The Merrill Social Work and Human Services Series

7TH EDITION

EXPLORING CHILD WELFARE

A Practice Perspective

CYNTHIA CROSSON-TOWER



CSWE 2015 EPAS Core Competencies and Practice Behavior Examples in This Text

Competency	Chapter
Competency 1: Demonstrate Ethical and Professional Behavior	**Ethical and Professional Behavior**
Behaviors:	
Make ethical decisions by applying the standards of the NASW Code of Ethics, relevant laws and regulations, models for ethical decision making, ethical conduct of research, and additional codes of ethics as appropriate to context	9, 14
Use reflection and self-regulation to manage personal values and maintain professionalism in practice situations	2, 8, 12
Demonstrate professional demeanor in behavior; appearance; and oral, written, and electronic communication	14
Use technology ethically and appropriately to facilitate practice outcomes	
Use supervision and consultation to guide professional judgment and behavior	13
Competency 2: Engage Diversity and Difference in Practice	**Diversity and Difference in Practice**
Behaviors:	
Apply and communicate understanding of the importance of diversity and difference in shaping life experiences in practice at the micro, mezzo, and macro levels	2, 3, 10, 11, 12
Present themselves as learners and engage clients and constituencies as experts of their own experiences	2
Apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies	3, 6, 7
Competency 3: Advance Human Rights and Social, Economic, and Environmental Justice	**Human Rights and Justice**
Behaviors:	
Apply their understanding of social, economic, and environmental justice to advocate for human rights at the individual and system levels	2, 6, 9
Engage in practices that advance social, economic, and environmental justice	1
Competency 4: Engage in Practice-informed Research and Research-informed Practice	**Research-informed Practice (OR) Practice-informed Research**
Behaviors:	
Use practice experience and theory to inform scientific inquiry and research	7
Apply critical thinking to engage in analysis of quantitative and qualitative research methods and research findings	
Use and translate research evidence to inform and improve practice, policy, and service delivery	4, 6

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CSWE 2015 EPAS Core Competencies and Practice Behavior Examples in This Text

Competency	Chapter
Competency 5: Engage in Policy Practice	**Policy Practice**
Behaviors:	
Identify social policy at the local, state, and federal level that impacts well-being, service delivery, and access to social services	5, 6
Assess how social welfare and economic policies impact the delivery of and access to social services	1, 8, 11, 14
Apply critical thinking to analyze, formulate, and advocate for policies that advance human rights and social, economic, and environmental justice	1
Competency 6: Engage with Individuals, Families, Groups, Organizations, and Communities	**Engagement**
Behaviors:	
Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks to engage with clients and constituencies	5
Use empathy, reflection, and interpersonal skills to effectively engage diverse clients and constituencies	
Competency 7: Assess Individuals, Families, Groups, Organizations, and Communities	**Assessment**
Behaviors:	
Collect and organize data, and apply critical thinking to interpret information from clients and constituencies	4, 11
Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the analysis of assessment data from clients and constituencies	8
Develop mutually agreed-on intervention goals and objectives based on the critical assessment of strengths, needs, and challenges within clients and constituencies	5
Select appropriate intervention strategies based on the assessment, research knowledge, and values and preferences of clients and constituencies	5
Competency 8: Intervene with Individuals, Families, Groups, Organizations, and Communities	**Intervention**
Behaviors:	
Critically choose and implement interventions to achieve practice goals and enhance capacities of clients and constituencies	4, 8, 13
Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in interventions with clients and constituencies	10, 11
Use inter-professional collaboration as appropriate to achieve beneficial practice outcomes	12
Negotiate, mediate, and advocate with and on behalf of diverse clients and constituencies	
Facilitate effective transitions and endings that advance mutually agreed-on goals	9

