acknowledge that he was abusive to her or to the them (children). BF is still in denial about abusing children. BF does not readily accept the fact that children have special (developmental learning) needs. He feels all their problems will vanish once they are discharged...BF also stressed the lack of an apt. as the only reason for children being in foster care...There had been approximately five reports of neglect reported to SSC (Special Services for Children) before all the children were placed in foster care...BM has always denied she is guilty of neglect or abuse. To her, the only reason the children are in foster care is because she has no apt.

Another non-kinship case involves children who were placed in foster care after their father murdered their mother by strangulation. It supports the thesis that witnessing (not physically experiencing) violence is in itself psychologically damaging to the children. In addition, as Hughes (1988) has suggested, shortly after being placed, the siblings exhibited signs of heightened anxiety, depression, aggressive behavior, poor sleep habits and problems at school.

According to the maternal family, BF started to abusing BM shortly after the birth of his son...Paternal family denies any history of domestic violence...This is a close knit Eastern European family...Until the murder, all family members were extremely close living in a two family home together. After the murder of mother, the maternal and paternal sides of the family split and began a bitter custody battle for children. The court decided, in the best interest of children, they would be placed until a decision could be reached about who would be the most suitable guardian...Female children have not visited BF [in prison]. Oldest daughter refuses to visit and therapist has made recommendation against youngest daughter visiting BF because of her

difficulty with coping with post traumatic stress reaction to BF's murder of BM.

### **Engagement Efforts**

As seen in the previous recordings and referred to in the literature, parents often engage in complete denial or justification of the family's violence. Efforts by caseworkers to engage the biological mother was evident in all the case records. In this entry a worker records her initial contact with the biological and maternal grandmother.

During the visit, I [case worker] explained what the [kinship] Family Center is about. I explained that I would be making home visits, testifying on behalf of the children in court. etc...I explained my understanding is that the family is working towards the return of the children to BM. MGM and BM said that they are anxious for the kids to be returned to BM; however, they know that BM must complete therapy [mother were court mandated to group for domestic violence]... I asked whether she [mother] was looking forward to the group. She shrugged, and said, "I know I have to go to get the kids back". She does not seem drawn to group. I told her that we could talk about the necessity or importance of the group.

In the following two case excerpts, the parents' denial is evident as well as the workers' efforts at engagement through the use of structured confrontation. Of particular note, in the proceeding excerpt, is the attempt by the worker to engage mother by addressing cultural differences.

BM appeared nervous, anxious and sad after children's visit. It is extremely difficult for BM to understand her sense of disempowerment. BM (a dominican immigrant) began to furiously blame SSC [Special Services for Children], the American Culture, etc. for her misfortune in losing her children...The supervisor also spoke to BM in an attempt to calm and relieve her of some of her pain and confusion [about children being placed]. She provided BM with a book, in Spanish, of foster care procedures...BM genuinely tried to understand what was expected of her from now on, in the way of being a parent...BF expressed a great deal of pain and discontentment

over not having the children home. He wanted to learn what he could do as a parent in order to facilitate the quick return of his children...I confronted BF with my concern over his (abusive) behavior with his children...I acknowledged his pain and feelings of being powerless with numerous service systems...I shared with BF the procedures for visits: place, time, length, expectations, roles, issues of foster parent confidentiality, etc. I asked BF to help his children...to understand their new situation I also meet with parents together, and we discussed their marital issues.

In another case, the worker makes repeated efforts to engage mother in addressing father's abusive behavior.

SW [social worker] informed BM that worker had learned of the family prior [domestic abuse] case...SW talked about the seriousness of BM present situation, trying to get her to address some of these issues herself. Each time SW would focus conversation on case issues, BM would redirect the focus to her worries about her children while they are in foster care. SW confronted BM with this observation. BM appeared upset but made no comment. SW enforced the need for BM and BF to receive counseling. BM stated that BF is not a bad person.

### **Maternal Family Relations**

In, both, kinship domestic violence cases reviewed the maternal grandmother and family were involved in children's care. However, a striking feature in these families were the conflictual relationship between the maternal grandmother and biological mother; supporting the literature's assertion of the importance of understanding the intergenerational family context. Apparent in the next case recording is the maternal grandmother's attempt to redeem her neglectful parenting of the biological mother by caring for her grandchildren and denying her own history of conflictual family relationships.

MGM is a 52 year old spanish speaking woman who is caring for BM's 3 children. She says that the three children have always spent a great deal of

time in her home and therefore are not finding the adjustment difficult. MGM enjoys caring for children but hopes they can return to their mother next year so she can spend time with her own mother who is ill in Puerto Rico...MGM says she feels BM can take care of the children as long as she doesn't "bring a man into the household"...She says that BM wouldn't be going to therapy if she [the maternal grandmother] didn't push her to do it. MGM seems to have no idea of why BM is unable to manage on her own. She says her other children are self-sufficient but then recounted an incident when she had to attend to a problem one of her daughters had with a boarder...BM talked about her Christmas at her mother's home. She is allowing herself to talk about her anger towards her mother and resentment that her mother manipulates her...BM spoke at length about her relationship to her mother; she feels that her mother never knew or loved her.

In the next family's case record, the oldest two children are placed with the maternal grandmother and the two youngest children are placed with the paternal grandparents. Despite maternal grandmother's kinship care of the two older children, note the biological mother's estranged relationship with maternal grandmother and her surrogate maternal relationship with the paternal grandmother.

BM said she was not close to her mother. She said when she had her daughter, at age 16, she went to live with her mother. When her mother kicked her out BM said she stayed with friends until she found an older man to take care of her and daughter...BM says she is very close to children's PGM's mother now, who's like a mother.

In all of the non-kinship domestic violence cases reviewed there is, either, maternal and/or paternal family involvement; and in 2 out of the 3 families there is evidence of conflictual family relations. For example:

Maternal and paternal family are in court fighting for custody of the children...Paternal family has been involved since placement...The maternal family has visited on 2 occasions. The maternal family interacts appropriately with children. All children are comfortable with maternal family and enjoy visiting.

BM is from the Dominican Republic. She came to the U.S. when she was 15/16 years old to live with her mother. This was the first time BM has lived with her mother. BM had been raised in Santo Domingo by her grandparents. While she lived with her mother, BM reports being submitted to unmerciful beatings and emotional abuse, by mother...BF's sister and mother are presently living with him and his sister has been doing much of the caretaking of the children during their home visits-BF relies on her heavily.

### **Transmission of Dysfunctional Intergenerational Family Patterns**

Tutty & Wagner (1994) assert that children who have witnessed their mothers being abused by their fathers learn aggressive or passive methods of dealing with conflict that leave them at risk for responding with violence or being victimized in their adult relationships. The proceeding recordings support the assertion of the intergenerational transmission of dysfunctional family relations and violence. Here the caseworker charted complex dysfunctional family relations after the biological mother's separation from her abusive partner.

BM reports MGM doesn't want her to go out with other men but BM feels she is young and still wants to have fun. She states when she was growing up her mother, she never let her go out or allowed her to develop herself as a person. BM feels her mother was not restrictive with her siblings. BM has 2 brothers and a sister from her mother's first marriage...Her 2 older brothers were raised by their [maternal] grandmother in Puerto Rico and still live there. Their father left MGM for another woman and BM is the oldest child from MGM's 2nd marriage. Her 2 sisters live in New York City. BM says she doesn't know her father since her parents broke up when she was very young. According to BM her father was physically abusive towards her mother (kinship maternal grandmother).

The proceeding case scenario gives evidence to the intergenerational transmission patterns of abuse and patriarchal norms that appear to have foster domestic violence within this family.

BP's were born in Eastern Europe. BM came to NY with her parents at the age of 2...BM met her husband while both were vacationing in native country. Both family knew each other, and this was an arranged marriage...BM was a housewife and she cared for the 3 children, while BF worked 2 jobs...According to the maternal family, BF started to abusing BM shortly after the birth of his son...The two oldest children were well aware of the domestic violence between the BPs...Upon initial placement, son exhibited anger and acting out behavior in the FH (foster home). He would strike youngest sister in the face, and kiss her on the lips. In speaking with him and FM, he witness above behavior between his BP's and he viewed these acts as "normal"...[During custody battle] MGM claims that she was accosted by PGF [Paternal grandfather] in front of Family Court. According to MGM, PGF put a gun to MGM's head. A commotion ensued and court officers arrested PGF for gun possession. PGF posted bail and was released...Paternal family...continue to deny allegations of violence, both between the children's biological parents and the allegation of PGF accosting MGM. Paternal family avoids any discussion of the children's deceased biological mother. They continue to fight for legal custody for the children, as do the maternal grandparents...CW observed paternal family show favoritism towards the male child...Older [female] child has begun to express some resentment towards the paternal family because of the apparent favoritism towards her brother... Although the children are pleased to see maternal family, there doesn't appear to be a strong bond between maternal family and male child.

### **Summary**

A review of the domestic violence case records establishes a number of similarities between the kinship and non-kinship families. First, all of the families had recorded evidence of abuse by the fathers towards the mothers, with one non-kinship family having recorded evidence of reciprocal violence by both parents. Second, in most of the families (4 out of 5 families), there was evidence of substance abuse by the father. Third, there was maternal, and at times paternal, family involvement and patterns of (informal or formal) kinship care; nonetheless, there was, also, evidence of conflictual

family relations and, at times, dysfunctional intergenerational patterns. Fourth, there were patterns of spousal denial and repeated battery by the same or different partners.

The one major difference between the kinship and non-kinship families was in the area of sexual abuse of the children. Only, among the kinship families, was there documented evidence of child sexual abuse. As a result, in comparison to biological mothers with children in non-kinship care, it appears that the trauma incurred by both the children and kinship family members had the affect of diminishing the biological mothers' denial of their neglect and resistance to mandated domestic counseling.

## **THE ASSESSMENT STAGE**

### **Families Mandated for Domestic Violence: Understanding their Stories**

As mentioned in the previous chapter, assessment is the stage that determines whether family reunification is a viable permanency goal. As with this families mandated into care for neglect, the study reviewed the workers' documentation of the strengths and the capacity for change of families mandated into care for domestic violence. The proceeding profiles the workers' assessments of the families' coping strengths and limitations.

### **Family Strengths: Positive Child-Parent Bonds**

As with the neglecting families, the study found that even in domestic violence cases there was recorded evidence of sound parental-child bonds. The ensuing kinship recordings illustrate this bond.

CW has observed BM to be very loving and caring towards her children. She is genuinely interested in them, and enjoys being with them. She knows her children well. The children reciprocate this love and are eager to return to their mother...and with their sibs.

The BM has visited the children 4 or 5 times a week at kinship home. She is affectionate towards them and both BM and children seem to enjoy the visit.

There was also evidence of positive child-bonds among the non-kinship families mandated into care for domestic violence.

The meeting was a positive one...The children have essentially established their individual means of communicating their feelings to the parents...Oldest sib is tearful and shy. Next to oldest sib clings to father and mother. Easy going and basically ignores the foster parents and interacts a great deal with his sibs. Middle sib hugs parents, plays with siblings. Youngest sib cries,

occasionally clings to mother and plays with sibs. With some encouragement [by the foster mother] the biological parents were able to verbalize their desire for children to return home...Oldest sibs are not BF's biological children; however, he has legally recognized them as his.

Note, as cited in the literature, that despite the children's anger with biological mother, a "conflictual affectional" bond is still evident.

BM is loving and attentive...All three boys understand why they were placed in foster care. Two oldest boys expressed anger towards their parents...Despite these feelings of anger and confusion, all three boys wanted to return home with BM.

### **Sibling Bonds**

Sibling bonds were also evident amongst families mandated for domestic violence. The following kinship recordings substantiate the importance of sibling bonds when reliable parental care is compromised.

The children seem happy...The middle sister seems to be the parentified child, taking care of her oldest sister, who was molested by stepfather...All three children get along well together with occasional sibling fights.

The children enjoy visiting with each other. Youngest sib braided older sister's hair for most of the visit. Younger brother and sister tease each other. The kids talked about their summer plans and going home...The children reciprocate BM's love and are eager to return to their mother and with their sibs.

Non-kinship families documentation, also, supported the influence of sibling bonds. The siblings play together reasonably well unless a gift is being offered or toy has been brought by another sib. Then the other children become jealous and expect the same... Children continues to be very close. They embrace each other at one another's sight. They play together & communicate about the trip with foster family to Florida.

The next excerpt is a dramatic illustration of the importance of sibling bonds in the absence of parental care. After the children were placed, due to the father's murder of

their mother, the male sib's subsequent aggressive acting out towards his sister necessitated his transfer to another placement. Despite these occurrences his attachment to his sisters is still evident, as is the bond that the female siblings share.

Brother's relationship with his youngest sister needs improvement. There is some sibling rivalry. He's in a separate placement due sibling conflict. He acknowledged that he often fought with his older sister and tried to molest his younger sister but at times misses them both. Younger and older sister are in the same placement and have good relationship.

### **Extended Family/Kinship Guardianship Relations**

As charted in the case records of neglecting families, there was evidence that involvement by extended family members facilitated and supported the parental-child bond in families mandated for domestic violence. The following kinship case illustrations exemplify this involvement.

According to kinship MGM, her daughter has always provided good physical care of the children. She is aware of the agency's concerns about her daughter's judgement with men and the issues of domestic violence. Both she and BM have given consideration to this matter and have made plans for the BM and children's continued safety...Kinship mother has encouraged BM to attend the support group for battered women. She [MGM] has also discussed with her daughter the issue of new relationships, and has tried to explore with BM the idea of getting to know people before getting involved.

Despite a biological mother's conflictual relationship with her mother, this case recording illustrates the important role the paternal kinship grandparents play in supporting the biological mother's and her parenting of her children.

KGM [kinship grandmother] states BM did not tell her about sexual abuse of child and told her son not to tell his [kinship grandmother] because BM knew KGM would have taken the kids. KGM said she loves BM and hopes that BM gets herself together. KGM said she and her husband have helped BM

out many times with money and apts and BM had each time gotten involved with a man that resulted in a situation that was not healthy for BM or the kids...KGM said...there has been several occasions when she has taken care of the children to prevent CWA [Child Welfare Agency] from being involved...KGM said she is glad that BM got a "harsher punishment" this time because maybe BM will realize how serious it is. KGM said she and her husband can "read" BM and tell if anything is going on. KGM said she felt BM was doing good. I [caseworker] asked if BM and KGF [kinship grandfather] got along, KGM said yes. KGF has done a great deal for BM, including paying BM's rent at different times when she could not.

In contrast to the literature's mention of the tendency of some workers to treat the fathers or paramours as the "invisible man" (i.e. the tendency to exclude men from the helping process), the following recordings highlight successful kinship and non-kinship workers' efforts to assess and engage the biological fathers.

I [caseworker] asked whether there had been contact with either of the fathers recently. They [mother and grandmother] that they do not see [mother's last paramour] anymore. [First mother's paramour], however, lives in grandmother's neighborhood. He visits with his children fairly often [at kinship maternal grandmother's] home. Apparently this is okay with MGM. I asked how BM felt about the visits. She felt the girls should know their fathers; they enjoy his visits. BM said that he has not "bothered" her recently. She does not want him to know where she lives, however, as he has tried to "get back together" with her. She seemed somewhat fearful about his following her home...she has no intention of getting back together with him. I offered that visit between the kids and their dad could be held at the agency if they become uncomfortable in the future. MGM and BM seemed to agree that this was not necessary.

Despite the father's imprisonment for the murder of his wife, and the paternal and maternal families' contentious relationship, the non-kinship worker continues to assess and support the father's involvement and the children's relationship with, both, maternal and paternal family members.

The maternal family has visited on 2 occasions...All the children are comfortable with maternal family and enjoy visiting...Although the children

are pleased to see maternal family, there doesn't appear to be strong bond between maternal family and son. Paternal family has been very involved in visitation...All members of the paternal family act appropriately with children...male child and youngest female child are quite bonded to paternal aunt and family...BF has contacted CW and requested that his brother and sister-in-law care for his children.

### **Therapy Compliance**

Analogous to the strengths found with neglecting families, there was documented evidence, among the reunified families mandated for domestic violence, of sustained therapy participation and treatment gains. Nonetheless, there was also recorded evidence of initial resistance to therapy. The preceding entries highlight this initial resistance and the subsequent compliance.

BF was highly motivated to do anything in order to regain custody of his children...BF has been attending therapy. Therapist states "Despite his guardedness...he has made some genuine progress". According to therapist, BF has been more willing to reveal negative information about himself and appears less guarded and suspicious.

BM's therapist stated she feels BM is doing very well and using her therapy sessions positively. She also stated BM is putting her energy into working on her self and has gained an awareness about her patterns, specifically with men, and what causes them (pattern with men). Therapist said BM is emerging from her denial concerning the sexual abuse of son and realizing her part in it by not protecting him. Therapist said she could not make an assessment concerning BM's ability to care for her children. She said she was concerned about BM quitting therapy...and encouraged BM to stay with therapy.

This next excerpt is a remarkable illustration of what Hughs (1988) refers to as the promise of early intervention for short-cutting intergenerational transmission of violence.

Male child appears to be more identified on an unconscious level with a helpless, weak victim...It may be that this represents past experiences with

paternal figure. It is recommended ongoing therapy continue with the goals of building ego-strengths, exploring feelings associated with trauma of mother's death by father and facilitation of process and mourning...Youngest sister is a 4 yr. old foster child evaluated due to concerns about her learning and retention...Given child's trauma history she must be considered "at risk" for social-emotional problems and her development should be closely monitored...youngest sister appears to suffer from residual symptomatology from traumas she has suffered, including nightmares, bedwetting, mean and cruel behavior towards others, reenactment of the murder, a startle response, episodes of disassociation, periods of despair which includes death...The problems she is presently having are described as being unable to establish new relationships, intense attachments to the FM and repeating over and over like chanting "Daddy beat my mother, Daddy killed my mother, he beats my mother...etc."...Fortunately, she is in twice weekly psychotherapy. The MA (who has temporary charge) seems like a concerned and reliable person who takes very seriously the care of the child.

### **Family Limitations: Barriers to Reunification**

As previously mentioned, workers assessed the coping limitations among the families mandated for domestic violence that served as barriers to the reunification process. Among these limitations were compromised parental-child relations, placement separation anxiety, unplanned pregnancies, patterns of dependent-conflictual relationships.

### **Compromised Parental-Child Relations**

Evident in the succeeding scenarios is the workers' assessments of the kinship maternal grandmothers' appropriation of the parental role and the biological mothers' difficulty assuming the role.

This was the first time BM had a visit with her children that [kinship] MGM did not supervise the visit. Since MGM became foster parent the three girls were happy to be going out, because according to BM, their grandmother is

very strict with them and doesn't take them out to play frequently...The children seem to relate to BM as if she were their older sister, they want her to play with them and do what she tells them but the worker never heard them call her "Mommy". Before the hour was up, BM said she was tired and eager to go home to Queens before it was too late. The youngest sib refuse to leave the park and BM had a difficult time getting her off the swing. BM said that she never respected her but that she listens to MGM. BM said her mother (kinship maternal grandmother) tells her she is too "easy" with the children but she finds its difficult for the MGM to have fun with them.

BM reports before the girls were placed with her mother, she had them for four years and had no problems in handling them. BM admitted the girls listen to their grandmother more than to her because she is not firm enough with them.

The next case excerpts document the workers' keen assessments of the biological fathers' compromised relations with the children in care.

Due to the length of time spent in foster care (Almost 6 yrs.) the children have developed and established primary relationships with their foster parents. Issues for the children involve separation from their foster parents...and acceptance of their father in the parent role...BF will need help in accepting the fact that his children see their foster parents as their primary caretakers, not him. Although BF has completed a parenting skills class he has much work in front of him in ensuring his children's adjustment.

CW has observed paternal family show favoritism towards the male child...Older [female] child has begun to express some resentment towards the paternal family because of the apparent favoritism towards her brother...Son continues to enjoy reunions with paternal family, despite his oldest sister's refusal to visit with paternal family...Female children in care have not visited BF...BF [incarcerated for the murder of his wife] continues to want to care for his children when released and continue to support paternal family as a planning resource until his return. He lacks the understanding of his children's conflictual feelings towards him and the [paternal] family...FM explained to agency staff psychiatrist that it was hard for oldest sister to even see her paternal cousins because she sees them with their mother and it just reminds her of what she lost and makes her miss her mother.

All 3 boys understand why they were placed in foster care. Older sibs have expressed anger towards their parents, particularly BF. Youngest son, however, remains confused about his feelings towards BPs....Older sibs are clear about their feelings about their BF, "don't care for him". Both said that they don't want to come home if BF is there. They stated that they feel BM does not need BF...BF blames oldest son for the family's problems... Youngest son is the favored child. BF went on for a few minutes about how much he missed "my baby" and how difficult this was. SW then reminded BF he had 3 children. BF laughed somewhat awkwardly. BF seems to be in denial or unwilling to share with SW that there are problems within the family.

### **Placement Separation Anxiety**

As referred to earlier, the initial foster placement is often, the first in a series of painful separations for the children in care and their family. In the next non-kinship excerpts the children's initial placement separation reactions are documented following the first family reunions.

The child and the worker discussed the reasons for his crying. The child verbalized a sense of regret and anger when his father and mother left. Clearly, it is difficult for the child to understand the reason for the family's separation. Worker needs to reassure child of his parents love for him and of his love towards his parents. He feels responsible and guilty towards the present situation. Once again, child expressed a sense of worry and responsibility towards his mother. Worker spoke to him about the respective differences between child and adult responsibilities. Child expressed he missed his siblings [who reside in another foster placement].

BM was physically affectionate to the children. BM apparently was very tense and emotionally moved during the [first reunion] meeting, but was also very helpful and cooperative in explaining to the children their separation process...Towards the end of our reunion, the oldest child began to act out by refusing to leave the agency without his mother...After 20 minutes after the children's departure, FM was forced to return with children to the office. Oldest child...became physically abusive to FM (kicking, biting, and pushing FM).

The following kinship excerpt highlights another example of placement separation anxiety; that is, when the biological mother, during the unsupervised visitation period, undertakes the process of resuming the primary parenting role from the kinship guardian.

The goals over the 6-month period have been to assist the BM in reestablishing her parental relationship with her children and helping her in the separation process with her own mother who has acted as the children's parent over the past two years...I [caseworker] spoke privately with the children about how the visits with their mother were going. They did not say much. I let them know that I knew that things were not always wonderful before when they lived with BM, and that some scary things had happened. They acknowledged that this was correct. I told them that I wanted them to know that their safety was important to their mother and me, and that if they were frightened or needed to talk, they could call me or talk to their mom.