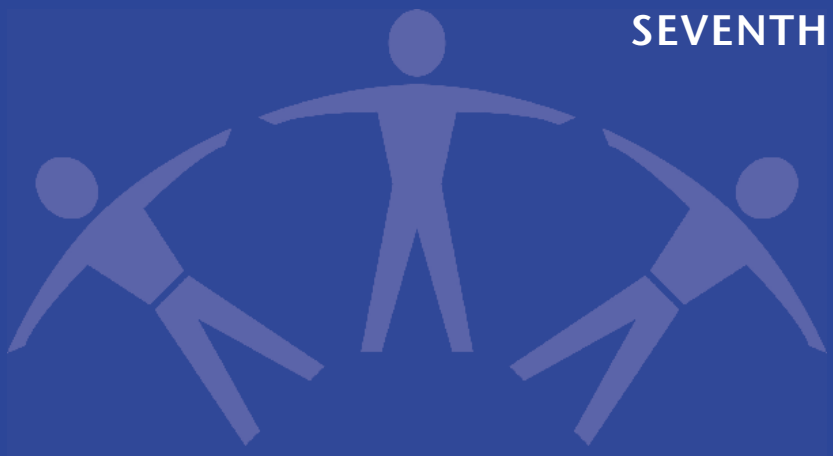


CSWE 2015 EPAS Core Competencies and Practice Behavior Examples in This Text

Competency	Chapter
Competency 9: Evaluate Practice with Individuals, Families, Groups, Organizations, and Communities	**Evaluation**
Behaviors:	
Select and use appropriate methods for evaluation of outcomes	3
Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the evaluation of outcomes	4
Critically analyze, monitor, and evaluate intervention and program processes and outcomes	12, 13
Apply evaluation findings to improve practice effectiveness at the micro, mezzo, and macro levels	

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SEVENTH EDITION



Exploring Child Welfare

A Practice Perspective

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For Andrew, whose journey
through the service system
has taught us a great deal,
with much love.

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Preface

We cannot forget that children are our most important resource. It is through our children that we can touch the future. Children must depend on all of us to protect and nurture them to meet that future. Usually that task falls to parents. But what if they are struggling, unable, or even unwilling to carry the burden themselves? Hillary Clinton, in her book *It Takes a Village*, expanded the African saying "It takes a village to raise a child" and spoke of how it is every citizen's responsibility to ensure children's well-being.

The services provided under the child welfare system are the tools that the "village," or society, uses to care for its children. These services vary greatly in purpose, intensity, cost, and procedures. To someone unfamiliar with the services for children and their families, they may seem like a maze. This book is designed to help potential practitioners understand these services and become comfortable using them and working within a variety of fields. The following pages emphasize the practice perspective from the vantage point of the professional as well as the child or family that is being helped. Because the goal is to empower the individual and family, the term *consumer* has become increasingly popular as a way of referring to those using services. By seeing the person as a consumer, rather than a "patient" or "client" as in the past, the practitioner becomes more of a guide or support as the family seeks to help itself. Thus, the analogy of the "village" becomes stronger by bringing to mind a community that helps its members rather than disempowers them. Certainly, there are times when a family is not able to care for its children and society must step in, but with increased community efforts to support family life, we hope that this is less likely to happen.

Plan for the Text

This book is designed to explore child welfare services from the least intrusive to the more intrusive and finally those that substitute care for the family. The chapters are arranged so that, after a brief background of child welfare and the family, the reader will recognize the services that support family life, those that supplement the family's roles, and those that substitute for what the family should provide.

The overarching theme of this edition is to consider trauma-informed practice. Many—if not most—of the children who come to the attention of children's services have experienced some form of trauma, whether it be child maltreatment, exposure to violence at home or in the community, exposure to addictions, or a variety of other assaults on their development. Our schools also report that a significant number of children in our educational system are impacted by trauma of various types. Recognizing this, it is vital that those who work with children and their families do so in ways that do not further traumatize them. Throughout the chapters of this text, the authors emphasize trauma-informed practice in an effort to prepare the future professional to meet the needs of traumatized children.

Chapter 1 presents a framework for child welfare by considering the past: how children were perceived and treated and the services available for them. Chapter 2 looks at

traditional and non-traditional families. It explores the roles and rights of family members in diverse cultures. The chapter also outlines internal and external stressors that may lead a family to seek help from the community.

Many children within our society live in poverty, which makes it difficult for them to develop normally. What are the implications of growing up in poverty? Chapter 3 answers this question. It also looks at current methods of fighting poverty and speculates about ways in which society might reduce child poverty.

Poverty is not the only social problem that plagues today's children. They must deal with many issues. Two of the most prevalent are violence and addiction. Chapter 4 explores the problems facing children who grow up in a violent society, who are addicted to drugs or alcohol, or have parents who are substance abusers. Many children are also brought up by parents who are involved in military service. Chapter 5 looks at the needs of and services for military families, a population with its own unique needs. Chapter 6 acquaints the reader with the services provided for children through education and socialization, outlining childcare and school-based services and how these might be trauma-sensitive. Chapter 7 looks at families that have parenting problems that lead to child abuse or neglect. Chapter 8 discusses family preservation services that strive to keep families together in their own homes and asks the question "What *really* is in the child's best interests?" Children may come to the attention of the court system for a variety of reasons. Juvenile court services for children are outlined in Chapter 9.

Today, a problem of troubling proportions is teens having children, at a younger age than ever, and attempting the challenging role of parenting. Chapter 10 examines this phenomenon and its impact on the teens and their children.

When families are unable to provide for their children, substitute arrangements must be made. Chapters 11–13 explore these arrangements. Chapter 11 provides insight into the foster care system, from entrance into the placement process to termination. It describes the roles, feelings, and attitudes of the birth parents and foster parents. The role of the foster care social worker also is discussed. Chapter 12 outlines the adoption process, from the ways children are released for adoption to the feelings of the adoptive parent(s) and the problems they face. But not every child is able to adjust to a home environment. Chapter 13 describes residential settings for children for whom the family is not a viable alternative.

The text concludes with Chapter 14, which explores the future for children and their families. What will this century bring in the way of policy changes, resources, and new problems to be faced? These are topics of discussion for today and challenges for tomorrow's practitioners. Case examples from field experience have been woven throughout the text to help the reader see the faces behind the words.

This seventh edition provides updated information about services and their impact on children, especially in the twenty-first century, with its pervasive violence and changing values. It should be noted that much of the research on child welfare is now being done in the Canada, Britain, and other European countries as these cultures strive to cope with improving their services to children. Although I have used these sources when they were germane to the issues in the United States, some of the most current literature was based on the policies of those particular cultures.

New to This Edition

New to this edition is the format of the text.

- Each chapter features Learning Outcomes to give the student an idea of what will be covered in the chapter. These correspond to the sections in the chapter and each section is summarized individually at the end of the section.

- Throughout the chapter, you will notice words in **boldface.** These are key terms that you should know. They are further defined for you at the end of the book in the Glossary.

In addition, there have been changes in the content.

- The book has been revised with thought to trauma-informed care and treatment, a concept that is the driving force in today's service provision.
- The chapter on poverty (Chapter 3) is new and reflects the current thinking and practice in dealing with this difficult issue.
- The chapter on court services (Chapter 9) has been rewritten by an attorney who specializes in juvenile court services and reflects the most up-to-date thinking.
- The educational settings chapter (Chapter 6) has been refocused to explore trauma-sensitive educational approaches.

Exploring Child Welfare: A Practice Perspective is a suitable text for both undergraduate and graduate students in the fields of social work, human services, psychology, sociology, counseling, and education.

Instructor Supplements

This text is accompanied by the following instructor supplements, which can be downloaded from Pearson's Instructor's Resource Center at www.pearsonhighered.com. Click on Support and then Download Instructor's Resources.

- Instructor's Manual with Test Bank
- PowerPoint® Lecture Presentations

Acknowledgments

Many have helped, directly or indirectly, with the completion of this text. My thanks go first to my family—my husband, Jim, my son, Andrew, and his dad, Charlie—who have made allowances and helped me out as I sought to get these revisions in on time. My appreciation goes to my dear friend Marcia Gagliardi, who has become one of my best advocates and source of encouragement. And once again to Peggyann Prasinos, my research assistant and friend, whose cheerfulness, creativity, and computer savvy are invaluable.

The contributors to this edition deserve mention: thanks to Lynne Kellner, Laura Garofoli, Catherine Sinnott, and Kathleen Craigen.