The next non-kinship excerpt is an example of another manifestation of placement anxiety; it presents the children and family's reactive anxiety during the planning and court approval process for the children's trial discharge to the family. Note the worker's effort to redirect the paternal aunt's inappropriate efforts to assuage the children's fears.

Everyone arrived on time. Children were excited to see PA [paternal aunt]. PA brought pizza and candy for children, in addition to their toys and clothes from their home. PA said to children that hopefully they can come to live with them (paternal family) after next court date. CW asked PA not to tell the children when they are coming home, as no one can be sure of that. PA apologized, however, stated she wishes to reassure the children. CW asked that she reassure them by coming to visit the children, in addition to telling them they are loved and missed. PA was agreeable...As the reunion ended male child started to act out (not coming out from under the table, crying uncontrollably, rolling onto the floor). He felt better after about 1/2 hr. Youngest girl also cried uncontrollably for 15 minutes; oldest female child cried silently.

## **Unplanned Pregnancies**

As with neglectful families, the study found evidence that families mandated for domestic violence, also, had a history of unplanned pregnancies. In the succeeding case record, the biological mother's histories of repeat unplanned pregnancies perpetuates her pattern of maintaining relationships with violent substance abusing men.

BM met and married daughters' BF. BM claims that during the 6 years they lived together, he continually beat her until he was arrested and sent to prison for robbery. She then worked as a home attendant for 2 yrs. to support herself and the girls until she met son's) BF and had son. Before they met he was in jail for 6 yrs and is an IV drug user. She denies drug abuse, but admits to smoking marijuana in H.S. BM admits she has difficulty "sizing up" people and was impressed by son's BF who paid a lot of attention to her...When daughters' BF came out from jail and found out she was with son's BF, he broke into a rage and stabbed her and son's BF. BM was referred to a shelter for battered women. She left the shelter and went to live to Massachusetts with son's BF, leaving the three girls with her mother. Oldest child told her MGM that son's BF had been molesting her and MGM told the shelter worker, who referred them for medical evaluation and allegations were verified. BM was pregnant with twins at the time. However, during a subsequent argument between BM and son's BF he stabbed her several times, causing death of twins.

Similar to the preceding case, a biological father displayed a tendency to employ child-bearing to legitimize his relationships. Despite the husband's separation from his wife (due to her deportation back to Santo Domingo) and her suspected birth of a child by another paramour in Santo Domingo, the biological father's remains committed to the marriage and committed to the care of his biological child and step-children in this current marriage. In contrast, after the break-up of his first marriage, he relegated the care of his oldest son, by this first marriage, to the paternal aunt.

The (BM's) two oldest boys are not by youngest sibs' BF...During the past year, BM gave birth to a son, her fifth child. BF, who has visited the

Dominican Republic once since her departure to clear up her immigration status, believes this is his child.

Conspicuous, in this case recording, is the biological mother's apparent expectations of her children's risk for unplanned pregnancies.

BM said she would never kick her kids out like her mother did to her, especially if they were pregnant. BM said she already spoke with her daughter and boyfriend about sex and wanted her children to be able to come to her with their problems and questions at anytime.

### **Pattern of Dependent-Conflictual Relationships**

As Rosenberg (1985) reported, women who come from violent homes as children and were socialized to accept traditional female roles, often repeat this pattern in their adult relationships. The next kinship case record documents how a biological mother's early childhood experiences with family violence led to the maternal grandmother's neglectful conflictual relationship with her. Subsequent to the biological mother's relationship with the biological father, she developed a dependent surrogate maternal relationship with the children's paternal grandmother. The paternal grandmother became the kinship guardian upon the children's placement. In the following case excerpt, the worker records of the paternal kinship grandmother's account of biological mother's dependency pattern.

KM [kinship mother] said BM gets absorbed in her own life and neglects the kids. KM said BM is not a partier but she "has to have a man in her life". KM said she feels BM is probably seeing someone now and tends to date younger men. KM said BM always tells her she will try harder to take care of the kids but then becomes self-absorbed...KM stated she is worried about BM. KM said BM has not been calling the kids as often and missed one weekend visit. KM said she might be seeing a man and stated that she was

worried this would distract her from her children....KM said she feels BM is trying hard now but fears once she regains custody of the children she will slip into her old patterns. KM said there were so many times when the kids would call her to bring food because they had not eaten dinner. KM said she would also be out of money because she would give it to her boyfriend.

In another domestic violence case, intergenerational conflict between a biological mother and a kinship maternal grandmother plays a factor in the mother's dependent-conflictual patterns.

BM has a child-like quality about her...unable to protect herself and children. Apparently her mother [the kinship maternal grandmother] has been aware of her daughter's inability to take care for herself but hasn't helped her to have a sense of herself. MGM seems to be dominating personality and BM easily gives in to her as the men in her life...MGM said BM is too easy to fall into a relationship if any guy is nice to her...She does not have a sense of herself and that causes her to fall into abusive relationships...BM has been keeping her therapy appointments. However, according to the therapist BM has no insight to her problems in her relationship with abusive men and its affects on her children. Therapist feels BM may benefit from attending program for domestic violence for children who are in foster care.

Absent from the literature, but evident in this study, is men's susceptibility to this conflictual dependency pattern. The following is a case illustration of this.

Indeed, BF's fears that negative information will be used against him have worked against him [in therapy]. At the same time BF has made considerable progress in expressing his feelings and talking more openly about the problems in his life...An important issue I've [therapist] been working with BF is the learning how to verbalize his anger...My guess is that keeping his anger bottled up led to problems in the past with his wife and kids, as it might have burst out violently at the wrong times...Another important issue for BF is raising his self esteem which is low now probably due to losing his father when he was young, his first marriage dissolving, and now all of his recent problems with his [current] wife and losing the kids. Where I [therapist] see his low self esteem causing him problems is in his relationship with his

current wife. As he has talked more openly about their problem I see a pattern of him being too willing to accept and forgive infidelity and irresponsibility on her part while again allowing his anger to build up.

Debbonaire (1994) points to the fear of deportation that immigrant woman face when considering leaving an abusive relationship. The following excerpt suggests this as a factor of the mother's conflictual-dependence.

BM presents as a fragile frightened and victimized person. She appears completely overwhelmed by this situation and cried throughout the interview. Her english was broken, she spoke primarily in spanish, translated by spanish speaking supervisor...BM remains in denial as to the abuse she and children suffered and she continues to protect her husband and blame the older children for their placement..When confronted with BF history of alcohol and domestic abuse, BM's first reaction was to offer excuses. She presents as accepting of his abuse. She describes him as a good provider for the family "we've never been on welfare". It is as though the family is expected to take whatever BF subjects to since he provides for them. When asked how she felt about the abuse suffered by herself and the children, BM states that she told BF he had to stop because the boys were getting older. BM says that when the children were removed she told the BF he could not return to the home. BF has been arrested for domestic violence in the past. BM has initiated counseling recently...BM reported to her counselor that BF is in El Salvador, where they originated.

### **Summary**

Again, during the assessment stage, it was found that, among all the families mandated for domestic violence, there were more similarities than differences. That is, despite the domestic violence experience, there was evidence of family strengths, such as sound child-parental, sibling and extended family bonds. In addition, there was notable evidence of the biological fathers and paternal family members involvement. As well as,

documented evidence of therapy compliance and treatment gains. Alternatively, there was documented evidence of the impact of family limitations on the reunification process among the kinship and non-kinship case records. For instance, recordings noted the tendency for biological mothers' to advocate their parental role to the maternal grandmothers'; as well as, evidence of compromised relations between biological fathers and the children in care. Various forms of placement anxiety reactions were charted, ranging from the initial placement separation reaction to placement separation anxiety stemming from the reunification planning process. Another commonly recorded barrier to reunification was the tendency of the parents (3 out of the study's 5 domestic abuse families) to stay in abusing relationships because of unplanned pregnancies. Along with this finding, there was evidence that all the families mandated for domestic violence had charted patterns of dependent-conflictual relations.

## **THE INTERVENTION STAGE**

### **Families Mandated for Domestic Violence Families: Changing their Stories**

As previously stated, upon completion of the assessment stage, families require support of their strengths as well as interventive strategies to address the reunification barriers. Review of successful domestic violence cases found that the areas of documented intervention focused on the identified areas of recorded family limitations, with the exception of unplanned pregnancies. The congruent recorded areas were poor parental-child relations, placement separation-anxiety, and conflictual-dependent relations. The proceeding are examples of the workers' efforts at addressing these limitations.

### **Compromised Parental-Child Relations**

The following recording presents a worker's attempt to prepare a newly trained foster mother to understand and address her foster children's reactive behavior. Prior to placement, the children had a history of poor parental relations and acting out behavior, associated with the experience of domestic violence.

Met with FM to discuss the children's emotional, physical, medical, and psychological well-being...worker described in detail my knowledge of the children's past living environment and the dynamics of their relationship with their mother, father and siblings. I gave FM suggestions on how to deal with children's common temper tantrums. Worker emphasized understanding the children's perspectives and objectives in behaving they way that they do. Apparently FM is willing and able to deal with the children's behavioral patterns...Worker reviewed with FM my interview with boys and my impressions of them. Worker particularly emphasized the mother/foster mother rivalry dynamics as a means of exploring these feelings openly. Additionally I addressed the children's possible reaction to seeing their

mother: e.g. difficulties in separating, possible regression of behavior, etc. Worker gave FM suggestions on handling the children, such as explaining to children in detail her plans for their return to the home.

In the absence of the prior custodial mother, the biological father and paternal aunt have committed to caring for the children. Accordingly, the worker made diligent efforts to support them in their developing relationship with and parenting of the children.

BF continues to struggle in his efforts to control his children; he has little trouble with his younger daughter., as she is manageable; however, BF has more difficulty with son who is subject to tantrums and aggressive/oppositional behavior. BF would not discipline the children in front of CW choosing to ignore any inappropriate behavior. After this was discussed with BF he admitted to worrying about being "mean" to the children, fearing that worker would not return kids to him...BF continues to spend more time with youngest daughter. Male sib ran around wildly unsupervised by BF and with little attention by him. When BF hugged and kissed daughter. on several occasions, male sib seemed to notice and looked sad. BF told worker he loves his children but wishes they were all good like his daughter. Worker told BF he has to learn to interact and spend time with the boys, as well. BF said he didn't realize he treated them differently. He asked son to sit on his lap but son didn't want to. Worker suggested BF actively play with him. He began to swing son, his foster brother and youngest daughter. Son responded to this. BF became very tired and had to sit down for a while. Nonetheless worker praised him for trying... Worker has observed BF to be limited in his parenting skills, yet he has proven diligent in his efforts to learn and cooperate with suggestion given to him by the worker and his present therapist...PA initially made little to no effort to interact with children, expecting instead, that they come to her. Since the children had little knowledge or memory of PA they were unwilling to approach her. Worker discussed this with PA who then made a greater effort to involve herself. A good relationship has now been established and the children recognize PA as primary caregiver.

Workers also made use of professional consultation and collaboration as means to intervene in compromised parental-child relations. In this case the worker collaborates with a psycho- therapist to support the biological mother's expressed parenting conflicts and dependency patterns.

CW and BM talked about how hard it was to balance her children and her personal life. BM said she realized she was responsible for her son's safety and she should have not have let perpetrator back into her home after son had told her about the initial abuse...CW called to see how the sessions were going now that they were being held at the BM's home. Therapist stated things were going well but he had some concerns about boundaries and structure in the home...CW asked therapist if he could do some family sessions regarding family communication and younger sibs return home. Therapist agree to this and said he would alternate between individual and family sessions...BM's therapist states she feels BM has been utilizing her sessions to explore her relationship with men and how they affect her children. Therapist feels BM's ability to express herself and be more assertive is a definite plus. BM states she is focusing all her energy into her family right now. Her actions reinforce this statement...BM and CW discuss any parenting concerns during home visits. BM has been able to utilize information learned in her parenting class in situations with her children.

### **Placement Separation Anxiety**

The next case recording presents an effective interventive strategy a worker employed to address the youngest child's difficulty separating from his parents at the end of the family reunions. In doing so, she uses use of several approaches: facilitating collaboration between the parents and foster parents, encouraging the child's ventilation of the child's anxiety and managing his reactive separation fears through a task oriented approach.

Worker met with the FMs [children are placed in separate foster homes] and BPs. Worker encouraged a positive flow of information and ideas. The meeting went well and much was learned of the children's development. The FMs concentrated on the strength of the children. Worker took the opportunity to stress some of the BPs good skills in rearing the children. The group reunion was so much more positive than the last. The FMs and BPs are beginning to feel comfortable amongst each other...Worker encouraged child to speak of his feelings towards his parents. I [caseworker] explained to him that he would eventually be reunited with his parents. In an attempt to give the child a concrete goal--worker explained that both his mother and

father were looking for an apt. for him and siblings. Worker urged child to fantasize how/could leave agency without screaming, yelling, kicking etc., as he promised worker during worker's last home visit. Child appeared calmer and more at ease with his parents and FMs at the end of reunion.

In the next excerpt the worker individualizes and responds to distinct forms of separation anxiety. More specifically she distinguishes between the foster child's and the foster mother's reactive anxiety.

FM tried to encourage child to talk about her feelings about returning to BF. Again child refuse to discuss it. FM went ahead and explained that in two weeks she and all her belongings would be with her BF. As FM explained this, child took stapler and began stapling the pages of her notebook together. She did so angrily - hitting and slamming the stapler...Worker asked if child was sad about leaving; would she miss FM; did she want to be able to see FM even though she was living with BF. To all of those questions, she answered yes...Later, child showed worker photo album that FM had put together for her, stating that she would show it to everybody in the world...FM spoke of her difficulty in getting child to discuss the move to BF. She expressed her concern about child once she was home and stated that she'd like to keep in touch but won't force it...Worker has observed to be very judgmental about BF. FM tends to color things in a negative light. FM says she doesn't like BF's neighborhood and describes it as "a jungle". FM says child will have difficult time because she's afraid of blacks. When asked if FM is afraid of blacks, she admits it. FM appears to be projecting her many of her own fears of her own onto child.

The following excerpt demonstrates the worker's use of collaboration, with the child's therapist, to inform the biological mother about her children's reactive fears and how to respond to them. This leads to the worker's efforts to address the biological mother's denial of her guilt feelings and need to address these issues in family therapy.

Child has been receiving weekly [play] therapy. The therapist stated that child has insomnia, severe depression and anxiety. The therapy's long range goals are to help child address feelings of separation and loss, and enhance feelings of belonging...Worker shared her concerns about how the child and sibs might be anxious, given the experience they had living with her in the past. The children's need to feel safe, and protected by her. They will also

need to be able to tell her how they feel towards her how they feel towards her because of the domestic violence. We spoke in greater detail of how child will need to have extra assurance of her safety due to her experience of sexual abuse by stepfather. BM seemed to be resistant, so we spoke about how painful the memories are BM. She said that she would go to therapy, but she also shared that she found it hard to talk..We (CW and BM) spoke about the possibility of family therapy to help the children deal with feelings that might come up during the move.

### **Pattern of Dependent-Conflictual Relations**

Another notable area of successful intervention involves to the workers' understanding of the distinct importance of domestic violence counseling for the batterer and the battered family members. In the following case illustrations, despite the family's prior involvement in counseling, there is a recognition of the particular need for domestic violence related counseling.

BM said she has not been going to therapy regularly but that she was willing to continue. Worker got the impression that BM would do anything the agency asked in terms of therapy, but that she did not see it as something which was going to help her...BM's therapist said that BM has not been very invested in the therapy. She said "I do most of the talking". The therapist did not feel comfortable recommending anything to the court. She said that BM had not focused on the issues of domestic violence or sexual abuse in therapy. She had suggested the domestic violence group as something that might provide BM with support and help her deal openly with the domestic violence which she experience.

Evident in the following excerpt is the worker's attempt to address the "co-incidence" pattern of domestic and substance abuse. (This pattern will be further discussed in the chapter on the helping process of families mandated for substance abuse).

Therapist reports that she sees BM on a weekly basis and sometimes twice a week; the children are also participating. She reports that the older sib remains very angry and resentful of BF and do not want him to return to the home. Therapist is considering recommending that the two older sibs attend an Alanon Adolescent group [An Alcoholic Anonymous related program for family members of alcoholics]. Therapist says that BM has not been referred to a group for battered woman...yet because she is having some health problems.

Despite the biological father's initial involvement in planning for the children's return, his sustained pattern of violence towards the biological mother impelled her to separate from him and seek an order of protection. As a result, the agency was compelled to attain a court mandate for parental domestic violence counseling in order insure the children's protection prior to discharge.

CW explained to BF that he is not allowed to return to his home till he complete an alcohol treatment and domestic violence program. BF nodded his head yes as CW explained...BM has been receiving supportive family counseling. It is our belief that BM needs counseling with a more clinical orientation...BM remains in denial as to the abuse she and children suffered and she continues to protect her husband and blame the older children for their placement. Agency has advised CWA attorney to request the court to order BM to psychotherapy...BF, like BM, is in denial as to the abuse of his wife and children. BF also denies that he is an alcoholic...SW learned that BF has only attended the alcohol program once and has not followed through on referral to batter's program...BM will discuss her marital relationship in counseling and ,if necessary, enroll in services for battered women. CW will provide BM counseling aimed at improving self awareness and self esteem. Worker will also provide educative counseling on domestic violence and, if necessary, refer BM for services to battered women. BF will enroll in and complete program for perpetrators of domestic violence. Worker has referred BF to offender program. Worker will monitor BF's participation in program...BM has obtained an order of protection for her self and children against BF...As of this date, BF has not followed through on the referrals. Again, agency has asked CWA attorneys' to get the court to order that BF attend an alcohol treatment and batterer's program...Home visits and phone calls by various workers on the case have confirmed that BF no longer lives with BM and has moved to another apt.

As previously mentioned, in contrast to the literature's emphasis on social workers' tendencies to treat the biological father as the "invisible man", the following excerpts documents efforts by workers to either defuse the parents' conflictual interactions or to support the father's development of effective parenting skills.

BM has not been able to focus her energy: BM is a narcissistic teenage-like mother who's very involved...Parents are like siblings to children rather than as parents... BF has begun to accept that he will not be living with BM and children. However, BF does want to do what he can just to get children out of foster care. BM's decision not to want to live with BF has caused problems at reunions, as both bring out their frustrations with each other in verbal battles. Worker has attempted to defuse this by allowing time before the reunion to voice their dissatisfactions.

BF has become much more cooperative with the agency...he now admits that his wife was abusive and neglectful of the children. BF also has become willing to discuss his marital problems and concerns about the BM's past and present behavior. BF recognizes that the children have special needs and problems related to the abuse and neglect experience...SW discussed the role of the homemaker and that PA was to teach BF to be caretaker (ie cooking, cleaning, laundry, child care). BF seemed irritated but PA confirmed that BF could benefit from this service. PA stated that BF had to learn to be both mother and father to his children.

### **Summary**

In the preceding, a range of successful case records interventive entries was documented amongst, both kinship and non-kinship, foster care placements. However, due to the study's limited sample size, a critical comparison of the kinship and non-kinship domestic violence documented interventions was not viable. Nonetheless, commonalities amongst the entries were evident. For instance, there was documented evidence among all the families mandated for domestic violence of the workers' efforts to

improve the biological parents relations with their children; as well as, there was evidence of the workers' efforts to prepare the foster parents to handle the children's domestic violence related acting out. Similarly, among all the families, there was evidence of documented interventions designed to address the range of placement related separation anxiety. The scope, of which, ranged from the family's initial placement separation fears (arising from the family's first placement reunion), to those of the biological/foster parents' separation fears (arising from the reunification process). The last set of documented interventions were targeted to address the pattern of dependent-conflictual relations amongst the biological parents. Of particular significance was the recognition of the specific need for family members to participate in domestic violence related treatment; corroborating family violence researchers' argument that the pattern of violence within families are far more complex, varied and require the consideration of interactional dynamics. Of equal importance, was the negation of the tendency to exclude battering men from the helping process. At the same time, these workers seemed to adhere to the empowerment perspective that allowed the battered spouse to control their own decision-making process about whether to remain in the abusive relationship. While, the limited scope of the sample population prevents the study from drawing definite conclusions, it does suggest that an agency's commitment to holistic family service and the provision of related staff training may advance the delivery of services that empower battered and their children spouses.

## **THE TERMINATION STAGE**

### **Families Mandated for Domestic Violence: Completing their Stories**

During the termination stage, three prominent documentation themes emerged from the case records of families mandated for domestic abuse: reunification ambivalence, a summary of the domestic violence recovery process and a review of the final reunification stage.

### **Reunification Ambivalence**

As mentioned in the previous chapter, an important element in effective in permanency planning involves addressing normative family reunification ambivalence reactions that surface prior to the return of the children. One of the ways that this ambivalence surfaced for the children, mandated for domestic violence, was in the form concern about of physical and emotional safety. For example, in the case of the father who killed the mother, the son's ambivalent feelings appear to be as a result from his conflictual attachment to his father and emotional turmoil about the death of his mother. Similarly, after having witnessed repeated occurrences of violence between the maternal and paternal family, the oldest daughter requests a change in discharge planning to independent living from the paternal and maternal family.

**Child visits with his father at Rakers [prison]. He has ambivalence about his father. He cares for him but fears him. After visits he becomes hyperactive and restless. Oldest sister's PPG [Permanency Planning Goal] was changed to independent living. She refuses all contact with paternal and maternal families. She is also refusing sibling contact She continues to state a desire to stay with the FF [foster family]. However, the agency plans on working**

with her towards sibling visits as well as a possible family resource even though the ppg is independent living.

The next case recording illustrates children's uncertainty about their own safety, related to their mother's history of violent partners and their adjustment to a new living environment. In response, the agency employs a staggered discharge plan to facilitate such family transitions.

We [CW and BM] discussed how each of the children has been responding to the overnight and weekend visits. It seems that they have enjoyed being home. However, BM realizes that it will take time for them to feel safe and secure in her home...I [caseworker] spoke with the girls about what it was like for them when they went home to their mother's home. They expressed feelings of comfort and excitement. However, they were shy about making new friends in the neighborhood... The girls said that the neighborhood is "very quiet". "It is like being in the country"... We discussed plans for gradual transition of the kids, and what that would mean for each of the children. The plan is for the youngest child to go home...and then the two older to go at the end of the school year. We spoke about the possibility of family therapy to help the children deal with feelings that might come up during the move...The staggered dates...will allow the mother to adjust to the stresses involved in caring for the children over a period of time.

Another form of reunification ambivalence appeared to arise during the transition of a child's attachment from the kinship/foster parents to the parental bond; that is, ambivalence stemming from a sense of divided loyalty due to the child's return to their primary dependency on the parental figure rather than on the kinship/foster parent. The following kinship and non-kinship scenarios are examples of this transitional reaction. Apparent in these records are the ambivalent reactions manifested among both children and adults.

**Youngest daughter has expressed ambivalence about leaving her grandparents due to her extreme attachment to them...Older children love being home with**

their mother on weekends and are eager for this (discharge) to be final... Younger sibs have shown some ambivalence about returning home due to their strong attachment to both their grandparents and their mother...Staggered discharge is being planned. Oldest children will be discharge first...CW called PGM [kinship paternal grandmother] to inform her that we [CW and supervisor] had spoken with BM about their [younger sibs] ambivalence in returning to her; however, BM wanted the children with her. PGM said she wanted this too but she was concerned BM would return to her "old ways" and the children would be in danger.

Worker suggested that one of the issues the therapist must address with BF is BF acceptance of his children's relationship with their FPs'. BF should be encouraged to allow his children to maintain contact with FP's if they express a desire to do so. (Older sib had previously expressed his fear that he would never see FM after discharge). BF should be assisted in understanding that FM's are not a threat to his relationship with his children.

### **Domestic Violence Recovery Process**

As with neglectful families, during termination, the study found that there were documented summaries of the respective rehabilitation process for each of the successfully reunified families mandated for domestic violence. Evident in the findings of the domestic recovery process was a shift in the pattern of dependent-conflictual relationships. In the following kinship foster care case, there was a shift in the biological mother's conflictual dependency pattern with men to a more positive dependency on her relationship with the maternal grandmother.

MGM fully supports the plan to discharge her grandchildren to BM. She states that she will continue to be highly involved in their lives, and to provide support. Presently, her daughter calls her several times daily, and this contact will continue as well as frequent visits...At this time, the BF no longer visits the children at grandmother's home. The family does not want to have contact with him, as he has threatened BM because she will not return to him. He is HIV positive...MGM recognizes that her daughter has a pattern of becoming involved with violent men. She attributes this to her daughter's

naivete and her difficulty in asserting herself. She has continued to encourage her daughter to attend counseling, and says that she also plans to attend a support group for battered women.

Evident in another case, a biological father's recovery from his dependent-conflictual relationship from his abusive wife. Here, however, there appears to be a transfer of this dependency from his wife to his sister.

BM returned to the Dominican Republic in order to straighten out her Immigration status...No progress has been made in securing BM return to this country...BM remain in denial as to the reasons for the children's placement in foster care. BM agreed to plan for trial discharge to BF and said she would attend marital and family therapy should she return...Agency is concerned about possible return of BM to the U.S. and how this might destabilize the family...There has been in the past, and remains at present, much conflict between BM and BF, none of which has been addressed since her departure for the Dominican Republic...BF is limited in his ability to anticipate the needs of the children. BF has been receptive to worker's suggestions regarding management of children but agency has concerns for their safety and well-being without someone to assist BF. BF has asked his sister to return to New York [from Puerto Rico] and help him with the children...BF's sister and mother are presently living with him; and his sister has been doing much of the caretaking of the children during their home visits- BF relies on her heavily; particularly for cooking and cleaning...With each visit, PA [paternal aunt] becomes more involved with children. She's taking a more active role, both in disciplining the kids and in displaying affection. The children, in turn, are more responsive to her. PA appears very happy when the kids positively acknowledge her and more willing to discipline when the kids act out. (Previously, she would tell BF to discipline them, refusing to deal with them when they got out of control)...BF has stated to his therapist that he is resolved to raising the kids on his own if BM is not willing to make some changes and take responsibility for her actions.

Conspicuous, in the following case record, is the biological mother's awareness of and commitment to recover from the effects of her intergenerational family violence experience.

BM has been able to recognize her responsibility and part in her child's sexual abuse by her boyfriend...[She] also has been able to recognize the pattern of

her relationship with men, and how it impact on her children...Mother has worked hard to repair the damage done to her family due to the sexual abuse of her son and the subsequent separation of the family...Despite the success of mother's therapy. She recognize how her childhood history continues to affect and has committed to remain in therapy after return of the child...The child [oldest daughter] is very eager to be reunited with her mother. She and BM have a strong bond. The two have been able to talk about younger brother's sexual abuse and particularly how [older] child felt. The child's relationship with her mother in the past year has become stronger as BM has learned to better communicate with her daughter...CW has observed BM become stronger parental figure over the last six months as she prepares to take over the role primary caregiver.

At the same time, in some cases there was evidence of the limitations of domestic violence recovery. Despite the maternal and paternal family's ability to care for the respective children in their care, in the following case they were unable to reconcile their apparent intracultural conflicts, fostered by unresolved feelings about the father's murder of the mother.

The agency is concerned that without CWA [Child Welfare Administration] involvement, there will be difficulties with sibling visits due to the conflicted relationship between the two families. Younger sibs seem to enjoying seeing each other since an adjustment in the visitation...Male child is on trial discharge with the condition that paternal relatives cooperate with visitation between he, sibs and his maternal family at least monthly. Agency social worker is facilitating visits and trying to promote a better relationship between paternal and maternal relatives who remain hostile towards each other but express caring feelings towards all the children....Since male child's trial discharge the paternal family are cooperating with his visits with maternal family and siblings. However, both families refuse contact with each other. Therefore, the social worker must transport male child in order for visitation to occur. Currently, this arrangement is working, but indicates potential problems when neither family is under CWA supervision...Animosity remains strong between the two families and there is no sign that they will be capable of resolving their respective issues in the future. We are not certain that the children will stay in contact with each other without continued CWA involvement.

## **Review of the Final Reunification Phase**

As Meyer and Palleja (1995) assert, termination is a time of review where all the themes of the case can be recognized and the helping process reviewed. As in the previous chapter, the case review of domestic violence cases revealed documented evaluations of the final reunification phase. Included in this review was: 1) the recording of the domestic violence recovery discharge themes; 2) the recordings of the worker's efforts to monitor the period of unsupervised visitation/trial discharge; 3) the recordings of the provision of prevention services to support the integrity of the family's reunification. Here the worker's efforts to support the mother's developing parenting skills while monitoring the integrity of the discharge process.

Worker spoke with child and sibs in BM's home about their overnight and weekend visits. The visit was generally relaxed and comfortable. The girls expresses feelings of comfort and excitement...The children see their mother daily at the MGM's home. They appear comfortable and connected to her. They visit her in her Queen's home on a regular basis. The overnight and weekend visits have been going well. BM visits at her mother's daily. She has assumed much of the responsibility for taking daughter to her medical appointments. Daughter suffers from chronic asthma, and needs daily treatments involving a ventilator. At the last home visit, the mother demonstrated a working understanding of how to use the machine and administer the child's medication. BM is cognizant of the responsibility of caring for an asthmatic child. She is also aware of the nearest hospital and the emergency clinic in her neighborhood in Queens...Child continues to attend (therapeutic) day center. Teachers state that child has adjusted...child used to act out frequently but most of this has ended...Individual and family counseling are provided around the issues of: 1) domestic violence 2) sexual abuse of middle child 3) transition of living with BM 4) adjustment to new schools and neighborhood...Worker spoke with child and sibs about school and the possibility of having a tutor come to their home to help them with math and reading after they returned to live with their BM...In SW's assessment, the first weekend discharge had gone well for BM and children. BM has shown ample evidence that she intends to get her life together without BF. The family has a wide range of services and activities available

to them. SW has no hesitation about BM's ability to nurture and protect her children.

With another family a worker documents a biological father's non-compliance with rehabilitative treatment, her efforts to insure the safety of the children and the quality of their family reunification.

Trial Discharge is requested upon directive of CWA for the following reasons: 1. BF is no longer living in the household. 2. BM has obtained an order of protection against BF on behalf of herself and children. 3. Home visits have been made to BM and to BF to verify their separate residences. 4. BM has been regularly attending her weekly counseling sessions, as reported by the prevention worker. The family will be monitored for 3 months by agency. Regular home visits will be made. Upon final discharge, the agency request that the preventive agency assume case planning responsibility for the family. BM will continue to receive counseling individually, as will the children...The family will be seen together. BM to attend psycho therapy and support group for battered women...BF cannot be incorporated into counseling sessions with BM and the children at preventive agency until he completes a counseling program for batterers and is regularly attending an alcohol treatment program...BF has been referred to both such programs by agency but has yet to follow through on the referrals. Risk is present if BF is allowed to return to the home at this time. BPs must be made to understand that the children will be removed form the home again if BF violates the order of Protection. BF must complete the counseling program for batterers and be regularly attending an alcohol treatment program before a decision to allow him to return to the home is made. Preventive services are needed for a minimum of one year.

### **Summary**

Finally, as with the neglectful families, the study of successfully reunified domestic violence cases revealed that during the termination phase there was recorded evidence of reunification ambivalence. And, as with neglected children, families mandated for domestic violence exhibited ambivalence during the children's transitional

attachment from the kinship/foster guardian back to their primary biological parent/family attachment. However, there was an additional form of reunification ambivalence, particular to domestic violence families, that stemmed from the fear about the resumption of family violence after the children's discharge.

The domestic violence recovery process was, also, apparent during this phase. That is, a parental shift away from conflictual-dependent relationships (i.e. abusive partners or family members) towards more positive family relationships or more independent functioning. Nonetheless, there was also documentation, in some of the families, of the limitations of this change. Lastly, as with the previous chapter, there was documented reviews, in all the successfully reunified domestic violence family case records, of the final reunification stage; that is, evidence of domestic recovery discharge themes, of workers' efforts to monitor the period of unsupervised visitation/trial discharge and the provision of discharge preventive services.

## **CHAPTER 5: SUBSTANCE ABUSE**

### **Literature Review**

During the past decade a record number of single-parent families entered the child welfare system because the mother had an identified problem of substance abuse (Azzi-Lessing & Olsen, 1996; Magura & Laudel, 1996; Farkas and Parran, 1993; Wilsnack and Wilsnack, 1990), affecting as many as 80 percent of all cases of substantiated abuse and neglect (Child Welfare League of America, 1990). The introduction of crack cocaine use in the mid-1980s had devastating consequences because of the drug's appeal to women, many of whom were of childbearing age. During these years, crack cocaine use among women quickly escalated and child well-being was reflected in a significant increase of child protected services (CPS) reports related to substance abuse (Carten, 1996). Public child welfare agencies in many parts of the country seem to be especially taxed by referrals concerning drug using parents. The result is the common practice of placing children in foster care primarily due to drug use. This is especially prevalent in Urban areas (U.S. House of Representatives, 1990; Select Committee on Children, Youth & Families, 1989; Weston et al., 1989). New York City, like other urban areas, was hit hard by the problem. Between 1982 and 1989 the number of substance abuse-related CPS reports doubled (Child Welfare Administration, 1993). There are an estimated 70,245 New York Families with a child under 5 whose mother is a problem drinker (Women's Report, 1990). In 1988 nearly 5,000 newborns were reported in the city to CPS because they tested positive for exposure to drugs (Carten, 1996).

Child bearing and rearing roles are gender specific roles, making drug use by women a particular concern to health care providers and policy makers. This linking of mothers and children has resulted in the elevation of fetal rights over maternal rights and the creation of policies such as the criminalization of maternal conduct during pregnancy (Gustavsson, 1991). Drug use by pregnant women can result in criminal prosecution as well as referral to child placing agencies. States such as New York, California, Illinois, Florida, Minnesota, Utah, Oklahoma, Indiana, and Massachusetts have amended their child reporting statutes to require reports of suspected abuse or neglect to be made in cases of prenatal chemical exposure. Estimates of the incidence of drug use by pregnant women vary considerably. A widely quoted study of data collection from 36 hospitals using a broad definition of chemicals estimated that more than 375,000 children are born yearly prenatally exposed to chemicals (Chasnoff, 1989). The Office of Alcohol and Substance Abuse Services estimates that at least 500 infants are born with Fetal Alcohol Syndrome each year in New York State, and at least four times that number are born with less severe fetal alcohol effects (Five Year Plan, 1988; Women's Report, 1990).

### **Maternal Drug Treatment Needs and Approaches**

Irrespective of differences in state laws, drug using mothers are regarded in a punitive fashion and present numerous challenges to the health and welfare system (Hartman, 1994; Chavkin et al., 1993; Chavkin, 1991, 1990; Everette, Chipungi & Leashore, 1991; Hill, 1977; Giovanni & Billingsley, 1970). Since alcohol and other drug abuse is often a familial trait, it is likely that a proportion of substance abuse women grew

up in a using family, were not nurtured as children, and lacked the role models of consistent nurturing parents. Similarly, the social supports of women who used alcohol and other drugs (AOD) are often AOD-using men and women, so that their current adult role models may be limited (Tracy & Farkas, 1994). Women who use AOD are likely to be in intimate relationships with partners who are users (Bennett, 1995; Lex, 1991). A high proportion of women in treatment for AOD use are victims of sexual and/or physical abuse (Lex, 1991; Hagan, 1987). In their AIDS/relapse skill-building intervention studies with drug dependent women, Gilbert et al. (1997), found the high rate of domestic violence and the strong association between childhood and partner abuse found in their studies suggested areas for intervention in chemical dependency. In particular, that the fear, rage and humiliation arising from abusive intimate relationships constituted a common powerful trigger for drug use. Gilbert et al. (1997) also found that among substance abusing women in their study there was a high rate of revictimization: almost two thirds of the women who had been abused by a partner or a spouse reported that they had also been physically or sexually abused as children.

Given the high co-incidence of substance use and domestic assault, many practitioners assume that substance use is a primary cause of violence towards women. Practitioners are not alone; those closest to violence-batterers, victims, and law enforcement officers-often attribute causation of domestic violence to alcohol or drugs. However, some researchers do not refer to the relationship between substance abuse and woman abuse as causal but as one of co-incidence (Bennett, 1995); that is, for some men and some situations, psychoactive drug use may enhance violence. For other men and

other situations, there is no relationship between their violence and their use of drugs, and still for other men, alcohol and drugs may actually prevent violence (Bard & Zacker, 1974; Coleman & Straus, 1983; Leonard & Jacob, 1988). Despite these differences, nearly three-fourths of alcoholic women suffer some type of sexual abuse compared to 40 percent of the general population (Miller et al, 1993); prescribing treatment and prevention approaches that take into account generational patterns of AOD use, sexual and physical child abuse as developmental risk factors for the child in placement.

The major problem confronting child welfare agencies nationally is how to work with the chemically dependent mothers while at the same time protecting children and preserving families. Women's parental and care giving roles have not traditionally been focus of substance abuse treatment, even though substance abuse clearly has an impact on a women's ability to parent. Most treatment settings, however, focus on abstinence and sobriety. Family reunification and long-term family functioning are rarely, if ever, dealt with during AOD abuse treatment (Magura & Laudel, 1996; Tracy & Farkas, 1994). Drug using women are likely to have experienced serious trauma during childhood and are likely to be living in hostile or non-supportive environments (Yandow, 1989). Isolation, feelings of helplessness, depression, and impaired self-esteem, and lack of confidence in one's ability to be a successful mother are common psychological characteristics (Tracy & Farkas, 1994; Amaro et al., 1989; Burns et al., 1985; Regan et al., 1987). According to Gustavsson & Rycraft (1993) these psychosocial variables need to be addressed using an ecological perspective. With this perspective, the unit of assessment is expanded and the drug dependent mother is seen in the context of her environment. The need for specific

treatment geared towards women is being recognized, and experiential programs are being developed (Magura & Laudel, 1996; Scannapieco, 1994; DiLeonardi, 1993; Brown, 1992; Rahdert & Finnegan, 1993; Tollett, 1990). The urgency of the drug crisis has led to an expansion of treatment programs, a diminished focus on evaluation and research, creating a paradoxical situation of an increase in demands for solution with limited understanding of the effectiveness of proposed remedies (Agenda for Children Tomorrow, 1990). As a result, Goldberg (1995) calls for additional research on the causes of women's substance abuse in order to improve treatments designed for women.

For women, the barriers to treatment for alcohol problems are numerous. These include the greater social stigma felt by alcoholic women; denial or lack of awareness among friends and families; dual addictions; and a lack of resources to apply for treatment. In addition, the lack of discrete services, ineffective outreach/intervention, the lack of child care options, and the failure to address women-specific treatment issues and to provide ancillary services to keep many women free from entering treatment (Women's Report, 1990).

According to Tracy and Farkas (1994) to meet the child welfare system's goals of child protection, family preservation, and to meet the treatment system's goals of abstinence and sobriety, social work practitioners must deal simultaneously with the mother's recovery and the child's safety and well-being. Alternative models for understanding drug use as a coping mechanism are central to understanding the root cause of drug use for women (Mason, 1991). According to Nelson-Zlupko, Kauffman, Dore (1995) women often use chemicals to cope with what appear to be unsurmountable

stressors. Chemical use may actually succeed as a coping mechanism for a period of time. At some point, however, the negative effects of drug use outweigh its benefits (Woody, 1989). Using this perspective, practitioners can help women to identify the components of the environment that are unhealthy and oppressive and that trigger their drug use. Having identified these sources of struggle and stress, women can then be helped to develop and use more effective, safe and nondestructive alternative coping strategies (Woodhouse, 1990; Anglin, Hser & Booth, 1987). Workers must be able not only to identify and document the impact of alcohol and other drug abuse on parenting, but also assess substance use and abuse within the larger context of family functioning and behavior, including parental use of formal and informal supports, availability of community resources, parental desire and capacity to parent, the child's attachment to the family, the child's special medical/developmental problems, and the likelihood that in-home services can reduce risk (CWLA North American Commission on Chemical Dependency and Child Welfare, 1992).

### **Natural Addiction Recovery**

According to Cloud & Granfield (1994a) the termination of alcohol or drug use without clinical intervention has received limited empirical attention. However, research exploring this phenomenon has found that significant numbers of people discontinue their excessive intake of addictive substances without formal or lay treatment. While the actual size of the "natural" recovery population remains unknown, researchers agree that their numbers are large (Goodwin et al, 1971) and some even contend that they are

substantially larger than those choosing to enter treatment facilities or self-help groups (Biernacki, 1986; Peele, 1989). Some have estimated that as many as 90 percent of problem drinkers never enter treatment and many of these suspend problematic use without it (Hingson et al., 1980; Roizon et al., 1978; Stall and Biernacki, 1986). Despite opposition, research on natural recovery has offered insight into how people successfully transform their lives without turning to professional or self-help groups. For example, most ex-smokers discontinue their tobacco use without treatment (Peele, 1989), while many "mature-out" of a variety of behaviors including heavy drinking and narcotic use (Snow, 1973; Winick, 1962). Researchers examining such transformations frequently point to factors within the individual's social context that promote change. Not only as patterns within the individual's social context as Zinberg (1986) illustrated, but the experience of quitting as well can be understood from this perspective (Waldorf, Reinerman & Murphy, 1991).

Findings from Cloud & Granfield (1994b) of former (AOD) addicts who overcame their alcohol and other addictions without benefit of treatment can offer new perspectives to mandated child welfare workers and AOD treatment providers. They concluded: 1) access to important resources played a major role in the process of recovery, 2) changing social networks, particularly those consisting of heavy drug and alcohol users, was essential to successful recovery for these respondents, 3) The respondents in the study had a "stake in conventional life"; coming from typical middle-class environment, with greater life investments; thereby probably benefit from less traditional forms of intervention, 4) for individuals who are adverse to treatment because

of the implicit disease or life-long addiction label, referrals should view AOD problems as existing along a continuum from mild to severe; viewing treatment similarly, from the least intensive to the most and suggest treatment to match the individual characteristics/life situations. Perhaps Biernacki's (1986) investigation of former heroin addicts is the best known text on natural recovery. Emphasizing the importance of social context, Biernacki demonstrates how heroin addicts terminated their addiction and successfully transformed their lives. Most of the addicts in this study as well as others initiated self-recovery after experiencing an assortment of problems that led to a resolve to change.

Biernacki found that addicts who arrest addictions naturally utilize a variety of strategies. Such strategies involve breaking off relationships with other drug users (Shaffer & Jones, 1991), removing oneself from a drug-environment (Stall and Biernacki, 1986), building new structures in their lives (Peele, 1989), and using social networks of friends and family that help provide support for this newly emerging status (Biernacki, 1986). Although it is unclear whether the social context of those who terminate naturally is uniquely different from those who undergo treatment, it is certain that environmental factors significantly influence the success of efforts employed to stop (Cloud & Granfield, 1994a).

While this literature on natural recovery has been highly instructive, much research has focused on the addict's unwillingness to undergo formal treatment such as therapeutic communities, Methadone maintenance, psychotherapy, or regular counseling in outpatient clinics (Biernacki, 1986). Many of those rejecting professional intervention

nevertheless participate in self-help groups. Of those not choosing natural recovery, self-help groups have been the most popular avenue of recovery for people experiencing alcohol and drug problems (Cloud & Granfield, 1994a). This may be due in part to the fact that groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or Cocaine Anonymous (CA) medicalize substance abuse to alleviate personal responsibility and related guilt (Trice and Roman, 1970). Moreover, these groups create support communities which helps facilitate behavior change. Despite their attractions and the popularity of these groups, many professionals remain skeptical about their effectiveness. Research has demonstrated that addicts who affiliate with self-help groups relapse at a significantly higher rate than those who undergo hospitalization alone (Hingson et al., 1980). Others have raised concerns about the appropriateness of self-help groups in all instances of addiction (Lewis, Dana and Blevins, 1994). Peele (1989) estimates that nearly all of those who affiliate with such groups relapse within the first year; contending that these groups are not very effective in stopping addictive behaviors since such groups subscribe to the ideology of lifelong addiction; as such, relapse maybe be viewed as part of the lifelong recovery process. Adopting the addict-for-life ideology, as many members do, has implications for a person's identity as well as ways of relating to the world around them (Brown, 1991). Somewhat between the two positions of skepticism and optimism are the findings of Emrick, Tonigan, Montgomery, and Little (Cloud & Granfield, 1994a). Their meta-analysis of 107 studies on AA effectiveness reports only a modest correlation between exposure to self-help groups and reduced drinking behavior. They additionally point out the compelling need for further research on the personal

characteristics of individuals for whom these programs are beneficial and those for whom they are not.