Also, I thank the reviewers of this edition—Pamela Bailey, Montgomery County Community College; Joyece E. Dykes Anderson, University of South Carolina; Ebony English, Community College of Allegheny County; and Sheri Weistaner, Lewis-Clark State College.

This book would not be possible without the numerous students and colleagues over the years who have motivated me to explore ever new vistas in child welfare and my son, Andrew, through whose experiences I have seen child welfare services through new eyes.

Brief Contents

1. Children: Our Most Important Resource 1
2. The Changing Family 21
3. Children and Families in Poverty 55
   by Lynne Kellner and Kathleen Craigen
4. The Impact of Violence and Addiction on Children 87
5. Children Against the Backdrop of War: Addressing the Needs of Military Families 109
6. Trauma-Sensitive Educational Settings 129
   by Laura M. Garofoli
7. Child Abuse and Neglect: Protecting Children When Families Cannot 147
8. Family Preservation or Child Placement? Serving the Child's Best Interests 187
   by Lynne Kellner and Cynthia Crosson-Tower
9. Juvenile Court Justice: Promoting the Rights and Welfare of Children and Families 215
   by Catherine C. Sinnott
10. Teenage Pregnancy and Parenting 233
    by Lynne Kellner
11. Children in Family Foster Care 265
12. The Adoption of Children 297
13. Children in Residential Settings 337
14. Our Children's Future 375

Contents

1. Children: Our Most Important Resource 1

The Need for Child Welfare Services Today 1

A Brief History of the Plight of Children 2

Abortion, Infanticide, and Abandonment 4

Child Labor and Education 4

Early Efforts to Care for and Help Children 7

Out-of-Home Care 7

Childcare 8

Advocacy in the Provision of Children's Services 9

Providing Services for Children Today 13

Today's Children 13

Services for Today's Children 14

Services in the Future 15

Becoming a Child Welfare Worker Today 16

SUMMARY 18

2. The Changing Family 21

A Picture of Today's Family 21

The Family as a System 24

Family Roles and Rules 25

Communication Patterns 25

Observation of the Family as a System 26

Types of Families and How They Function 28

The Emotional Climate of Families 29

The Family Life Cycle 31

The Impact of Culture on Families 34

Families with Anglo-European Roots 34

Families with Native American Roots 36

Families with African American Roots 38

Families with Hispanic Roots 40

Families with Asian Roots 42

Families with Middle Eastern Roots 44

Family with Diverse Sexual Orientations 45

Stresses on Families and How They Cope 47
Parental/Family Dysfunction 47
Role Definition and Inequality 48
Parent–Child Relations 48
Disability 49
When Families Need Help 49
The Family as a Resilient Unit 50
SUMMARY 52

3. Children and Families in Poverty 55
by Lynne Kellner and Kathleen Craigen

Demographics: Who are the Poor? 55
Defining Poverty 55
Demographics 57
Geographic Distribution of Poverty 58
Family Composition: Child's Age and Family Structure 58
Cultural Membership and Risk of Poverty 59

Causes of Poverty 61
The Great Recession and Employment Difficulties 61
Child and Family Homelessness 61
Parents' Education and How Children Are Affected 62
Disabilities 63
Immigration 64
Additional Causes of Poverty 65

Impact of Poverty 66
Impoverished Environment 66
Health, Development, and Education 69

Efforts to Alleviate Poverty 73
Prevention Services and Assistance Programs 74
Opportunities for Youth 78
Why Poverty Endures 79
Shaping the Future of Poverty Prevention and Services 80
How to Reduce Child Poverty Right Now 82
SUMMARY 85

4. The Impact of Violence and Addiction on Children 87

Children and Violence in the Community 88
War in the Streets 88
School Violence and Bullying 92

Violence at Home and in Intimate Relationships 95
Violence in Families 95
Peer Violence in Relationships 97

Children and Their Parents' Substance Abuse 98
Substance-Abusing Parents 98
Children and Adolescents Who Abuse Substances 104
Effects and Treatment of Adolescent Drug Abuse 106
SUMMARY 108