### **Practice Implications**

Knowledge about natural addiction recovery self-help and professional interventions can be useful to child welfare case managers in several ways. First, it can be employed to support and monitor the recovering process of the AOD biological parents. Moreover, this knowledge base can facilitate the caseworker's assessment of parental non-compliance with court mandated AOD rehabilitative treatment services. The worker is aided in developing differential assessments of AOD parents' recovery needs (e.g. lack of environmental supports/resources, the need for changing social networks or need to better match treatment services to parents' individual characteristics/life situations). In turn, after addressing these issues and the need for related behavioral/environmental changes with the parent, the casemanager can locate and advocate for more individually suited rehabilitative programs and/or needed referral services. However, it is equally important for the parent to be advised of their need to comply with court ordered treatment mandates and their related time constraints. If in doing so, the parent is unable or unwilling to comply with the AOD rehabilitation, their behavioral pattern can be employed (in the "best interest" of the child) to help them to consider voluntarily relinquishing their parental rights. Or, as a final alternative in the face of parental AOD non-compliant rehabilitation, prepares the case manager to confront the difficult decision to legally seek to terminate parental rights. In short, knowledge of

**the natural recovery process can aid the worker to support their AOD addicted parents recovery process; as well as aiding the worker to assess and intervene with those parents who are resisting addiction recovery.**

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## **THE EXPLORATION STAGE**

### **Families Mandated for Substance Abuse: Exploring their Stories**

#### **Placement Precipitant: Maternal Substance Abuse**

According to the case records reviewed, 50% (9 out of 18) of the study's sample population were families mandated into care because of child neglect due to maternal drug abuse. While there was ample indication within the case records to suggest that paternal substance abuse, also, affected the welfare of children in the study, the primary casework efforts recorded were those directed towards the rehabilitation of substance abusing mothers; in 5 of out of the study's 9 families, referred for substance abuse, there was documented evidence of paternal substance abuse. Substantiating the literature's assertion that childbearing and rearing roles are gender specific roles that make drug use by women a particular target for child welfare services. In short, the composition of the study's substance abusing families entailed the substance abusing single mother, the neglected children and, at times, available partners and or extended family members. The following kinship excerpts are recorded examples of the mothers' acknowledgement of the placement precipitant.

Met with BM...[She] was on her way to Methadone program. She told me [case worker] the child had to be taken away from her because she had left her at a friend's home without leaving food for her; although, she and friend had an arrangement of sometimes caring for each other's children (including feeding them). She admitted to drug use at that time and her need for treatment.

Of another kinship family, the case worker recorded.

CW met BM at agency. BM is a small attractive African American woman, age 31. She was very open about her drug history and how the children came

into placement...BM spoke of her relationship with oldest sib in care. She said they get along well, however, there was a times when sib paid no respect to her. This occurred while BM was using drugs...BM and CW talked for about 1/2 hours. BM relayed to me [CW] a lot of her history. She talked about difficulty of having her youngest child taken right from hospital [Child was born with positive drug toxicology].

As with the kinship cases, the following are recorded examples of the circumstances that led to placement of the children of non-kinship substance abusing mothers.

BM presents herself as a limited and anxious hispanic woman who has minimal education and has a history of heroine abuse...According to BM, she lived with her mother and three children until mother died and one of BM's sisters was murdered. Two yrs later, youngest son was born with a positive toxicology. At that time, the two youngest children were placed with MA but oldest daughter was placed with PGM. Oldest son was placed in foster care and was adopted. According to BM, he was released for adoption after BM signed surrender papers ignorant of what the document read...BM shared she feels very alone and frustrated about her living situation...She has a history of being unable to provide adequate care for her children (at one time mother lived in an abandoned building with her children).

In the proceeding family, placement was precipitated when a non-kinship mother gave birth to a baby with positive drug toxicology. Her 2 year old daughter was also placed, at that time, because she was left her in the care of a substance abusing maternal grandmother.

BM denies using drugs since birth of last child. She claimed smoking crack 2 times a week while pregnant and also with older sib. BM claims she is attending rehabilitation meetings twice a week and also parenting classes. BM states MGPs are not supportive of her...BM states that her parents (whom she and BF resides with) are currently doing drugs and often "have company doing drugs in the living room". BM stated that she must get out of her apt because there is a great temptation for her to do drugs.

## **Engagement Efforts**

As expected there were charted notations of the biological mothers' initial resistance to services. The following kinship case recording illustrates this resistance and the case workers' engagement efforts.

When BM came in, I [CW] could see that she appeared frustrated. She said, "I know you've come here to watch us, so go ahead". At this point, MGM left the room, saying "I'll let you two talk". MGM took kinship child with her. I addressed the situation by saying to BM "I know this isn't fun for you to have a social worker come to your house twice a month". When BM did not respond, I said "What do you think about that?" BM replied, "I think it's stupid". I explained to BM that unfortunately there would continue to be a social worker in their lives until her child was out of the foster care system. I also mentioned that it might not seem to them like foster care since they were a family. BM agreed with this comment. I tried to convey to BM that the system did not differentiate between families in kinship care and regular foster care.

In this next kinship case the worker makes an efforts to support and normalize the mother's feelings and concerns.

It was very difficult to speak one-on-one to BM. She was visibly uncomfortable, as she could not maintain eye contact...I let her know that I felt she was a very strong person...I explained that many times when people go through extensive treatment, they learn a lot about themselves, and as a result become more self assured and independent. BM then confided in me, and said, "I am thirty-six years old, and never been on my own. I went from my mother's house to the BF". BM also stated that she realized that it was going to be quite difficult to have seven children to support plus herself...Much of BM anxiety around getting the children as quickly as possible was due to guilt about getting involved in drugs and, therefore, not being able to care for her children. She realized that her mother was overburdened. She said she owed her mother a lot.

Like in kinship records, the proceeding non-kinship case documents the worker's efforts at addressing a mother's initial denial and resistant.

BM appears to be evasive with CW. She is at times resistant to sharing important information with CW. She says she will follow through with service referrals to substance abuse program. However, she does not follow through...BM denied present drug use; however, she stated she did drink and use cocaine in the past.

Of equal importance in this case were the efforts designed to support and prepare the foster care mother for the children placed in their care. The succeeding excerpt illustrates a non-kinship worker's keen engagement efforts, particularly, in the area of coping with a child's initial separation anxiety.

FM arrived promptly. She shared feelings of anxiety about meeting foster child. Worker assured FM that as a first time foster parent, these feelings are quite usual. Worker gave FM a foster parent's manual and discussed FM's role in facilitating foster child's adjustment to foster home...[During a subsequent meeting with this foster parent the caseworker records the following], FM shared that child is doing well and appears to be doing well until she sees natural family and has to return with FM. Worker acknowledged how difficult it must be for FM to see child become so anxious at separation. FM is able to express her despair at not knowing how to calm child. Worker tried to help FM understand child's feelings and alternatives in helping child deal with separation. Worker emphasized that child needed to ventilate herself and it was not realistic to expect her not to cry. Worker assured FM that in time, the separation will be less difficult for everyone. FM is receptive to worker and shares her concerns.

### **Family Maternal Relations**

As previously suggested, attachment theory maintains that other reliable parental caregivers can enhance or substitute for faulty or compromised bonds. A significant distinction between the study's kinship and non-kinship substance abusing families was the involvement of the maternal family; that is, all of the substance abusing mothers' children, who were placed in kinship care, were under the guardianship of the maternal grandmother and had the supportive involvement of other family members. The

proceeding entry is an example of sustained maternal family's involvement and a generational kinship care pattern.

MGM explained how painful it was for her when she found out that BM was using drugs. She said she was a wonderful parent to her children prior to her drug involvement. MGM's sister informed MGM that she witnessed BM smoking crack. MGM stated she didn't want to believe it until she observed how different BM was acting. She reported the entire family got involved and begged BM to stop, but she didn't, and MGM and her sister were put in a position to care for her children. MGM said she grew up in a foster home with her great aunt and uncle because her mother died when she was 2 months old.

As with the above family, in the following case, another maternal grandmother's sustained involvement is noted; as well as a familial pattern of drug abuse.

MGM and I [caseworker] had a discussion about the history of BM's drug problem...BM used to bring the kids to stay with her [maternal grandmother] whenever she was busy trying to get drugs. Gradually, it became more and more frequent until at one point the kids were simply living with MGM. At this point, MGM realized that BM could not care for her kids...It was apparent to me [caseworker] that MGM felt a lot of shame... MGM shared how worried she was when BM was with the girl's father, and how good it makes her feel that she is doing better and will be able to take care of them. She said that drugs have wrecked her children's lives. She said they turned them into different people and were only interested in her when they wanted money, and took her things.

In contrast to kinship foster care's maternal family involvement, non-kinship biological mothers' family involvement was negligible. The following illustrates how a biological mother's sustained drug use and her resulting unplanned pregnancies disrupted her extended family's involvement.

According to the mother, neglect of her three children was caused by her alcohol and drug addiction; she voluntarily placed and gave legal guardianship to MA. Less than a year later, MA stated she did not want to care for her sister's children and would like to relinquish her legal guardianship back to BM, placing them back into care. Five months later BM

gave birth to a baby, who was born with a positive toxicology to cocaine. Efforts made to re-engage relatives to plan for children were unsuccessful.

### **Intergenerational/Familial Patterns of Childhood Trauma and Drug Abuse**

As Miller et al. (1993) and Gilbert et al. (1997) respectively found, substance abusing women tended to have histories of childhood abuse and intergenerational family alcohol and other drug use. Concurrently, almost half (4 out of 9) of the study's case records of substance abusing families had documented evidence of intergenerational/familial patterns of childhood trauma and drug abuse. The following are striking examples.

According to MGM, MGF abused drugs and was emotionally and physically abusive towards MGM. MGM denies that MGF was abusive to their children; however, they did observe MGF strike MGM. MGM and her children left husband and they moved in with MGM's father. It is during this time that MGM reports BM became "rebellious" and ran away from home. After leaving home and having two children BM returned to live with MGM and her second husband...MGM and BM both claim that MGM's husband [BM's stepfather] did not get along with her and her children, and he pressured them to leave home. BM and her two children moved to a shelter. MGM believes that BM became involved with drugs during this time.

The proceeding records a mother's concern and identification with oldest son's drug use.

BM stated [to CW] that oldest son is smoking marijuana on a daily basis. She continued that he has disassociated himself from his old crowd and is now hanging out with the "neighborhood hoodlums". BM said that he has become disrespectful and abrasive. At one point he told her that if he did not continue to receive money from the agency, he would "do what has to be done" and sell drugs to make ends meet...She added that he was feeling "alone and unheard". BM went on to say that when she had felt the same way she had turned to the streets...[In a subsequent note in this case records other family members substantiated a patterns of childhood trauma and generational/familial substance abuse], Both MA and husband define their

own role of parenting in opposition to their own up-bringing. MA's husband states that his father was "a drunk and used to beat on us all the time" ...MA states that her main goal is being an effective parent; is to provide her children and her kinship nephews with more structure and stability than she enjoyed as a child. MA stated that MGM never provided her with structure or discipline as a child and believes that is one of the reasons that her two sisters "got lost to the streets".

The following is a striking example of a foster child at risk for intergenerational drug use.

The child expressed his feelings strongly (about his parents continued drug use)...He was at the blackboard. When I (CW) saw the blackboard, it read something like this, "The boy was angry at his parents because they did drugs and he asked them to stop. If they keep doing it, he will do drugs". After reading this, I noticed that BF was standing next to me. I called (the child) over to us and said, "Do you feel like this boy?" and he said "No". After he walked away, BF turned to me and said, "Okay, let's just erase this". BF then erased the blackboard with his hand.

### **Summary**

A review of case records, taken during the exploration phase, supports what is known about child welfare substance abusing families. All of the study's children came from single-parent families, in which the biological mother was the identified substance abuser. However, 3 out of the 5 of the biological fathers, in the kinship families, and 2 out of 4, in the non-kinship families, were also substance abusers; supporting the literature's assertion that women who use drugs are likely to be in intimate relationships with partners who are users. Similarly, in both the kinship and non-kinship families, almost half of the families had evidence of intergenerational/familial patterns of childhood trauma and drug abuse; also, supporting the literature's recommendation that

**treatment approaches should take into account intergenerational patterns as risk factors for the children in care.**

**The differences between the substance abusing kinship and non-kinship substance abusing families under study appears to be the affect that the drug abusing parent has on the integrity of the family system. That is, in all the kinship families, despite parental and or generational drug abuse, there was evidence of a sustained maternal family involvement (with the maternal grandmothers taking the primary responsibility for placement care). Whereas, in the non-kinship substance abusing families, only 1 out of 4 that had sustained any family involvement. Hence, in non-kinship families, the parents' and or familial/intergenerational drug abuse patterns appears to have been quite disruptive of the family system. In short, where in some families, the parents' drug abusing appears to rally the extended family to come together; in others, drug abuse becomes the fracture that weakens or compromises its functioning. To understand what may account for these differences, the findings of the assessment phase of substance abusing families will be considered.**

## **THE ASSESSMENT STAGE**

### **Families Mandated for Substance Abuse: Understanding their Stories**

As with the families mandated into care for neglect and domestic violence, there was recorded evidence of the strengths and the capacity for change for successfully reunified families mandated into care for substance abuse. Areas routinely assessed, in both kinship and non-kinship substance abusing families, were child/sibling/parent attachment bonds, supportive family/foster parent relations and therapy compliance.

### **Family Strengths: Positive Child-Parent Bonds**

Among all the substance abuse kinship case records there was documented evidence of positive child-parent bonds. The following are examples of positive kinship child-parental attachment bonds recordings.

Both in kinship home and the agency. BM has been attentive and affectionate with child and has talked to her about school and her behavior at [maternal grandmother's] home. Child demonstrates attachment to her BM.

CW has observed appropriate boundaries and strong attachment between BPs and children.

Mother's biggest strength is her belief in family, as she does her best to make visits, give children love, affection and respect.

Similarly, among the non-kinship substance abuse case records, there was documented evidence of sound child-parental attachment bonds. The proceeding recordings are examples of positive non-kinship child-mother bonds.

BM has a loving and nurturing relationship with her children. She visits her children consistently and expresses concern about their well being...BM has

great strengths which we [agency] believe will help her enhance the functioning of her family. However, these strengths will take time for her to enhance and implement.

BM is always happy to see her children; she interacts with them in an affectionate and generally appropriate manner...They [children in care] appear to have a close relationship with their mother...All three [mother and two children] are able to converse easily and appear bonded and fairly at ease with each other.

### **Biological Father Involvement**

Although there was limited involvement by the biological fathers, 3 out of the 9 case records documented worker's efforts to assess paternal-child bonds (1 kinship and 2 non-kinship records) during fathers participation in family reunions. The following are the noted instances.

BF is loving with his son and engages him in play...Worker observed how BF is able to maintain calm and be soothing to child during a tantrum, which lasted for 20 mins...child cease crying and began to interact with the rest of the family members.

BF shows affection to his biological son, as he cuddles and kisses him. BF also shows love and affection for his stepdaughter. He regards her as his daughter and engages her in play activities and conversation. BF's strength includes his reliability and his determination to reunify his family.

[Kinship] MGM simply said, "Well, those kids love their father". I [caseworker] agreed that they do indeed love their father very much. I added that would not change because BM and BF were not together...BF arrived at the end of our [worker and kinship maternal grandmother's] visit. He was coming to meet with the boys when they got home...BF maintains a close relationship with MGM even though he and BM are not together.

## **Positive Sibling Bonds**

As suggested in the attachment literature, in order to ameliorate excessive placement anxiety, workers' need to assess and support sibling relations. Case reviews revealed that among all of the substance abusing families, there was documented evidence of positive sibling attachment bonds. The proceeding are noted examples.

Child currently resides in same foster home with her younger sister. The sibling have a good relationship and gain strength form each other Child is protective of younger sister and they look to each other for support... Younger sib [in care] has strong attachment to her sister and she has placed her in a parental role in order to fill the void of an absent mother.

Child was previously placed in another foster home but was transferred to his sibs' kinship home to ensure bonding...The children in care and the sib residing with BPs see each other weekly and their attachment remains strong.

Child's relationship with sibs [in care] has improved. Younger sib [in care] knows he has six sibs, but does not have a close relationship with siblings not living in foster home. He lives in foster home [with the next two older sibs], with whom he has a strong bond...bonding between all siblings is also encouraged.

After the adoption of her younger sib, it is striking to note this child's sustained and unresolved separation anxiety.

BM is still awaiting an appointment with legal aid regarding her younger daughter to locate her whereabouts. Daughter was adopted by foster mother, at another agency, during BM's 2 yr. incarceration. Child [in care at this agency] indicates depressive mood regarding the separation from sibling which occurred several years ago. She constantly talks about sib and has saved a birthday card that she has brought to give her sister.

### **Supportive Kinship Relations**

As with the families mandated for neglect and domestic violence, this study of successfully reunited substance abuse cases documented supportive kinship relations that facilitated the child-parent bond in families mandated for substance abuse.

Child communicates well with KMGM [kinship maternal grandmother], who provides stability. KMGM has been very supportive of her daughter's role as mother with child. She has allowed BM to participate in the child care responsibilities (such as, shopping with them and school conferences). This has resulted in providing a close mother-child relationship.

The visit went very well. MGM seemed to enjoy this time, as she felt that she was not in charge of the kids. She sat back, and enjoyed watching BM interacting with her children.

BM continues to be a great help to her mother, who is disable with a hip injury...She visits child in kinship home more frequently and every weekend. She assumes responsibility for caring for child at these times; CW has observed her cooking for child, braiding her hair, playing with her etc. Child demonstrates strong attachment to her.

In the next case, the assessment describes the maternal grandmother's conflict between her culturally-supported belief in kinship caretaking and her asking for help.

Before the children came home from school, I [CW] talked with MGM, about the difficulties she might have caring for four children plus a baby. She expressed that she did have difficulties...She inquired about a homemaker; however, she was hesitant to say more because she did not want to appear incompetent. I explained that was not the case. I said that the agency had many support services for foster [kinship] mothers because we understood how difficult it was. I also explained that the Family [kinship] Center at the agency was different from the traditional foster care because, in the Family Center, the foster mothers are mostly all grandmothers and aunts who have special and sometimes similar needs.

### **Supportive Foster Parent Relations**

Although not as frequently documented, (2 out of 4 of the non-kinship cases), there was some evidence of foster parents' support for the child-parental bonds.

FM continues to be receptive and keeps worker informed of all pertinent information on child's well being...Due to younger sibs pos[itive] tox[icology at birth] his development and care has been difficult and slow. CW and FM have worked closely with BM around helping her to manage child's difficult behavior...BM has made progress in understanding this child's special needs for supervision and structure.

FPs maintain regular contact with SW and follow through with tasks appropriately. FM has unusually positive and supportive relationship with BPs and this has helped children adjust well to her care and the separations from their parents...Both BPs have bonded with FM who they look for support. FM appears comfortable with this role.

### **Therapy Compliance**

Another notable finding was that two-third's [6 out of 9] of the successfully reunited substance abusing families, maintained consistent family therapy attendance and participation. The following are examples of their treatment responses.

Child appears to be traumatized child who has been witness to domestic violence, has had several [foster] placements has possibly been abused herself, and has evidence of self injurious behavior...Child's progress continues to be slow. Her tentative foster care status continues to be a source of anxiety for her...Child is, however, attempting to make her needs known in therapy and this is positive for the attainment of her treatment goals.

Child has a warm, caring manner which can be attributed to family supportive system...Therapist states that child has accepted living with MGM instead of BM and spends sufficient time with BM within [kinship] home environment. Issues of abandonment, loss and anger re: adoption of her younger sib [in care] are ongoing. Child may have to deal with this for the rest of her life.

BM and children are seen in separate sessions. BM's sessions have focused on family communications, readjusting to family life, alternative to punishment and the development and use of coping skills...The focus during

the children's sessions have been the issues of readjustment as a family unit, sharing, peer pressure and the development and use of coping skills. The children appear to enjoy the counseling sessions. They report that they apply, although not consistently, what they have learned to their daily lives. The family also participates in a parent and child group. They actively participate in the group discussion and activities.

### **Family Limitations: Barriers to Reunification**

As in the previous chapters, among substance abusing families, workers documented coping limitations that served as barriers to the family reunification process. Areas particularly cited were compromised child-parent relations, placement separation anxiety, domestic violence, unplanned pregnancies, and inconsistent drug recovery.

### **Compromised Parental-Child Relations**

All of the case records of substance abusing families, had recorded evidence of the detrimental impact of drug abuse on parental-child relations. The following are examples of kinship workers' assessment of this impact.

A permanency planning goal of discharge to relative is being sought in order to provide consistency, stability and permanency in child's life. BM seems to be having difficulty correcting problems in her life. She has been non-compliant with entering drug rehabilitation since child has been in foster care for over 4 yrs...Child has accepted MGM's role and spends sufficient time with BM during her visits to KMGM home.

In another instance the mother's substance abuse interfered with the initial bonding with her newborn and her return to mother's care.

Child (in placement for the last two years) was placed with maternal great aunt since birth and is extremely attached to her...MGA [maternal great

aunt] sounded as if she had strong feelings about BM [drug rehabilitation] progress, and how it would affect the child. MGA added that it was not only becoming difficult to imagine the child leaving her, but that it was becoming difficult for the child as well. She said that the child was becoming closer to his relatives in the [kinship] home..."He won't even go to visit [BM's] home and stay there without us" ...[A subsequent note records]...CW and BM also discussed the progress child was making in his transition to BM's home. Although BM still wants child to be returned to her, she is aware of his attachment to MGA's home. CW and BM explored [kinship] custody as an option for the child as opposed to foster care. CW will discuss this further with MGA.

Like kinship families, there was also evidence of compromised non-kinship parental-child relations.

BM continues to reside with her parents who continue to be substance abusers. BM agrees to CW's suggestions readily but often does not follow through. CW will work with BM more closely than in the past to help her feel more confident about entering a residential drug program. CW believes that BM is serious about planning for her children but needs extra support and encouragement to begin to change her life.

Despite the biological mother's commitment to the care and return of her children, the next case excerpt illustrates her persistent difficulty providing care for her youngest son.

Due to younger sib's pos. tox. his development and care has been difficult and slow...Worker observes the difficulty BM experiences at times in trying to handle this child. He is very aggressive and stubborn at times. He is most responsive to FM...Although BM has interacted well with children while in care, she has not been responsible for her children since they were born. Although BM is committed to providing the best care for the children, they are needy children. BM appears to have benefitted from parenting skills program. However, her skills need to be enhanced, strengthened and reinforced.

### **Placement Separation Anxiety**

As manifested in the families mandated for neglect and domestic abuse, all of the families mandated for substance abuse provided evidence of placement separation anxiety. In the following excerpt, the oldest children living in kinship care with the maternal grandmother discussed their separation fear about plans to discharge their younger sibling to his kinship maternal great aunt.

CW spoke with [oldest] sibs. They admitted to feeling frustrated in regards to their younger brother. Oldest sister [in maternal grandmother's kinship care] said she felt that they [the kinship maternal great aunt's family] "baby him too much". Whenever they or their mother want to take him out, she continued, he cries until one of MGA's children accompany him. Oldest son [in maternal grandmother's kinship care] also reported that MGA family rarely took younger to their place to visit. Oldest son added that he wished younger brother could live with them [at maternal grandmother's home]...CW, oldest daughter and oldest son had a long discussion about their brother. They both believe he should be going back to their mother instead of MGA taking custody. They both admit that if custody is granted, then younger brother will never go back to BM.

The following recording offers a striking example of a child's separation reaction triggered by the biological mother's repeated drug relapses and the agency's change of permanency planning goal to adoption by the foster mother.

Oldest sib refuses to discuss feelings [with her therapist] re: BM and possible permanent separation. It appears feelings maybe too painful and she is unable to cope with the idea of a permanent separation from the mother. She appears to have drawn even closer to her youngest sister. Her behavior has begun to mimic younger sib and it is possible that she maybe manifesting a need to stay close to sib...Oldest sib's relationship with her FM continues to need refinement. She still does not appear to feel safe in this relationship. Although the FM continues to make a sincere attempt to give oldest sib the security she appears to crave. It is possible she has not attempted to bond with FM due to her wish to return to her BM.

The following entry demonstrates how kinship placement can mitigate separation anxiety.

The child's trial discharge to her mother's custody has gone smoothly, primarily because her mother has moved permanently into MGM's home and child has not had to change households. Child's relationship with mother and MGM are very close and the family functions smoothly.

Similar to kinship families, there was documented evidence of separation anxiety among all non-kinship families. The following excerpts are examples.

At the end of reunion visits, it is sometimes difficult for the child. However, she appears to have adjusted more and usually does not cry. BM and MA are supportive of child and assure her that they will return.

As mentioned earlier, placement is, often, the first in a series of painful separations for the children in care. In the next case record, despite the agency efforts to mitigate the trauma of a child's multiple foster placements, his separation fears persists.

The sib's removal from his natural family and removal from different foster homes has had a debilitating affect...He has made progress in making the transition from one foster home to another...He has decreased acting out behavior. He has also discuss his feelings about reunification; however, he is still insecure about his future and stability as a result of unstable past.

### **Domestic Violence**

A review of mandated substance abuse cases substantiates Bennett's (1995) contention that there is a "co-incidence" relationship or an association between drug abuse and domestic violence. The study found that at least half of the kinship and non-kinship drug abusing families (5 out of 9) provided evidence of domestic violence. The following two families offer striking examples of the association between drug abuse and domestic violence. Despite these parent's compliance with drug rehabilitation mandates,

they are unable to acknowledge and attend to their abusive relationship and its affects on the children.

BM has reported several incidents of conflict between herself and husband in the past years, some involving violence...CW witness loud, angry arguments between the BPs during home visit at which one of their children in care [who was on a supervised visit] was present and was very frightened and upset. BPs minimized the importance of these conflicts, and do not feel that their marital problems affect their readiness for the return of their children...CW and BM discussed the safety of her children, what she wants for them, and her ability to be the primary caretaker...It appears that the BF has been physically abusive to her and that BM is ambivalent about their future together.

As with the preceding family, in another case the worker assesses the impact that family violence has on a biological mother's functioning.

BM presents as a frail, soft spoken woman who is depressed. Although suffering from intense guilt over her effect on her daughters' life, she has had clearly been unable to separate from BF, with whom she has had a destructive relationship...It seems to SW that BM presents a classic scenario of "battered women syndrome"...Despite BM's current attempt at recovery at a drug treatment center, it is SW's assessment that prognosis is poor. Given the long term nature of her substance abuse, her dependent relationship with BF (an active substance abuse who is in consistent denial), her consistent inability to care for her children as well as her HIV status. It could be said that it is unlikely that the children will be returned to her...However, she has been able to establish a bond with her children to the extent that they know and love her. She has visited regularly and the children have been happy to see her.

Plasse (1995) suggests that success in staying free of drugs can depend largely on the life-sustaining connection that a parent has with their children. Despite the pessimistic prognosis in the previous case, the subsequent recording describes the positive influence that this mother's attachment bond and her fear of losing her parental rights to her children had on her commitment to treatment.

The mother has subsequently agreed and is participating in a battered woman's group; in addition, she has begun to seek help from her family to assist her with planning for children's return.

### **Unplanned Pregnancies**

As with the other family sub-groups in this study, a conspicuous pattern of unplanned pregnancies among both drug abusing kinship and non-kinship families was found. Almost all of the study's families mandated for substance abuse (8 out of 9) had documented evidence of a pattern of unplanned pregnancies. Kinship workers record the following examples.

Although BM and her husband stated that they would be ready for the children to return...The agency is requesting another extension of placement for all foster children for a variety of reasons...Another consideration involves the upcoming birth and its effects on the family. The agency would like an opportunity to assess the newborn's safety in the home before placing the older children with their parents.

Also evident in the aforementioned family is a developing intergenerational pattern of unplanned pregnancies. The following illustrates the worker's effort to address this with the pregnant teenage mother in care with her kinship maternal grandmother.

Oldest daughter (who is a mother of a two years old and currently expecting another child) and CW discussed her feeling about being a teenage mother. She discussed her feelings towards her mother, as well as her feelings about her mother's mistakes...We discussed life choices, parenting, respecting her mother, conflicting attitudes, addressing abandonment issues and hurt feelings.

Like the kinship families, all of the non-kinship substance abusing families had documented evidence of unplanned pregnancies. The following excerpt demonstrates the parent's sustained pattern of unplanned pregnancies.

BM informed SW that she is four months pregnant. BM is aware that continued [drug] use will force us [placement agency] to recommend placement for child who resides with them and unborn child...In light of BP's past successes, we continue to be committed towards reunifying this family. However, if BPs do not demonstrate their commitment to their children in placement by entering drug treatment programs immediately, we will request a change of ppg [permanency planning goal] to 04 [adoption]. We request that the court support our recommendation for a twelve month extension with the condition that the agency submit a petition to TPR [terminate parental rights] if natural parents have not made significant progress within the next six months.

In this note a worker briefly documents her attempt to address the issue of unplanned pregnancy.

Worker explored BM's need for family planning services, but BM stated that she is not sexually active and therefore not in need of these services...Despite worker's efforts to get BM to use birth control, she is again pregnant and is awaiting delivery of this child's discharge within months of the children in care discharge.

Observe another striking example of a mother's pattern of unplanned pregnancies.

BM is not symptomatic but has the virus...BM and husband are reconciled. She is currently 3 months pregnant, has had children [in care] tested for virus but failed to tell husband. Now that children have tested negative she promises CW that she will no longer have unprotected sex and will tell husband of virus status.

### **Inconsistent Substance Abuse Recovery**

As indicated in the literature and supported in this study's findings, a pattern of inconsistent drug rehabilitation is frequently apparent during the reunification process. In

all kinship and non-kinship cases, there was recorded evidence of drug relapses prior to the parent's ability to attaining long term abstinence and sobriety. The proceeding two kinship recordings support Tracy & Farkas' (1994) explanation for this based on the psychiatric characteristics of the drug abusing mother.

BM stated that she had begun using again out of "loneliness" about 2 months ago. BM stated she was using crack/cocaine and alcohol; but had been "controlled" in her use but that her counselor and family had begun to notice it because of her weight loss and "disconnecting". She checked herself into [drug] detox[ification] after a friend died of cirrhosis [of the liver]. BM stated that she is committed to her recovery and realizes that she needs to "plug into" permanent [drug rehabilitation] resources.

The proceeding lends support as well to Nelson-Zlupko et al. (1995) and Mason (1991) assertions about the use of drugs as a coping mechanism.

There is concern about BM's occasional [drug] relapse. It appears to be a coping mechanism for BM. Therefore, CW has started to talk with BM about alternative coping mechanisms.

Similarly, the following kinship recording illustrates Bennett's (1995) finding that substance abusing woman are likely to be in intimate relationship with substance abusing partners.

Children were removed from BPs' home because of drug use and placed with MGM. 3 yrs later BPs moved in with MGM and the household situation became intolerable because of BPs return to drug use. As situation deteriorated in the household MGM felt trapped. She fled the home, taking the children with her. Once in Georgia, she had a nervous breakdown and stroke. The children were brought back to NY and placed in care...BM married BF. Two weeks after their marriage BM relapsed [on drugs] and on the advice of a long-time [drug] counselor went to rehabilitation...BM has completed drug rehabilitation but there is no indication that the BF has also done so even though he currently resides with BM.

As with the kinship families, there was recorded evidence of drug relapse among the non-kinship families. After recording consistent successful family reunions, the worker records a change in the mother's behavior during a family reunion.

During visit BM greets all children affectionately. She sits at table while children play by themselves. She does not engage children as a group; instead, she interacts with them individually. BM appears distant and "strung out". Verbally BM states her desire to have children with her and is aware that this will not happen unless she rehabilitates. [In a subsequent contact with this mother, the worker records]...BM appears sober and alert; yet is not realistically involved in planning. Mother is aware that she must complete drug rehabilitation program and obtain housing.

Since alcohol and other drugs abuse can be a familial trait, Tracy & Farkas report that a proportion of substance abusing women grew up in a using family, were not nurtured as children and lack consistent parental models. The following illustrates this intergenerational pattern of drug use, relapse, poor nurturing and parenting.

MGPs admit using drugs, and claim to be social users. They reportedly dropped out of drug treatment program because BPs discontinued going to the program. They requested a referral to a more structured program that they can enter together. MGM appeared under the influence of a substance or a hangover. MGPs do not seem to think that they are responsible for BM's drug use or the children's placement. [After subsequent contacts with the biological parents in this family the worker records the following]...BM is 4 months pregnant...BM has not followed through with any drug rehabilitation drug programs she has been referred to in the last 6 months...SW is in the process of referring her to a residential program for pregnant women. BM attends most reunions and is concerned about children's development. SW believes that BM is serious about planning for her children but needs extra support and encouragement to begin to change her life.

## **Summary**

A comparison of the kinship and non-kinship families during the assessment phase with successfully reunified substance abusing families reveals both their similarities and differences. In terms of similarities, all of the families had documented evidence of positive parent-child and sibling bonds, supporting the literature's assertion about the importance of parental and sibling attachment for family reunification. Another area of similarity was the positive impact that parental-kinship and parental-foster guardianship relations can have facilitating the reunification process. Although more evident in kinship families than in non-kinship families, there was validation that many families complied and profited from mental health treatment; suggesting that mental health intervention can interrupt dysfunctional substance abusing family patterns.

Other areas of similarity were well-documented coping limitations that served as barriers to reunification. Among both the kinship and foster care records, there were assessments in the areas of compromised parental-child relations, placement separation anxiety, domestic violence, unplanned pregnancies and inconsistent drug recovery. In relation to compromised parental-child relations, there was ample evidence of the impact that drug abuse had on the parental-child relations; at times, resulting in severe damage to the parental-child bond, compelling at least temporary replacement of this bond by an extended family member. With regards to placement separation anxiety, while there was evidence of this reaction in all of the study's substance abusing families, children in kinship families appeared to have a tempered reaction; seemingly, due to the facility in which maternal kinship bonds alleviated and sublimated the children's separation from

their parents. Domestic violence proved to be another common area between kinship and non-kinship families. At least half of the study's substance abusing families had, as Bennett (1995) terms it "co-occurrence" of substance abuse and domestic violence. Furthermore, 4 out of the 9 substance abusing parents had intergenerational domestic abuse histories; validating Gilbert et al. (1997) assertions that, among substance abusing women, there is a high rate of domestic violence and a strong association between childhood and partner abuse. In addition, unplanned pregnancies were a consistent pattern among the majority of the study's drug abusing parents; however, due to the limited size of the sample study, the diversity of case histories and dynamics, comparison between kinship and non-kinship families in this area was not possible. Nonetheless, it is probably safe to conclude that in most drug abusing families, there is a need during the reunification process to identify and assess for the risk of unplanned pregnancies. Finally, with regards to inconsistency of compliance in the drug rehabilitation process, while there was a noted pattern of drug abuse relapse in both kinship and non-kinship families, in kinship families the recovery process was associated with outpatient drug rehabilitation and 4 out of 5 of the families complied with family therapy; whereas, in non-kinship families the recovery process was associated with long term residential drug rehabilitation and 2 out of 4 of the families complied with family therapy; indicating a divergence in need between the kinship and non-kinship families; that is, the locus of rehabilitation for the kinship drug abusing family appears to be the extended family system. Whereas, in lieu of a viable extended family system, in the non-kinship drug abusing family the locus of rehabilitation appears to be the parent.

The most conspicuous areas of differences between the kinship and non-kinship families involved the functioning of the extended family support system and involvement by the biological father. As previously mentioned, in kinship families, extended family members were assessed to be involved but have relatively ineffective family connections to the addicted biological parents. Whereas, in non-kinship families, the functioning of their extended family system was so compromised that it could not serve as a viable kinship care resource; often, presenting with patterns of intergenerational childhood trauma and drug abuse. Foster placements appeared to provide child care respite for the addicted parents until they could develop new ways of coping without the use of drugs and the social supports necessary to substitute for their compromised or irreparable family support systems. Another difference was the disparity in the biological fathers' involvement. In kinship families only 1 out of 5, as opposed to 2 out of 4 of the fathers in the non-kinship families were consistently involved. Although the sample difference is small, a conjecture for the difference can be that, in lieu of a functioning maternal family system, the biological mother and/or the non-kinship caseworker were prompted to aggressively seek the support of the father. This supposition is strengthened by the fact that, even in instances where fathers were involved, there was a general absence of documentation about the viability of the paternal family support system; leading to speculation that casework services tend to disproportionately focus on maternal family involvement and support.

In summary, the findings of the assessment phase with substance abusing families supports the literature's contention that substance abuse compromises the integrity of the

family system; and, at times, results from and leads to cyclical intergenerational behavioral patterns. Given this, the focus of the assessment is expanded to the drug addicted parent as seen in the context of their environment. In the case of the substance abusing kinship family that includes the kinship guardian and other extended family members; in addition, as Tracy and Farkas (1994) suggest, the assessment should include how family history and patterns affect drug abusing parents and what are the intergenerational risk factors to the children in care. In the case of the non-kinship family, the assessment should include the parents, available extended family members, and the relationship between the biological family and the foster family members. In doing so, like with the kinship family, pertinent family history, behavioral patterns and risk factors can be assessed. It is with this comprehensive understanding that the worker can develop and implement effective interventive strategies.

## **THE INTERVENTION STAGE**

### **Families Mandated for Substance Abuse: Helping to Change their Stories**

Due to the nature of mandated child protective services, the treatment modality, clients level of motivation, time frame, worker's level of skill, and goals of the services have been preset; leaving it to the caseworker to work within these constraints to engage, assess and intervene in their client lives. When examining the case recording about interventions with families mandated for substance abuse, the documented interventions were consistent with identified barriers to reunification; specifically, compromised parental-child relations, placement separation anxiety, domestic violence, unplanned pregnancies and inconsistent drug recovery.

### **Compromised Parental-Child Relations**

As the proceeding kinship case illustrates compromised parental-child relations impels worker's efforts to restore these estranged relations. Prior to transfer to kinship care, the child was placed in a foster placement. During collateral visits to the maternal grandmother's home, the worker began to explore the grandmother's ability to function as a kinship caretaker.

**BM abandon child to the care of a friend (who became certified foster mother) because of BM's drug problem and subsequent incarceration. Child was physically abused and neglected by BM's friend...CW asked MGM interests in the child. MGM said that she loved the child very much and would love to have her back with her (maternal grandmother cared for child prior to biological mother abandoning her to friend's care)...The homestudy process was explored. Based on my [caseworker] initial observation of the home and the closeness of the MGM and child's relationship, it appears that**

**this transfer [of care to MGM] is the best plan for the child...[Kinship] MGM often encourages BM to visit with the child and participate in child care responsibility. MGM has stated that she would be willing to accept care and custody of child if BM chose to transfer this responsibility to her.**

**Next, the same worker makes an effort to engaging the mother in drug rehabilitation and planning for child's return.**

**BM will visit child in kinship home bi-monthly. BM will re-enter drug program and complete parenting program. Agency to monitor child's school functioning and support MGM and BM in child rearing responsibilities...Despite BM's non-compliance with drug rehab referrals, CW continues to encourage BM's compliance; and provide referrals and advocacy to different drug programs for BM.**

**After initial efforts towards reunifying the child with her biological mother failed (the child was in care four years), the worker, ultimately, succeeded in transferring the child's legal guardianship to her kinship maternal grandmother.**

**There has been no progress made towards achieving the ppg [permanency planning goal] in that BM has not yet complied with services nor cooperated with drug rehab. services or parenting skills classes. The goal was changed to discharge from parent to relative. MGM is very good caretaker and the child is bonded with MGM. Child stated that she would like to live in an apt. with her BM some day but she enjoys living with her MGM. "we have fun together"... She has no contact with her father, and his whereabouts are unknown...BM is not planning for child. BM has agreed and signed a notarized letter that she would like for MGM to become legal guardian rather than have court terminate rights because of her non-compliance with drug rehabilitation.**

**The following non-kinship case excerpt highlights a worker's interventive efforts at supporting the parental-child relation. It should be noted that although the children were initially placed with the kinship maternal aunt, the aunt was eventually found to be unfit as a guardian; and, as there were no other relative resources, the children were transferred to**

foster care pending their return to the mother's care. In this record the worker documents her efforts at strengthening the parental-child relationship.

Although, BM has been involved in children's care, MA appears to have had the most significant role in the children's life...BM and MA interact appropriately with sib and child. However, MA assumes more of the parental responsibility with child. Worker has worked with MA around allowing BM to assume responsibility for her children. MA is working on this matter and has slightly improved...BM has made great improvements in assuming parental responsibilities with her children. MA has allowed BM to assume parental role.

There was also documented evidence of this worker's efforts at improving the biological father's relations with these children.

Male sib's alleged BF was released from correctional facility. Ever since, he has attended agency visits and plans to petition for paternity of his son. Initially, BF of male sib [in care] had reservation as to whether or not this sib was his own child. Worker worked with BF around these feelings. Worker stressed to BF the importance of claiming paternity if he wanted to be considered as a resource for male sib...BF has filed for paternity, visits consistently and has been very supportive of BM...BF is loving with natural son and engages him in play. BF is also affectionate and attentive to his stepdaughter.

### **Placement Separation Anxiety**

The proceeding is a dramatic illustration of a worker's efforts at addressing two types of placement separation anxieties: a mother's abandonment fears and the children's loss of their former foster family.

When girls left room, I [caseworker] began to discuss the girls' very strong attachment to FM [prior to children's transfer to kinship care they were placed in foster home]. I asked BM how she was handling this situation. BM sounded surprise that the girls were bringing up FM. BM said, "this is the first time they've really talked about wanting to see FM. BM added that perhaps it was because they saw CW and also perhaps because they did not want to hurt their "mommy's" feelings. I [caseworker] agreed...At this point,

BM was able to talk about why it might be difficult for her to permit girls to maintain contact with FM...BM said, "What if they don't want to come back to me?"...I tried to explain to BM that right now the girls love her and FM and that by allowing them to maintain contact with FM she would be showing the girls that she respects their feelings...Although BM was open about her fears regarding the girl's previous FM, she understood that it was important for their growth to maintain their relationship in some way with FM...It was strange coincidence that when phone rang, it was FF [foster father]. The girls were very excited about speaking with him. BM also spoke with him. An arrangement was made for girls to visit FPs [foster parents] around Thanksgiving.

The following excerpt highlights a worker's efforts at supporting and normalizing a foster mother's concerns about the child's inconsolable placement separation anxiety.

FM shared that child is doing well and appears to be doing well until she sees natural family and has to return with FM. Worker acknowledged how difficult it must be for FM to see child become so anxious at separation. FM is able to express her despair at not knowing how to calm her. Worker tried to help FM understand child's feelings and alternatives in helping child deal with separation. Worker emphasized that child needed to ventilate and it was not realistic to expect her not to cry. Worker assured FM that in time, the separation will be less difficult for everyone. FM is receptive to worker and shares her concerns...At termination of [reunion] visit it continues to be sometimes difficult for child. However, she appears to have adjusted more and usually does not cry. BM and MA are supportive and assure child that they will return.

### **Domestic Violence**

As previously discussed, there was a documented evidence of an association between drug affected families and domestic violence. The following case record documents a caseworker's diligent efforts, with various family members, to interrupt the family's entrenched domestic violence patterns.

I [caseworker] spoke with BF for more than an hour on the telephone. BF discussed his frustration and anger with his marriage and with his wife. BF even stated that he wanted to file for the children once he obtained his own

place. I asked BF not to involve the children in his struggles with his wife. I explained that the children were already in a difficult situation, as they were already in foster care. BF said that he understood the caseworker's fears. He realized, he continued, that it would not be fair to the children, especially since he was not visiting consistently. Caseworker offered to meet with BF and BM to discuss their future, and how it would affect the children. BF stated that he would call next week to make an appointment.

In the subsequent meeting with the parents the worker records.

I [case worker] brought up the issue of therapy. They [parents] both agreed to attend. I told them that I would make the initial referral for them. We had discussed therapy before, as certain patterns seemed to be evolving; BF and BM get into a fight, and they explode; eventually, they make-up. However, because they never resolve the issue, this anger begins to simmer again, and another fight erupts. I explained to them that a therapist might help them break down their anger; that is, help them to understand each other's hurt, pain, etc. They agreed this might be helpful.

Within the same family, the worker attempts to mitigate the mother and teenage daughter's aggressive behavior towards each other.

BM stated that oldest dir's behavior was out-of-control. During the weekend, she and daughter. had gotten into a fight. She added that dir. had put her hands up to hit her. BM said she had told daughter that the next time she did something like that, she would hit her and "teach her a lesson". CW expressed strong concerns about this. After CW had explored alternative coping mechanisms with BM, she stated that she was just hurt and frustrated by her daughter's behavior.

Next, the worker makes additional efforts to also intervene in the emerging generational violence pattern among the oldest sibs in this family.

CW spoke with [parenting teen] daughter about last week's incident, in which she hit her [teen] brother for hitting her baby son...CW sat with MGM, oldest son and oldest daughter and talked about the CW's concerns about their change in attitude and in behavior, which have recently been exhibited in the home. CW discussed oldest son's and oldest daughter's relationship with each other, as well as their individual relationship with their mother. In both areas, oldest son and daughter expressed hurt and pain. They both stated that

they chose to respect each other's space by ignoring each other instead of arguing...During discussion MGM hardly spoke. CW said that it would be impossible to expect change over-night. She added that with time everyone might be able to move past their anger and resentment.

In this final case excerpt, the worker's attempts to mitigate the culturally-supported pattern of violence within this family.

At one point, the middle son admitted that a boy pushed him at school. BM angrily replied that he needs to hit back and defend himself. CW suggested that we look at his possible fears of physical fighting due to his experience watching the violence between his parents. BM seemed to appreciate these concerns.

### **Unplanned Pregnancies**

As previously remarked, unplanned pregnancies patterns were evident in the records' of drug affected families. The ensuing kinship scenario depicts worker's interventive attempts in this area.

Oldest sib had been discharged from the hospital this afternoon (after the birth of her baby)...Even though CW, MGM and oldest daughter. acknowledged the joy of new baby, they still continued to discuss the importance of protecting oneself from more pregnancies...CW visited with oldest daughter and the new sib's new baby. Oldest daughter and CW discussed the advantages and disadvantages of being a teen-age mother.

In a subsequent contact with the oldest boy in this family the worker records the proceeding.

Oldest sib was pushing a baby carriage when worker made HV (home visit)...He continued to say he didn't want to be pushing any strollers like his sister and her boyfriend. He stated that he plans to be "safe". He related that he has a new girlfriend in the neighborhood...Caseworker took this opportunity to review safe sex and to emphasize how important it was to avoid contracting STD, HIV, AIDS, etc.

In this non-kinship case excerpt, a worker briefly documents her attempt to address the issue of repeat unplanned pregnancy.

Worker explored BM's need for family planning services, but BM stated that she is not sexually active and therefore not in need of these services...Despite worker's efforts to get BM to use birth control, she is again pregnant and is awaiting delivery of this child's discharge within months of the children's (in care) discharge.

### **Inconsistent Drug Recovery**

The final area of assessed limitations involves the pattern of inconsistent drug recovery. As previously mentioned, there was confirmed case evidence that relapse was part of the rehabilitation process. As Nelson-Zlupko et al. (1995) advise workers can assist substance abusing mothers to identify the components of the environment that trigger their drug use. The following kinship case records demonstrates the case worker's endeavors to address these underlying issues.

When asked whether he [drug counselor] thought she [biological mother] might be using, he replied, "Her actions are telling me she is; however, she has no dirty urine [positive toxicology]"...CW confronted BM about her lack of consistent attendance at drug program. BM said she has been very upset and sad, because her friend has AIDS. When I asked her whether she was able or felt comfortable talking with her [drug] counselor, she replied that she had already told him...BM keeps all of her feelings inside - all her anger, sadness, frustration, etc. When they become too much for her, she tends to use drugs.

In a subsequent recording, the worker attempts to mitigate this mother's relapse pattern and her apparent ambivalence about reunification.

We [CW and BM] had been planning for trial discharge of the child for past six months. This was delayed, however, by BM's avoidance of casework appointments to plan for discharge, and by the disclosure to agency by her

**Methadone program that she had positive drug test (mostly for cocaine)...At an extension of placement hearing, worker again discussed with the BM the necessity for her to show her commitment for caring for the child...Not just by visiting, but keeping appointments with worker in order to plan for return for child and for establishing that she is drug-free as she declares.**

**This final note appears to confirm that, in addition to drug relapse, other non-compliant behavior may signal parental ambivalence and the possibility of sabotage of the reunification plan.**

**BM continues to receive support from her drug counselor. She is open to discussing any issues with him which effect her recovery...Trial discharge was court ordered. The court attorney presented records of one year drug free status for BM...Trial discharge was not approved (again) due to BM's failure to complete parenting program...BM started a parenting program, but did not follow through with her goals. BM assured CW that she has spoken to her drug counselor about her lack of participation in the parenting program. BM stated that she is ready again. CW will have her enroll in the next set of sessions.**

**Like the preceding kinship family, the following non-kinship case illustrates parental drug relapse and reunification ambivalence.**

**BPs have recently begun to use drugs again. Although their use is sporadic, we predict a complete relapse, particularly by the BM, if they do not commit to drug treatment immediately. Neither parent is currently in a drug treatment program and we are currently helping the parents connect with the appropriate services. We have advised them that this is their final opportunity to plan for their children...and that if they do not commit to services immediately, we will have to request a ppg to 04 (discharge to adoption). Prior to relapse, we were preparing the family for trial discharge.**

**The next case recording about this family records the worker's efforts to address the parents' pattern of inconsistent drug recovery and unplanned pregnancy.**

**BPs continue to live with their baby in Tier II shelter facility...BM began drug day treatment program, where she is receiving individual and group therapy and vocational services. However, her attendance needs improvement. BF**

entered an outpatient drug program where he receives individual and group counseling weekly. Agency test him regularly for drug use and he has remained drug-free. He is currently caring for child at home during the day because there is no day care available at BM's program. The agency is assisting to locate day care services for family. When day care is in place, BF will seek educational services or employment. BM is currently 6 months pregnant with her fourth child...She is currently taking necessary actions to add unborn to the family's public assistance budget...BM will be transferring to a drug program where her baby can accompany her. BPs and children in care continue to have weekend visits at their Tier II residence. The children have responded well to increased visitation and they have developed stronger attachments with their parents. BPs have demonstrated a renewed commitment to completing drug treatment and we plan to continue working with the family towards reunification. When both parents have remained in a program and drug free for six months, we will again consider trial discharge. At the time of discharge we expect family to have permanent housing and preventative services in order to facilitate as stress-free a transition as possible.

### **Summary**

An examination of the substance abuse case during the intervention phase established that there were basic similarities between kinship and non-kinship workers interventive efforts. First, there were commonly documented efforts directed towards parental drug relapse, (3 out of 5) in kinship and (2 out of 4) in non-kinship cases, that appeared linked to parental ambivalence during completion of the reunification process. (A review of the general pattern of reunification ambivalence among drug affected families will be presented in the next chapter.) Second, there was a striking pattern of unplanned pregnancies in both kinship, (4 out of 5, and non-kinship, 4 out of 4 families). However, there was a characteristic difference in the kinship and non-kinship workers' response to unplanned pregnancy. That is, in (1 out of 5) of the kinship cases vs. (3 out of 4) of the

non-kinship cases, parents had unplanned pregnancy just prior to the discharge of their children in care, delaying or complicating the discharge plans. Due to limited non-kinship parenting and child care resources, non-kinship workers were more apt to address unplanned pregnancies as a immediate barrier to discharge. In contrast, although there was documented evidence of a historical pattern of unplanned kinship pregnancies (that did not generally pose as a barrier to discharge), characteristically, kinship workers documented efforts were, primarily, directed at addressing reunification barriers between estranged sibling/kinship family members. In the area of domestic violence there was no appreciable difference in quantitative intervention efforts by kinship and non-kinship workers. That is, in 2 out of 5 kinship case records and 2 out of 4 non-kinship case records, there was documented evidence of interventive efforts directed towards drug related domestic violence. However, due to kinship family involvement, there appears to be a difference between the range of kinship and non-kinship casework interventive options. Often, as in the kinship cases presented, workers had a relationship with extended family members and were present during the domestic crisis; offering the kinship worker a range of interventive and preventive opportunities. In contrast, in non-kinship drug related domestic violence cases there were documented second hand accounts, followed by parental denial or minimization of its severity. Only when there was sufficient documented evidence to establish domestic violence as a barrier to the reunification process were workers' able to intervene in the 'best interest of the child'; limiting the non-kinship workers' to confrontive or structured limit setting options.

With regards to compromised parental-child relations and separation anxiety, there was a notable difference between the kinship and non-kinship interventions. Family involvement, appears to lessen the placement separation trauma incurred by kinship children as compared to non-kinship children; often, parent-child reunions took place within the kinship home rather than the agency, giving these children more of a sense of permanency and security in their parental relations than to those placed in foster homes. This appeared to result in less frequent and sustained mental health treatment interventions for children in kinship foster care.

When reviewing the findings in the intervention phase with successfully reunified families, it is striking to note that, among the kinship and non-kinship case records, there was ample evidence of the fit between the workers' assessments and their interventions. In other words, workers' interventions focused on identified areas of limitations (ie. compromised child-parent relations, separation-anxiety, unplanned pregnancies, domestic violence and inconsistent drug recovery), the focus differed. Among the kinship families, the strategic focus was to facilitate change in parental dysfunctional drug related behaviors, while strengthening kinship bonds and ameliorating compromised family functioning. As a result, given kinship members sustained involvement and bond, intergenerational/familial patterns were readily evident and accessible to change; allowing workers interventive opportunities directed towards, both, parents and kinship members. In contrast, non-kinship families, were often without sustained extended family involvement or sound family bonds. This compelled workers to target their interventions primarily on the parent and, often, utilizing the foster parent's involvement to support the

parents' drug and parenting rehabilitation process. In addition, the method the workers' employed to facilitate change of non-kinship parental drug addictive behavior was to advocate for long term drug rehabilitation programs. It appears that the structure and support of these programs served as a therapeutic replacements for compromised or absent family support systems.

## **THE TERMINATION STAGE**

### **Families Mandated for Substance Abuse: Helping to Complete their Stories**

In line with Meyer and Palleja's (1995) recommendation about the importance of the termination phase, there were three prominent documented termination areas that merged in the records of families mandated for substance abuse: reunification ambivalence, a summary of the substance abuse recovery process and a review of the final reunification stage.

### **Reunification Ambivalence**

In both kinship and non-kinship cases, during the termination phase there was recorded evidence that kinship and non-kinship workers attempted to, either, address the child's, biological or kinship family expressed ambivalence about reunification. The following 3 kinship cases provide examples of expressed reunification ambivalence.

**BM has had one child returned to her care, but admits that she is not prepared for (another) child's return at this time. However, BM continues to plan for this child's future while developing a significant relationship with her newborn son...Recently agency received approved ppg (permanency planning goal) change for older sibs in care (with kinship maternal grandmother) to independent living. They are ambivalent about living with mother and her husband. They do not wish to be adopted (by kinship maternal grandmother). Instead, they wish to remain with MGM until they are able to care for themselves. Although both (older children in care) expressed strong attachments to their BM, they still choose not to live with her and her husband. They are also very attached to their grandmother, and wish to remain in her care. They both benefit from the casework services and independent skills training they now receive from their foster care agency.**

The proceeding case scenario demonstrates how a mother's difficulty terminating her abusive relationship with her husband ambivalently affected the relationship with her child and the child's return to mother's care.

At child's therapy session, issues of loss, separation anxiety and self esteem were discussed. She reported to the therapist that her father often yelled and hit her. Her relationship with her natural parents is confusing. She appears to be angry and saddened by her father's abuse and her mother's inability to protect her from her father...She told CW "I don't want to live Mom, if her dad's at home"...Child continues to express ambiguous feelings in her relationship with mother. She desires to return home to the mother she loves but is not certain that her mother cares for her. During recent phone call from mother, she reported that her mother asked her to lie about talking to the father who her mother put on the phone. Not only was this confusing to the child, because her greatest concern is her mother's safety but, her mother's asking her to conspire with her to protect the father...This is a cause of anger and sadness to the child. By conspiring with child's father, who is fearsome to child, her mother, who has express a desire to have her returned to her, appears to be preventing this reunification from taking place. Also, her mother's behavior indicates that she may not be able to insure provision of a safe and secure environment for the child, if she returns home... Discharge plan interrupted due to BM's continued involvement with BF. Unsupervised visitation to resume following BM's termination of drug use and proven commitment to leaving BF.

The next excerpt documents the worker's understanding of a kinship grandmother's reunification ambivalence.

MGM appeared depressed. She phrased this feeling as "I'm getting by with the help of God"...MGM told me that she was looking forward to a time when the children would be back with BM, and she would once again have time for herself...MGM then began to speak excitedly about working again or going down South. When I asked her whether her husband would go with her, she replied that she did not know. She added, however, that she planned to go anyway. It appears to me (CW) that MGM will become even sadder about her life when kids are out of her home. They at least give her something to focus her mind on - something to do. When they are gone, I imagine that MGM will view her life as even bleaker.

Non-kinship workers documented efforts towards helping foster parents confront their ambivalence regarding child's return to mother's care as well.

During HV (home visit) with child's FM, she asked worker if he would be with her for the next school year. Worker shared probably not, since agency hopes to return children home before school starts. Worker explored with FM her feelings about losing children. FM shared she is very happy for children. Children have always remained loyal in feelings to their natural mother and have never given hope to return home. FM shared she will miss them greatly. However, she is aware it is the best for them. Their BM has worked very hard to get both children back... FM shared she will be preparing the children to return to BM.

The following record illustrates a worker's attempt to mitigate the maternal grandmother's disappointment about mother's reunification ambivalence.

MGM seemed happy about the news (CW was going to arrange first weekend visit for children with BM). However, BM did not appear to be overjoyed...She appeared nervous about the idea of the weekend visit and asked if she could wait another month before CW do the request. MGM seemed disappointed and asked BM what was she waiting for. CW intervened and informed MGM that this was a big step for BM, it had been a long time since BM was in charge of anyone, other than herself; and we should give her a little more time. MGM agreed to this.

As previously noted, drug recovery inconsistency, at times, serves as an indicator of reunification ambivalence. The following is an example of how despite mother's bond with her children, her family's generational drug abuse pattern serves as a reunification barrier.

BM continues to abuse drugs. She understands that she needs to join a residential program. But remains hesitant to take the necessary initiative to secure [rehabilitative] housing apart from her substance abusing parents (maternal grandparents)...BM attends most reunions and is attentive and affectionate with her children. She is openly concerned with their development, particularly with the issue of obtaining quality education for oldest daughter. BM is serious about planning for her children but needs extra support to help her fear of entering a residential program. BM is

cooperative with SW; SW plans to work with BM to help her begin the changes necessary to regain custody of her children.

### **The Drug Recovery Process**

The monitoring of parental drug rehabilitation compliance was an area of consistent charting. The following kinship case recordings monitored the mothers' drug recovery.

Worker called BM's previous worker for background information...she told me that BM has history of drug abuse and has relapsed 2 times...BM entered detox 2 months ago and then received follow-up treatment. She has remained drug-free...Her counselor states she is progressing positively in drug treatment...BM is drug free one year. She continues to make excellent progress with her sobriety.

According to Cloud & Granfield (1994b) and Shaffer & Jones (1991), respectively, two of the successful strategies for drug abuse recovery are: breaking off relationships with drug users and changing social networks. In this next case the worker supports the biological parents need for a change from their joint drug treatment efforts at community out patient programs to separate attendance at long term rehabilitative drug treatment facility; as well as their eventual decision to break off their relationship.

Parents have been referred to 3 different drug treatment programs but have not yet shown the ability to remain drug free...Both BPs have come to believe that they need an long term drug rehab program...BM graduated from rehab(ilitation) program. While at treatment center, she also completed parenting classes and a home health aide training program...BM has changed in her thinking; whereby, she realizes that she is the only one to blame for losing her children rather than anyone else or the system...BF visits two children at a time on Saturdays, his open day. He mixes it up so he can spend time with all of them. The children are involved in an aspect of his program, COSA (Children of Substance Abuse). They enjoy this a lot...BF spoke of his drug treatment, his recovery, and the difficulty staying "clean". He told me (CW) that two of his friends had left the program to get high. These two men, like him, had arrived at the last step of recovery. He said that it was difficult for him to see this happen. He added, however, that by witnessing

**this he had been able to see what kind of situation/ environment to stay away from to avoid "picking up". He stated, "it's all people and places. If you're able to stay away from the people who are using drugs and the places in which they hang out, then that's the best way to avoid getting pulled in". BF appeared positive about his recovery, although he did say that what happened between him and BM was incredibly difficult. BF stated that he still loved BM very much. He said that he was very hurt as well as angry with her. I encouraged BF and said that I too had noticed his positive attitude about himself. BF now realizes that he must "do it for himself", as he puts it.**

**The following provides additional support for Plasse's (1995) contention that parent's dependence on their life-sustaining connection with their child can be a contributing factor to a commitment to long term drug recovery. Despite a mother's repeated drug relapse history and the agency's change of permanency planning goal from parental discharge to adoption, She makes significant headway in her recovery process and reunification with her children.**

**According to her drug counselor, BM has a steady attendance record but she has tested positive for cocaine 5 times in 2 months...Despite lapses BM has been regularly attending her bi-monthly reunions with children and appears motivated and caring about her children. She strongly desires to have them in her care...Agency intends to seek a suspended judgement for BM, conditional on her remaining drug free in these next months prior to the TPR (termination of parental rights) hearing. Therefore children will remain in care until such time as their legal status is clarified...CW congratulated BM on attending rehabilitation program and got the name and telephone of her program counselor...CW spoke with rehabilitation counselor about BM's progress. Counselor reports BM is doing well and had passed all drug test...Since learning that the agency is petitioning for termination of parental rights and adoption, mother has actively been fighting the case so that the children will be returned to her...BM has entered drug rehabilitation program and has been drug free. She has completed parent training and attends numerous workshops through her drug program. BM visits regularly and has developed a positive relationship with the children. Therefore discharge to adoption is no longer appropriate for these children as BM is capable of caring for them.**

Peele (1989) and Biernacki (1986), respectively contend that substance abuse recovery also involves building new structure in the drug user lives and the use of social network of friends and family that help provide support for their recovery process. In the proceeding case record the worker charts her preparation of mother for the transitional process of her children to her care; emphasizing assessment and advocacy for preventive discharge services.

BM will benefit greatly from the service of a homemaker. BM will be providing care to her children (in care) and a new born due in September. Although BM has interacted with her children while in care, she has not been responsible for caring for them since they were born. Although committed to providing the best care for her children, they are needy children...BM appears to have benefitted from parenting skills program. However, her skills need to continue being enhanced, strengthened and reinforced...BM was commended for her achievements. The possibility of day and weekend visits, with a trial discharge target date was discussed. The Agency is receiving written updates from the Methadone program in order to begin home visits for children. During next 6 mos. worker will continue to work with NM around Methadone dosage being lowered, continuing attendance in literacy program and possible trial discharge...Worker made BM aware of the need to child proof home for (infant) child. Worker set up tentative home visit, to help BM child proof home, BM was in agreement...Weekend visits are being held and have gone well. Children appear to be making gradual positive adjustment to the home...BM appears to be patient with son's demanding ways. She has also made progress in being able to manage and discipline him...During case work contact in the home, worker observed BM to keep house tidy and organized...BM continues receiving pre-natal care...She is expected to deliver within one day. BM appears to be managing the children well. She does not appear to be overwhelmed. MA (maternal aunt) and BF continue being very supportive with BM. BM continues to be awaiting homemaker to be assigned.

### **Review of the Final Reunification Phase**

As in the two previous chapters, the study demonstrates that during the termination phase of families mandated for substance abuse, there is a recognition of the

respective case themes (i.e. placement reasons) and a review the helping process. The following kinship case scenario records a worker monitoring of a drug recovering mother's unsupervised home visits with her children.

The service priorities in this case are to continue to discuss with BM different issues, such as discipline, her change in role with children, and the change of lifestyle from single to full time parent and to discuss with the children their feelings about going home to live with BM and boyfriend...I (caseworker) asked BM about boyfriend and his relationship with girls. She (mother) said she likes having him (boyfriend) around because he reinforces what she says (to the children). She (mother) said it makes her feel better to have the additional support because she thinks that sometimes she is too soft with them (children). We talked about why she thinks she is soft and what she feel about it. She said she feels bad - like she's being mean - when she enforces discipline. I (caseworker) asked what happens when she is soft. She said the problem persists and she ends up feeling frustrated...(When complaining about her oldest daughter's defiant behavior) we (caseworker and mother) talked about other ways to find out what's going on with this child by taking with her and setting limits...MGM said girls had a nice weekend with their mother. The visits between BM and the girls have helped strengthen their relationship. These visits have also helped the girls become accustomed to the new role that their mother now plays in their lives; that is, they now view their mother as a full-time caretaker and disciplinarian rather than as someone with whom they simply visit. At this point, the agency is planning to begin monthly weekend visits for the girls. We hope to begin trial discharge at the end of the school year.

As Cloud & Granfield (1994a) suggest, access to important resources plays a major role in successful recovery. The following records the above mentioned worker's efforts with coordinating ongoing family support services following reunification.

The agency will provide the family with a referral for family therapy and will assist family with starting therapy...CW is assisting BM in locating appropriate sight for family therapy. We are also investigating the many school in neighborhood for possible fall trial discharge...CW asked BM if she still wanted to go to current neighborhood clinic for family therapy of seek family therapy services closer to the new apt she intends to move into and live with children upon their discharge...CW gave BM the information about

the mental health center for family therapy and after school services for the children most convenient to her new apt...CW to ensure that children are registered at pediatric clinic, new school and family therapy at their local neighborhood.

As with the kinship records, non-kinship case recordings documented a review of the respective case themes and the helping process. In the proceeding recording, despite the mother's expressed commitment to her children's return, the worker's must make efforts to provide discharge services to monitor the mother's recurrent pattern of drug abuse and involvement in abusive relationships.

Agency is requesting permission to start weekend visits of the children with their BM. She has completed drug detox. and inpatient drug treatment program, where she continues to receive individual/group counseling and parenting skills classes. BM has secured adequate housing and is visiting children consistently...CW informed BM that she was proud of her accomplishments in completing drug program. But at present time she needed to give her children priority in her life, not an abusive relationship. BM said she asked husband to leave at the end of the month.

The following records the above mentioned worker's coordination for ongoing family support services following reunification.

CW reports that children are visiting weekends. Trial discharge has been requested. The goal is to enroll BM and children into family therapy. CW sent BM referral for on going family therapy. Preventive services will be requested for this family after the trial discharge has ended for approximately a year. These services will include individual counseling, family therapy and seeing BM is drug free.

## **Summary**

**In all of families mandated for drug abuse, there were documented evidence of expressed reunification ambivalence by the child, parent and/or placement guardian; supporting Meyer and Palleja (1995) suggestion that the ending of the helping process may reactivate feelings of loss. In the case of the recovering substance abusing parent, the loss maybe of the addictive lifestyle, thereby triggering regressive behavior and compelling the worker to be aware and prepare to address this reactive termination response. Drug relapses appeared to be common manifestations of reunification ambivalence. In 3 out of 5 of the kinship cases and 2 out of 4 of the non-kinship cases, there was documented evidence of parental drug relapse prior to trial discharge; prompting a delay in discharge planning or, in instances where there was a sustained pattern of parental drug relapse, a change in the permanency planning goal and a request for termination of parental rights. An interesting feature of this drug relapse-reunification ambivalence pattern is that, the delay or change of permanency planning goal, can become the catalyst to parental commitment to rehabilitation treatment and sustained drug abstinence.**

**Similarly, in both kinship and non-kinship families, an unplanned pregnancy pattern appeared to be a manifestation of reunification ambivalence. That is, 2 out of 5 of the kinship cases and 4 out of 4 of the non-kinship cases had unplanned pregnancies prior to discharge of children in care; necessitating a delay in discharge and an increase in prevention services. In short, among both kinship and non-kinship cases, there was evidence that, at best, ambivalence about discharge was a normative part of the**

reunification process; compelling the workers to identify and address reunification fears on the part of the mother.

In relation to the drug recovery process, the study revealed that the recovery process for drug affected families paralleled the literature's account of the natural addiction recovery process. That is, the study's drug addicted parents (who underwent different forms of rehabilitative treatment) matched the recovery process of the natural recovering addict (i.e. those who "mature-out" or overcame their alcohol and other addictions without benefit of treatment). The common factors in both modes of recovery included: a recognition of the inconsistency of the drug rehabilitative course (drug relapse) as part of the normative recovery process; identifying components in the addicts environment that are unhealthy and may trigger drug use; developing safe and nondestructive alternative coping mechanisms; breaking off drug using social networks; the addicts attaining a self-resolve to the recovery process; accessing important environmental resources that match the addicts specific needs/life situation; and the use of friends and family to support the addicts newly recovering status.

In closing, as with the previous mandated groups, there was evidence of documented reviews about drug affected families' final reunification stage. However, recording was not as complete as in the other phases of the helping process with these families. While, there were consistent documentation of the case themes in all case records, there was a disparity in the charting of unsupervised visits and the trial discharge process among the kinship and non-kinship cases. Specifically, there was consistent and detailed documentation in 4 out of 4 non-kinship case records of unsupervised visits and

the trial discharge process as compared to that of 2 out of 5 in the kinship case records. The difference in the quality of the documentation appears to be characteristic of the general difficulty in monitoring kinship families during unsupervised visitations and the trial discharge period. That is, in instances where the child was, either, discharged to the kinship guardian or the child was returned to a parent who had moved into the kinship guardian's home. Consequently, there was less frequent and more generalized charting during these periods. The workers' meager charting, in these instances, may reflect the fact that, after a child's safety in the kinship home has been assessed and secured, it becomes difficult to monitor the more spontaneous and less structured parental-child contact that occurs in a kinship foster home.

## **CHAPTER 6: SUMMARY AND CONCLUSIONS**

Prior to discussion of the qualitative findings, demographic profiles for the various mandated subgroups, (families mandated for neglect, families mandated for domestic violence and families mandated for substance abuse), will be presented. For the purpose of a comparative analysis of the helping process, the study's sample population was categorized by the officially mandated placement reason or placement precipitant. However, it should be noted that, due to the multi-causal nature and complexity of child abuse, many of the study's families demonstrated concurrent elements of other subgroup placement precipitants. These concurrent patterns are evidenced in the proceeding family profiles.

### **Profile of the Families Mandated for Neglect**

As expected, all of the study's 18 families presented some evidence of child neglect. However, it was established that 4 out of the study's 18 families were mandated into care specifically for the neglect of their children. The length of the placement stay of these families ranged between 3 to 9 years. As referred to in the literature, these families were characterized by single mothers who were chronically unable to provide adequate shelter, food, and/or supervision of their children. An indicator of chronicity, in all of these families, was that their children had been previously mandated into care for neglect. In addition, all the case records had documented evidence of compromised maternal-child relations, placement separation anxiety and dysfunctional intergenerational family

patterns. Other notable characteristics were that 2 out of 4 cases had recorded evidence of domestic violence by the biological father towards the biological mother. In addition, 3 out of the 4 had a pattern of parental unplanned pregnancies. Despite these serious risk factors, there were also recorded evidence of family strengths that contributed to successful reunification efforts with these families. Among all of the neglecting families there was evidence of sound attachment bonds between child/parent/sib and/or relative; evidence of a generational pattern of informal kinship guardianship; and evidence of consistent family therapy attendance and participation (See Table II, p. 190).

### **Profile of the Families Mandated for Domestic Violence**

A review of all the case records revealed that, irrespective of the mandated reason for placement, 11 out of 18 of the families in the study had incidents of and/or histories of domestic violence. Of these families, 5 out of the 11 were mandated into care because of documented domestic violence by the biological father towards the biological mother and/or the children. The length of placement stay of these families ranged between 2 to 4 years. All of the 5 mandated domestic violence families had documented evidence of intergenerational domestic violence and placement separation anxiety; 3 out of 5 had documented evidence of parental drug abuse, intergenerational poor maternal-child relationship/bonding and a pattern of parental unplanned pregnancies. As with the mandated neglected cases, there were also recorded evidence of family strengths. All of the successfully reunited domestic violence families had evidence of sound attachment bonds between child, parents,sib and/or relative; 2 out of 5 had evidence of

intergenerational patterns of informal kinship care; 4 out of 5 maintained consistent family therapy attendance and participation (See Table III, p. 191).

### **Profile of the Families Mandated for Drug Abuse**

After reviewing the case records of all the families under study, there was documented evidence that 14 out of the study's 18 families included drug abusing parents. Of these 14 families, 9 families were specifically mandated into care for maternal drug abuse. The length of placement stay ranged between 4 to 6 years. All of the 9 families mandated into care had documented evidence of drug relapse, placement separation anxiety and unplanned pregnancies; in addition, 5 out of the 9 had documented evidence of intergenerational/familial substance abuse. Related to this finding, 3 out of the 5 (with generational/familial substance abuse) had evidence of poor generational maternal-child relationship/bonding. Other noteworthy findings among these substance abusing families were: 5 out of the 9 families mandated into care for drug abuse had evidence of domestic violence; and 6 out of the 9 families had chronic housing problems. Despite these risk factors, and like the families mandated for neglect of the children and substance abuse, there was recorded evidence of family strengths in these successfully reunited families. Among these were: evidence that all of the families mandated for drug abuse had sound attachment bonds between child/parent/sib and/or relative; 3 out of the 9 families had evidence of a intergenerational pattern of informal extended family guardianship; and 6 out of the 9 maintained consistent family therapy attendance and participation (See Table IV, p. 192 ).

**Table II**

**Profiles of the Families Mandated for Neglect:  
Length of Stay 3-9 Years  
*Number of Families of Neglect = 4***

<b>Strengths</b>	<b>Child-Paternal Bonds</b>	<b>Child-Sibling Bonds</b>	<b>Child-Relative Bonds</b>	<b>Generational Patterns of Informal Kinship Care</b>	<b>Compliance with Family Therapy</b>
	All Families	All Families	All Families	All Families	All Families
<b>Barriers</b>	<b>Compromised Parental Relations</b>	<b>Placement Separation Anxiety</b>	<b>Dysfunctional Generational Family Patterns</b>	<b>Domestic Violence</b>	<b>Patterns of Unplanned Pregnancies</b>
	All Families	All Families	All Families	2 out of 4 Families	3 out of 4 Families

**Table III**

**Profiles of the Families Mandated for Domestic Abuse:  
Length of Stay 2-4 Years**  
*Number of Domestic Abuse Families = 5*

<b>Strengths</b>	<b>Child-Paternal Bonds</b>	<b>Child-Sibling Bonds</b>	<b>Child-Relative Bonds</b>	<b>Generational Patterns of Informal Kinship Care</b>	<b>Compliance with Family Therapy</b>
	<b>All Families</b>	<b>All Families</b>	<b>All Families</b>	<b>2 out of 5 Families</b>	<b>4 out of 5 Families</b>
<b>Barriers</b>	<b>Compromised Parental Relations</b>	<b>Placement Separation Anxiety</b>	<b>Generational Domestic Violence</b>	<b>Generational Poor Maternal-Child Relations/Bonds</b>	<b>Patterns of Unplanned Pregnancies</b>
	<b>All Families</b>	<b>All Families</b>	<b>All Families</b>	<b>All Families</b>	<b>3 out of 5 Families</b>

**Table IV**

**Profile of the Families Mandated for Substance Abuse:  
Length of Stay 4-6 Years**

*Number of Substance Abuse Families = 9*

<b>Strengths</b>	<b>Child-Parental Bonds</b>	<b>Child-Sibling Bonds</b>	<b>Child-Relative Bonds</b>	<b>Generational Patterns of Informal Kinship Care</b>	<b>Compliance with Family Therapy</b>		
	All families	All families	All families	3 out of 9 families	6 out of 9 families		
<b>Barriers</b>	<b>Compromised Parental Relations</b>	<b>Placement Separation Anxiety</b>	<b>Pattern of Substance Abuse Relapse</b>	<b>Patterns of Unplanned Pregnancies</b>	<b>Generational/Familial Substance Abuse</b>	<b>Domestic Violence</b>	<b>Chronic Homelessness</b>
	All families	All families	All families	All families	5 out of 9 families	6 out of 9 families	6 out of 9 families

## **SUMMARY OF REUNIFICATION HELPING PROCESS**

The findings of this study suggest that there are case characteristics and casework practices that are commonly found during the stages of the helping process with successfully reunified families; that is, the reunification helping process.

### **THE EXPLORATION STAGE**

As Meyer and Palleja (1995) suggest during the exploration stage an effective strategy includes engagement, contracting, collecting and organizing data in a coherent manner takes place. The study found that during this stage there were four areas commonly documented among all the families under study: 1) placement precipitant 2) engagement efforts 3) maternal family relations 4) transmission of dysfunctional intergenerational family patterns.

#### **Placement Precipitants**

Among the families of neglected children, the precipitating placement factor was primarily attributed to compromised attachment bonds; wherein, the parent's poor attachment to the child was the contributing factor of the neglect. Among the families mandated for domestic violence, the precipitating factor was primarily attributed to the overlap of violence towards and/or witnessing of violence by the children; placing them at risk of being physically, sexually abused and/or emotionally traumatized by the family's violence. And, among the families mandated for substance abuse, the precipitant was

primarily attributed to the neglect arising from maternal substance abuse. However, in the latter group and as previously cited in the literature, there was ample evidence of children being, also, mandated for paternal substance abuse.

### **Engagement Efforts**

Engagement efforts were also a common documented area among all of the study's subgroups. Among the families of neglected children, workers tended to utilize family reunion activities to contract a commitment by the biological mother to develop and improve their compromised attachment bonds with the children in care.

In contrast, in the families mandated for domestic violence, there was evidence of intact maternal-child attachment bonds; attributed to the fact that, in most instances, the biological father was the main perpetrator who targeted the violence towards the biological mother and, at times, spilled it over to the children. In these cases workers engaged parents/family members in reunion activities designed to strengthen and enhance their compromised relationship with the children in care. In addition, workers often used reunion activities to engage parents in an examination of their violent relationship, their denial about its impact on the children and their resistance to seeking help.

Finally, in the families mandated for substance abuse, the workers' engagement efforts were, also, directed at strengthening and enhancing parental/family members' relationships with the children in care. However, there was also documented evidence of workers' utilizing reunion activities to explore with the mothers' the impact of her drug abuse upon the children and her resistance to treatment. Lastly, although not as

frequently charted, there was a documented instance of a worker's efforts to engage and prepare a foster mother to cope with a child's acute placement separation reaction.

### **Maternal Family Relations & Transmissions of Dysfunctional Intergenerational Family Patterns**

Other areas commonly documented during the exploration stage, among all of the families under study, were maternal family relations and the transmissions of dysfunctional intergenerational family patterns. Among families of neglected children, there was evidence of maternal family strength and limitation. As a strength, there was evidence of both maternal extended family members efforts to enhance or substitute for compromised parental-child bonds. However, there were also recorded dysfunctional intergenerational attachment bonds among neglecting parents; that is, parent's neglectful behavior was attributed to their own history of childhood trauma and poor attachment bonds with their parents. Similarly, among the families mandated for domestic violence, there were recorded involvement by maternal extended family members supporting the return of the children to the biological mother. Nonetheless, these family relations were not without their own limitations. There was evidence of intergenerational family violence patterns; that is, patterns where the parent acted out their childhood experience of family violence and/or placed the child, in care, at risk for responding with violence or being victimized in their adult relationship. As with the two previous types of mandated families, among families mandated for drug abuse, there was recorded evidence of maternal extended family members being involved and supporting the children's return to their mother. However, this involvement was only evident with the children placed under

kinship care. Children who were placed in non-kinship care because of their mothers' drug abuse had negligible extended family involvement. In addition, and as referred to in the literature, the review of cases revealed that in both kinship and non-kinship families mandated for drug abuse (4 out of 9 families) had documented evidence of intergenerational patterns of childhood trauma and substance abuse.

## **THE ASSESSMENT STAGE**

Assessment is the critical stage that determines whether family reunification is a viable permanency goal; that is, are there sufficient coping strengths and a capacity to change within the family to warrant planning for the children's return to the family? The study found recurrent documented areas of both coping strengths and limitations. The areas of documented strength were: 1) parental-child bonds 2) sibling bonds 3) supportive kinship/foster parent relations 4) therapy compliance.

### **Family Strengths:**

#### **Parental-Child/Sibling Bonds and Supportive Kinship/Foster Parent Relations**

Among all three of the study's subgroups, there was documented evidence of sound parental-child bonds. During this phase, workers' charted evidence of the children's renewed or enhanced affectional bonds with the biological parent(s). In the few instances where the children's bonds with their biological parent were not viable, kinship extended family bonds served as parental replacements for the biological affectional bond. Sibling bonds were also prevalent within each of the subgroups; often, mitigating the children's placement separation anxiety by serving as a surrogate affectional bond until the parental bond was reestablished.

The manner in which kinship/foster parent relations facilitated the parental-child bond was recorded among all of the subgroups. However, there was, also, documented evidence of the limitations of these family/foster supports; for instance, at times, kinship/foster parents relations with the children would undermine the parents' role and

responsibilities. There was, among families mandated for domestic violence, also, contrary to the literature's assertion of a tendency by workers to treat the biological fathers' as "invisible men", evidence of workers' efforts to assess and engage fathers' in the reunification process.

### **Therapy Compliance**

Finally, as a recorded strength, there was evidence of therapy compliance and sustained treatment gains among all of the successfully reunited families. Characteristic of the families of neglected children and the families mandated for domestic abuse, there was evidence of initial parental resistance to individual/family therapy and/or domestic violence counseling. However, when confronted with the possibility of losing their parental rights to the children in care, all of the reunited families in these two groups became compliant with their treatment. Similarly, there was recorded evidence among families mandated for substance abuse of initial parental resistance, followed by compliance to treatment. For these families, the most significant indicators of treatment gains, during the reunification process, involved drug detoxification and rehabilitation.

Unlike the two previous subgroups, individual/family therapy and/or domestic violence counseling gains was evident in only two-thirds (6 out of the 9) of the substance abusing families; the remaining one-third of the families were reunified either upon the parent attaining drug rehabilitation or the child's discharge to a kinship member. After discharge, the remaining families were provided with on-going aftercare individual/family therapy. It should be noted that compared to the other study subgroups,

the children mandated for family drug abuse averaged the longest placement stays, between 4-6 years in placement. Thus, the onerous nature of substance abuse recovery and the need to expedite permanency planning, appeared to compel workers to use successful drug rehabilitation as the primary measure of the family's ability to be reunified.

### **Reunification Barriers**

During the assessment stage, in addition to recorded appraisals of family strengths, case records revealed evidence of family's reunification barriers. Recurrent barriers noted among the study's subgroups were: 1) compromised parental-child relations; 2) placement separation anxiety; 3) unplanned pregnancies; 4) "co-incidence" of domestic violence and substance abuse.

### **Compromised Parental-Child Relations**

This review of case recordings indicated that among all the subgroups, compromised parental-child relations manifested themselves in abdication of parental role/responsibilities, or difficulty in managing children's behavior. At times these patterns were associated with parents' poor intergenerational family bonds. The former pattern was seen as validating attachment theorists' proposition that there is an association between the parent's childhood attachment experiences and their manner of relating to their children. Particularly, striking was the additional negative impact that these poor parental-child relations had on children mandated for substance abuse. In contrast to

children of the other subgroups, they were the most frequently placed into care; were placed in care at the youngest age, averaged the longest of placement stays, and would be the most likely to be discharged to a kinship guardian rather than to be returned to parent.

### **Placement Separation Anxiety**

Placement separation fears were another frequently recorded occurrence among all of the study subgroups. In this context there was evidence of different forms of, what attachment theorist refer to as, reactive placement fears. The most frequently charted was a behavioral/physical form, occurring after the initial placement, in which the child in care displayed inconsolable/uncontrollable problematic behaviors (eg. severe anxiety/depression, bedwetting, insomnia, eating disorders, rebellious or defiant acting out, social withdrawal). Another expression of separation fear took place among kinship/foster care parents during the transitional process of the biological parents reestablishing their relationships with the children in care. That is, after having established a foster/kinship guardian bond, these placement caretakers often found it difficult to relinquish their guardianship; at times, undermining the parents' efforts to have the children returned to their care. An associated reactive fear was evident among the biological parents towards the foster/kinship guardian. This manifested itself often in the form of the biological parent taking a defensive/hostile stance towards the caretaker or, prior to the child's return to the parent, their refusal to acknowledge or support the child's sense of separation and loss of the guardians. A final type of reactive fear was noted among children, who had a bond with their parents but, whose parents were

inconsistent with planning for their return home; thereby, impelling the agency, after a period of time, to change the permanency goal to adoption. This shift prompted the child to change their behavior towards the kinship/foster guardian; often, becoming aloof or rebellious with the kinship/foster guardian, in an apparent attempt to displace the reactive fear about being abandoned by the parent.

### **Unplanned Pregnancy Pattern**

Unplanned pregnancy patterns were a recurrently documented reunification barrier for all the study's families. These took various forms. The most conspicuous was that of a parent's unplanned pregnancy, or birthing of a child, just prior to the discharge of the child in care; often, resulting in the impeding or delaying of the trial or final discharge plan. Another involved teenagers, in care, repeating family patterns of unplanned pregnancy by acting out sexually or becoming teenage parents. Biological parents' dependency needs appeared linked to another form of unplanned pregnancy pattern; that is, unplanned pregnancies that enabled a parent to maintain their conflictual sexual relationships, often with abusive or substance abusing partners; this, posed another barrier to permanency because of the dependent parent's inability to insure the placement child's safety. Finally, among parents of neglected children, despite these parents' conspicuous history of neglect of their existing children, they continued getting pregnant; often, resulting in reunification barriers for their children in placement.

## **Domestic Violence and Substance Abuse**

Among all the families mandated by domestic violence, there was a distinct recorded pattern of intergenerational dependent-conflictual family relationships posing as barriers to reunification. In other words, where biological parents, who came from violent homes as children and were socialized to accept dependent roles, continue to repeat this pattern in their adult relationships; thereby jeopardizing the children's safety if returned home. However, domestic violence was also a documented barrier that was identified within each of the study's subgroups. Among the families of neglected children, 2 out of 4 case records (1 kinship record and 1 non-kinship record) had charted evidence of domestic violence. In both instances evident of abuse by the father towards the mother and an intergenerational pattern of maternal family violence. Lastly, there were two prominent recorded barriers among the families mandated for drug abuse: 1) the "co-occurrence of domestic violence and substance abuse 2) inconsistent substance abuse recovery. As stated in the previous chapter, 5 out of the 9 families had documented evidence of a "co-occurrence" of substance abuse and domestic violence complicating and, often, delaying the reunification process. Furthermore of these 5 families, 4 had documented evidence of intergenerational domestic and substance abuse patterns. Inconsistent substance abuse recovery was another associated reunification barrier. Among all of the families mandated for drug abuse there was evidence of an alternating pattern of drug abstinence and relapse. The parent's failure to maintain drug abstinence and evidence of successful rehabilitation would then undermine reunification plans.

## **THE INTERVENTION STAGE**

**As Meyer and Palleja (1995) make clear that intervention stage should directly reflect findings of the assessment stage. Accordingly, the study documented congruence between intervention and assessed reunification barriers. However, it should be noted that the most effective interventions, documented in painstaking descriptive narratives; chronicled the case workers' use of intuitive skill throughout the case in a slow and on-going evaluative process. Despite this challenge to data analysis, the study yielded valuable generalizations. Hence, among all of the study's families, there were consistently recorded attempts by workers' to address compromised parental-child relations, placement separation anxiety and domestic violence. Among families of neglected children and families mandated for substance abuse, there was evidence of workers' efforts to address unplanned pregnancy patterns. In addition, among families mandated for domestic abuse and substance abuse, workers recorded efforts to address the inconsistent course of drug rehabilitation.**

**While a range of particular interventive efforts were documented in the aforementioned areas, due to their complexity and individual family dynamics and histories, a comparative analysis of interventive efforts across family subgroups was not possible. However, caseworkers' attempts to address common reunification barriers were noted.**

### **Repairing Compromised Parental-Child Relations**

Among the children of neglecting parents, workers' efforts to address compromised parental-child relations included: collaborative planning among the agency's units; as well as, the use of court ordered time limits as a means to have parents address the consequences of their non-compliance. In families mandated for domestic violence workers' interventive efforts to address compromised parental-child relations included: preparing a new foster parent to handle the foster children's post traumatic acting out behavior; (after children were abandoned by their abusive biological mother) supporting a biological father plan to have his children returned to his care; collaborating with the family's therapist to address a biological mother's parenting conflicts and dependency patterns. Among families mandated for substance abuse, workers' employed one of two interventions to address poor parental-child relations: either, they attempted to reconcile estranged family members so as to engage them in the reunification process; or employed court ordered mandates to engage resistant drug using addicted parent in complying with rehabilitation and the planning for their children's return.

### **Allaying Placement Separation Anxiety**

As with compromised parental-child relations, workers, among the different family subgroups, documented a range of interventive efforts directed at allaying placement separation fears. Among all the family subgroups, placement fears among kinship children were rarely recorded. It appears that, by its nature, the kinship reunification process may have diminished reactive placement separation fears, as the

children were placed with extended family members and, often, had spontaneous unsupervised visits with their biological parents. However, case records of children placed in non-kinship homes had a number of different types of charted efforts by workers to temper placement separation fears. For instance, at times non-kinship workers' recorded the use of supportive reassurance to mitigate the differential fears between the older and the younger siblings in a family. Older siblings needed reassurance about eventually being able to return to their family; whereas, the younger siblings, having weaker attachments to their parents, needed supportive reassurance about not being abandoned by their foster parents. Related to this apprehension, in all the family subgroups, there was evidence of workers' successful efforts to manage children's initial placement reaction. For instance, workers' recorded their strategies to assist children with the initial difficulty separating from their parent at the end of family reunions (eg. facilitating collaboration between the biological and foster parents, encouraging the child to ventilate his anxiety and managing his reactive fears through a task oriented approach). In addition, all three of the study's subgroups had charted efforts by workers' to moderate kinship/foster parents' and children's acting out of their transitional separation-attachment fears. In other words, the child's and/or placement guardian's reactive anxiety to the initial period of unsupervised visitation between the child and parent. As a result, recordings charted the workers use of identification, validation and supportive direction to mitigate the acting out of these fears and facilitate the reunification process.

### **Confronting Domestic Violence Barriers**

Domestic violence related interventions were recorded among all of the study's families. For instance, a worker charted her attempt to assist a biological mother, mandated into care for neglect, to recognize how her violent-dependent relationship placed her at risk of battering her own child. In another family, mandated into care for substance abuse, a worker documented her repeated efforts (among the parents and teenage siblings) to interrupt the family's entrenched domestic violence patterns. Among families mandated into care for domestic violence, the primary interventive strategy focused on engaging the biological parents in domestic violence counseling. Despite domestic families involvement in individual or family counseling, there was a recognition by the worker that entrenched dependent-conflictual patterns (at times intergenerational in nature) needed to be, particularly, addressed. As such, workers' employed engagement strategies such as voluntary or court mandated domestic violence support groups for the battered/abusing spouse and traumatized children. The most dramatic and revealing interventions were those recorded during family reunions when workers' attempted to diffuse the biological parents' provocative and aggressive behavior through the use of limit setting, ventilation and task oriented counseling.

### **Interrupting Unplanned Pregnancy Patterns**

Efforts to address reunification barriers posed by unplanned pregnancy patterns, while evident, were the least documented. Among families of neglected children and families mandated for substance abuse, there was evidence of workers' marked efforts to

interrupt parental unplanned pregnancy patterns that delayed discharge. This was dramatically illustrated by a worker's efforts to advocate, on behalf of a single mother of 6 children, for a tubal ligation that was denied by a sectarian hospital. In another recorded effort, a worker attempted to disrupt a kinship care family's intergenerational cycle of repeat unplanned pregnancies by providing family planning counseling to a parenting teenager and her sexually active teenage brother.

### **Disrupting Inconsistent Substance Abuse Recovery**

Finally, inconsistent substance abuse recovery (drug relapses), found among families mandated for domestic violence and substance abuse, was another frequently documented interventive area. Efforts included workers': 1) assisting parents' to identify elements in their environment that triggered their relapses and aiding them to find alternative non-destructive coping mechanisms; 2) assisting parents' to recognize and address, prior to discharge, their drug relapse as an acting out of reunification ambivalence; 3) use of administrative limit setting (e.g. changing the permanency planning goal to adoption) to assist parents' to confront the consequences of their resistance to drug rehabilitation; 4) advocating for permanent housing for parents whose substance abuse has resulted in homelessness.

## **THE TERMINATION STAGE**

### **Reunification Ambivalence**

As previously mentioned, the study's findings validate Hess & Falaron's (1991) contention that effective permanency planning requires in addressing the normative family reunification ambivalence that often manifest itself just prior to the return of the children in care. The study found that among all of the family subgroups there was documented evidence of worker's efforts to address varying forms of this ambivalence. A particular form of reunification ambivalence, noted across all of the subgroups appeared during the final transition of children from the kinship/foster bond to the original parental bond. In short, after children reestablished their primary dependency back to the parent, they appeared to develop a sense of conflicted loyalty between the parent and placement caretaker; necessitating the worker's validation and normalization of this ambivalence. Kinship/foster parental reunification ambivalence was also frequently recorded among all the study's subgroups; that is, despite kinship/foster parents' positive support for the child's return home, they expressed ambiguous feelings about the loss of their caretaking role. However, unlike the separation reaction evidenced by some kinship/foster parents, (expressed throughout their placement guardianship) normative kinship/foster parental reunification ambivalence occurred in the final reunification stage and did not undermine the reunification process. In addition to these two forms of reunification ambivalence, the study found distinct forms of reunification ambivalence among the different family subgroups.

Among families of neglected children there were signs of parental reunification ambivalence. This was manifested, just prior to discharge, by parents' inconsistent court attendance, irregular contact with the children in care and non-compliance with court mandated referred services. Among families mandated for domestic violence reunification ambivalence manifested itself in family members' expression of concern for physical and emotional safety. For instance, prior to discharge, workers' recorded their attempts to assuage children's fear about the resumption of violence upon return to the family; and, recorded their attempts to temper parental guilt and insecurities about not being able to protect the children from family violence. Among families mandated for substance abuse, due to the "co-incident" of domestic violence and substance abuse, reunification ambivalence also manifested itself in the children's concerns about their safety after discharge. In addition, parents' drug relapse patterns, just prior to discharge, served as another indicator of parental reunification ambivalence. In short, indications of reunification ambivalence were marked by two major themes: a regression of behavioral functioning by the acting out family member(s) manifested just prior to trial or final discharge; followed by, a positive response to the worker's identification, supportive direction and/or reassurance.

### **Reviewing the Recovery Process**

During evaluation of the termination stage, the study found indications of distinct modes of rehabilitation for each family subgroup. That is, within each case record, there was a documented review of a patterned recovery course that was related to the respective

family subgroup. Accordingly, among families of neglected children, the transforming of compromised family relations appeared to facilitate the parental-child's attachment recovery process. Whereas, in families mandated for domestic abuse, reformation of inherent patterns of dependent-conflictual family relations appeared to facilitate the domestic violence recovery process. And, in families mandated for substance abuse, parental sobriety appeared facilitated by workers' recognition and support of the normative drug recovery process (i.e. the inconsistency of the drug rehabilitative course {drug relapses} prior to attainment of permanent sobriety; identifying environmental and coping stressors that lead to relapses; self-resolve by the addict to recover; attaining the social network to support the parent's newly recovering status).

### **Review of the Final Phase of Reunification**

As Meyer and Palleja (1995) assert termination is a time where the themes of the case can be recognized and the helping process reviewed. The study found that during this phase, among all of the subgroups' case records, there was evidence of: themes associated with each subgroup's placement precipitant, evidence of workers' efforts to monitor the period of unsupervised visitation/trial discharge and the provision of discharge prevention services. For instance, in a case of a mother referred for neglect due to mental illness, the worker reviewed the mother's progress in parenting, the parental-child attachment process and the provision of family and community discharge services designed to monitor the mother's fragile mental health functioning. In another instance, a worker reviewed a battered mother's autonomous functioning, developing parenting skills

and the provision of a staggered discharge plan for the 4 returning children; thereby, safeguarding the integrity of the final reunification process. In a case of a newly drug recovering battered mother, the worker reviewed the mother's drug and domestic violence recovery course, the children's sense of security about their mother's parenting abilities and recorded the provision of family preservation discharge services. Table 5 illustrates the Helping Stages of the Reunification Process.

**Table V**  
**HELPING STAGES OF THE REUNIFICATION PROCESS**

<b>EXPLORATION</b> ▶▶	<b>ASSESSMENT</b> ▶▶	<b>INTERVENTION</b> ▶▶	<b>TERMINATION</b>
<p><b>1. Placement Precipitant</b></p> <p style="text-align: center;">▼</p> <p><b>2. Engagement of Family in:</b></p> <p style="text-align: center;">↕</p> <p><b>a. Family reunions</b></p> <p style="text-align: center;">↕</p> <p><b>b. Assessment of family relations and dysfunctional behavioral patterns</b></p>	<p><b>1. Family Strengths</b></p> <p style="text-align: center;">▼</p> <p><b>a. Parent-child/sibling bonds and supportive kinship/foster parent relations</b></p> <p><b>b. Therapy compliance</b></p> <p><b>2. Reunification Barriers</b></p> <p style="text-align: center;">▼</p> <p><b>a. Compromised parental/child relations</b></p> <p><b>b. Placement separation anxiety</b></p> <p><b>c. Domestic violence</b></p> <p><b>d. Substance abuse</b></p> <p><b>e. Unplanned pregnancy</b></p>	<p><b>1. Repairing compromised parental-child relations</b></p> <p><b>2. Allaying placement separation</b></p> <p><b>3. Challenging domestic violence barriers</b></p> <p><b>4. Disrupting inconsistent substance abuse patterns</b></p> <p><b>5. Interrupting unplanned pregnancy patterns</b></p>	<p><b>1. Mitigating reunification ambivalence</b></p> <p><b>2. Reviewing the family Rehabilitation process</b></p> <p><b>3. Reviewing the final phase of reunification</b></p>

## **CONCLUSIONS AND PRACTICE IMPLICATIONS**

Following Meyer and Palleja's lead (1995), the study's examination of the case records of successfully reunified families documented the four stages of the helping process. In sum, there was exploration of the placement precipitants, documentation of engagement efforts, maternal relations and dysfunctional intergenerational family patterns. This was followed by an assessment of the various family coping strengths (family bonds, supportive kinship/foster parent relations, therapy compliance) and reunification barriers (compromised parental-child relations, placement separation anxiety, unplanned pregnancy/domestic violence/drug relapse patterns). In turn, leading to recorded evidence of interventions designed to address the identified reunification barriers (repairing compromised parental-child relations, allaying placement separation anxiety, challenging domestic violence barriers, interrupting unplanned pregnancy patterns and disrupting inconsistent substance abuse recovery). Concluding with documented evidence of reunification ambivalence, the respective family subgroup's recovery process and a review of the family's final reunification stage.

Consequently, according to the study's evaluation of the family reunification helping process, there are a number of practice implications that apply to all of the families under study. First, among all of the study's subgroups, there was evidence of sound parental/child/sibling bonds and supportive kinship/foster relations: reinforcing the importance of assessment and casework efforts in support of family bonds and placement relations. Also, the transmission of intergenerational coping strengths and dysfunctional family patterns reinforce the importance of accurate assessments of family functioning

and related interventions designed to reduce the risk factors for children in care. Hence, caseworkers are encouraged to use family genograms to facilitate intergenerational assessments. In addition, the findings validated the importance of assessing the resiliency of the family affectional bonds. In that regard, the study findings suggest that family therapy appears to aid in the process of repairing family bonds. Second, as Littner (1967) suggests placement separation anxiety requires intervention to help, both, the child and parent (and at times the placement caretaker) tolerate the initial upset feelings triggered by the placement experience. As such, it is incumbent on the worker to recognize the importance of identifying and normalizing the placement separation reaction to all parties involved. Third, unplanned pregnancy and domestic violence patterns were evident among all the family subgroups; suggesting that further research should be undertaken to advance understanding of these patterns and evaluate the extent to which these patterns are prevalent within the general foster care population. Forth, while the study validated that ambivalence was a normative part of the reunification process, Hess & Falaron (1991) warn that unresolved reunification ambivalence is a contributing factor to reunification disruption and placement reentry. Thereby, establishing the importance of the worker's efforts to identify, validate and resolve reunification ambivalence during the termination process. The study also established the importance of continuity of care for family reunification. That is, as a standard practice, the agency referred the majority of their newly reunified families to its community-based family preservation unit. Collaboration between the agency's foster placement and family preservation staff during

the final phase of reunification served to increase the potential for enduring reunification and the prevention of placement reentry.

The findings also suggested specific practice considerations when working with each of the study subgroups. For families mandated for neglect, the findings indicate that the key to family reunification appeared to be in repairing the parental-child attachment bond. That is, the findings gave evidence to the transmission of intergenerational dysfunctional family patterns that eroded the parental-child affectional bond; indicating that family treatment with children of neglected children should, whenever possible, include extended family members to assess and intervene in compromised generational attachment patterns. In addition, as indicated in, both, the literature and the study's findings, families mandated for neglect also have large number of children, resulting from unplanned pregnancies. As such, worker must be mindful to assess the family dynamics, while providing family planning resources, that will aid in reducing the risk factors for further unplanned pregnancies.

For families mandated for domestic violence, the study's findings validated the literature's assertion in several areas. First, the findings substantiated that the overlap and witnessing of domestic violence are primary causes of trauma among children from violent families. Second, women who come from violent homes as children and were socialized to accept traditional females roles, can repeat this pattern in their adult relationship (Rosenberg, 1985). Thereby, setting forth the transmission of entrenched intergenerational dependent-conflictual family patterns. Consequently, these findings support the need for family members to participate in domestic violence related

treatment; validating family violence researchers' argument that the pattern of violence within families are far more complex, varied and require the treatment of discrete interactional family dynamics. However, contrary to the prevailing literature's claim that workers' tend to exclude battering men from the helping process, the study's findings gave evidence of successful workers' efforts to involve men. The agency workers' seemed to adhere to social work empowerment practices for battered spouses. That is, Peled et al. (2000) advises workers' to teach a battered spouse to assess and act on the degree of lethality in their situation and, thereby, strengthening the spouses's ability to protect themselves and the children. Mills (1996) prescribes respecting the battered spouse's choice whether to stay or leave the conflictual relationship and allowing the spouse the time and fluidity of choice for a self guided resolution.

As previously stated, maternal substance abuse was the precipitating factor for families mandated into care for substance abuse. The study's findings supported the literature's assertions about the gender differences in addiction and treatment approaches (Nelson-Zlupko et al.,1995). That is, it was prevalent among the study's substance abusing mothers to be reared in families mandated for substance use and family violence; to be involved in a relationship with drug abusing partners; to have an inconsistent drug recovery course; to carry the primary responsibility for child care; to be dependent on family members or public assistance for survival; and use drugs as a coping mechanism. Consequently, the literature and the findings indicate that caseworkers' need to help addicted mothers to identify components of the environment that are stressors and that trigger their substance use. In turn, assisting them to develop and use effective, safe and

nondestructive alternative coping strategies. In addition, workers' need to empower drug recovering mothers by providing financial, mental health and medical referrals for their general and family welfare. The findings also supported Atkinson's & Buttler's (1996) notion that, when maltreating addicted parents comply with court-ordered substance abuse treatment, their children are safe. It was not surprising that addicted parents who complied with court-ordered substance abuse assessments and treatment were more likely to have their children returned to their care. Nonetheless, Rittner & Dozier (2000) assert that, although most child welfare professionals recognize the association of substance abuse and child welfare referrals, actual rates of child abusers who are substance abusers are not known because not all investigated families are carefully screened for substance use. This appeared substantiated by the study's findings. That is, while half of the of the study's 18 families were mandated into care for drug abuse, there was documented evidence that 14 out of 18 families had drug using family members. Rittner & Dozier (2000) recommend that, with the increasing numbers of child welfare families mandated into care for substance abuse, accurate assessments of current and past family substance use is essential for effective case planning.

While the study's scope was limited in its sampling of successfully reunified foster care families from only one agency, its qualitative findings documented the basic elements of the helping process. Agency workers' appeared to be practicing from a family strengths perspective without failing to attend to barriers. A fundamental assumption for workers utilizing the strength perspective is the belief that human beings are resilient; surviving and thriving despite family/environmental risk factors (Early and

GlenMaye, 2000; McCarthy et. al., 1999; Smith & Carlson, 1997). Accordingly, workers attempt to understand the family in terms of its strengths, using collaborative partnership with its members and external resources in setting goals/plans for reunification. As Early and GlenMaye (2000) aptly state:

**"Together the social worker and family member take action, access resources, learn skills and practice behaviors that they have collaboratively decided will improve the family life" (Early & GlenMaye, 2000, p. 121).**

## APPENDIX A

**DATA FORM:  
CLIENT DEMOGRAPHY**

ID # \_\_\_\_ (01)

**THE CHILD**

Date of Birth \_\_\_\_ (02) Date of Placement \_\_\_\_ (03)

Placement age \_\_\_\_ (04) Date of Discharge \_\_\_\_ (05)

Length of Stay \_\_\_\_ (06)

Placement Re-entry Y \_\_\_\_ N \_\_\_\_ How Many \_\_\_\_ (07)

**PLACEMENT CHARACTERISTICS**

Placement Reason \_\_\_\_\_  
\_\_\_\_\_ (08)

Initial Court Findings/Mandates \_\_\_\_\_  
\_\_\_\_\_ (09)

Initial Permanency Planning Goal \_\_\_\_\_  
\_\_\_\_\_ (10)

Change of Permanency Planning Goal \_\_\_\_\_  
\_\_\_\_\_ (11)

**CASE CHARACTERISTICS**

Is there evidence of the family being involved in identifying and assessing the precipitating problem needs? Y\_ N\_ (12)

**Recorded evidence of family involvement in identifying and assessing the precipitating placement problems and needs:**

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(13)

**Is there evidence of case plans reflecting an assessment process?**

Y\_\_\_ N\_\_\_ (14)

**Evidence of a relationship between progress notes and the initial case plan** \_\_\_\_\_

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(14)

**Evidence of a relationship between progress notes and the final case plan** \_\_\_\_\_

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(15)

**Is there evidence of a case plan that reflects the changes required for the child's safety with the parents? Y\_\_\_ N \_\_\_ (16)**

**Recorded evidence of the changes required for the child's safety** \_\_\_\_\_

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(17)

**Is there evidence of a case plan that reflects agency and parental responsibilities?**

Y\_\_\_ N\_\_\_ (18)

**Recorded evidence of agency and parental responsibility**\_\_\_\_\_ (19)

**Is there a case plan that reflects the permanency planning goal?**

Y\_\_\_ N\_\_\_ (20)

**Evidence of a relationship between the case plan and the permanency planning goal**\_\_\_\_\_ (20)

**Is there a case plan that documents services to support the achievement of the goal?**

Y\_\_\_ N\_\_\_ (21)

**Evidence of recorded case plan services that support achievement of the goal**\_\_\_\_\_ (22)

**Is there documented evidence of family members being engaged in appropriate services that specifically target identified problems and needs? Y\_\_\_ N\_\_\_ (23)**

**Evidence of a relationship between services and identified problems and needs\_\_\_\_\_**  
\_\_\_\_\_  
\_\_\_\_\_ (24)

**Recorded evidence of engagement of family members in these services\_\_\_\_\_**  
\_\_\_\_\_  
\_\_\_\_\_ (25)

**Is there evidence of coordination of the multiple services provided to all family members, including foster family care and parental-child visiting Y\_\_\_ N\_\_\_ (26)**

**Recorded evidence of coordination of these services with all family members\_\_\_\_\_**  
\_\_\_\_\_  
\_\_\_\_\_ (27)

**Recorded evidence of coordination of these services with foster care family members\_\_\_\_\_**  
\_\_\_\_\_  
\_\_\_\_\_ (28)

**Recorded evidence of a coordination of services related to the child-parent visits \_\_\_\_\_**

\_\_\_\_\_  
\_\_\_\_\_ (29)

**Is there evidence of monitoring and assessing the family's adherence to the service plan?**

**Y\_\_\_ N\_\_\_ (30)**

**Recorded evidence of monitoring and assessing the family's adherence to the service plan\_**

\_\_\_\_\_  
\_\_\_\_\_ (31)

**Is there evidence of an assessment as to whether and when should reunification should occur? Y\_\_\_ N\_\_\_ (32)**

**Recorded evidence of an assessment as to whether and when should reunification occur**

\_\_\_\_\_  
\_\_\_\_\_ (33)

**Is there recorded evidence of family strengths Y\_\_\_ N\_\_\_ (34)**

**Recorded evidence of family strengths**\_\_\_\_\_

\_\_\_\_\_

(37)

**Is there evidence of a change/or lack of change in parental behavior related to reason for placement? Y\_\_\_ N\_\_\_ (38)**

**Recorded evidence of a change/or lack of change in parental behavior related to reason for placement**\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ (39)

**Is there evidence of persistent family problems/limitations? Y\_\_\_ N\_\_\_ (40)**

**Recorded evidence of persistent family problems/limitations**\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ (41)

**Are there documented psychological/mental health evaluation? Y\_\_\_ N\_\_\_ (42)**

**Psychological/mental health findings**\_\_\_\_\_

\_\_\_\_\_ (43)

**Psychological/mental health treatment outcome(s) Y\_\_\_ N\_\_\_ (44)**

**Documented treatment outcome(s)** \_\_\_\_\_  
\_\_\_\_\_  
(45)

**Is there evidence of preparation of all family members for the transitional process of the child's return home, including the development of a specific plan for the child's protection? Y\_\_\_ N\_\_\_ (46)**

**Recorded evidence of preparation of all family members for the transitional process of the child's return home** \_\_\_\_\_  
\_\_\_\_\_  
(47)

**Recorded evidence of a specific plan for the child's protection** \_\_\_\_\_  
\_\_\_\_\_  
(48)

**Is there evidence of an assessment/interventions made as a result of the child's/family's expressed ambivalence about reunification? Y\_\_\_ N\_\_\_ (50)**

**Recorded evidence of an assessment/interventions made as a result of the child's/family's expressed ambivalence about reunification**

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(51)

**Is there evidence of coordination for on going family support services following reunification? Y\_\_\_ N\_\_\_ (52)**

**Recorded evidence of coordination for on going family support services following reunification**

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(53)

**Is there evidence of case planning and worker visits during the initial unsupervised/overnight stays that monitor the child's safety in the home until reunification has stabilized? Y\_\_\_ N\_\_\_ (54)**

**Evidence of case planning for the initial unsupervised/overnight stays that monitor the child's safety in the home until reunification has stabilized**

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(55)

Evidence of worker visits during the initial unsupervised/overnight stays that monitor the child's safety in the home until reunification has stabilized \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_ (56)

Comments \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (57)

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