5. Children Against the Backdrop of War: Addressing the Needs of Military Families 109
Today's Military: Another Culture 109
The Military Culture as it Impacts the Military Family 112
Reasons for Enlistment 112
Belonging to the Warrior Society 113
Types of Military Families 115
Military Men 115
Military Women 115
Dual Military Couples 116
Families of the National Guard and Reserves 116
Issues Facing the Children of Military Families 117
Living with Change 117
Effects of Deployment and Return 118
Educational Issues 120
Spillover of Violence 121
Financial Concerns 123
A Strength–Based Approach to Working with Military Families 124
SUMMARY 126

6. Trauma-Sensitive Educational Settings 129
by Laura M. Garofoli
At-Risk: Trauma and Academic Failure 130
Creating Trauma-Sensitive Educational Settings 133
Childcare 133
K–12 Schools 134
Social Workers in Educational Settings 138
Educational Rights of Traumatized Children 140
SUMMARY 145

7. Child Abuse and Neglect: Protecting Children When Families Cannot 147
Historical View of Children and Their Welfare 147
Child Neglect Throughout History 148
Child Labor and Maltreatment 149

Sexual Mores and Abuses 149
Efforts to Control Child Abuse 150

Maltreatment Defined 152
Physical Abuse 152
Neglect 158
Sexual Abuse 162
Emotional or Psychological Abuse 170

Reporting Child Maltreatment 172
Intake 173
Assessment 174
Case Management and Treatment 176

Court Intervention in Protective Cases 177
Juvenile or Civil Court 177
Criminal Court 178
The Effect of Court Involvement on Children 179

The Role of the Protective Services Worker 179

Future of Protective Services 182
Customized Response and the Necessity of Training 182
Community-Based Child Protection 183
Encouraging Informal and Natural Helpers 184

SUMMARY 184

8. Family Preservation or Child Placement? Serving the Child's Best Interests 187

by Lynne Kellner and Cynthia Crosson-Tower

Brief History of Family-Based Services 188
Colonial America to 1875 188
The Emergence of Charitable and Private Organizations 189
Public Child Welfare Services 190
The Emerging Concept of Permanency Planning 190
Children in Care Today 192

Types of Family-Based Services 193
Theories That Underlie Family-Based Services 193
Family Support Services 195
Family Preservation Services 195
Preservation or Child Placement? 198

Assessing Effectiveness of Family-Based Services 201
Family Preservation Workers 203

Preserve the Family or Place the Child? 204

Shaping the Future of Family-Based Services 209
Attention to Cultural Diversity 211
Program Design, Evaluation, and Continuing Research 212

SUMMARY 213

9. Juvenile Court Justice: Promoting the Rights and Welfare of Children and Families 215

by Catherine C. Sinnott

The Origins and Purpose of the Juvenile Court 216

Juvenile Court Cases 217

Delinquencies 218
Status Offenses 220
Care and Protection Cases 221
Disposition of Care and Protection Cases 222
Appeals Cases 223

Trauma in the Juvenile Court 224

Challenges in Juvenile Court Settings 225
Time Delays in Juvenile Court 226
Complexities of Social Work in the Juvenile Court 226
Coping with Trauma in Court 227

Trends in Juvenile Justice and Child Welfare 228

SUMMARY 230

10. Teenage Pregnancy and Parenting 233

by Lynne Kellner

Historical Perspectives 233

Defining Teen Pregnancy 234
How Teen Pregnancy Came to Be Viewed as a Problem 234
Fluctuations in Teen Birth Rates 237

Risk and Protective Factors 241

Individual Factors and Childhood Experiences 241
Family Factors 244
How Teens Make Decisions about Fertility and Childrearing 246

Impact on Mother, Father, and Child 248

Medical Concerns 248
Education and Developmental Issues 250
Economic Instability 250
Family Structure and Dynamics 252

Intervention Programs 254

Primary Prevention: Focusing on Sexual Antecedents 255
Primary Prevention: Nonsexual Antecedents 257
Primary Prevention: Sexual and Nonsexual Antecedents 258
Secondary Prevention: Services for Teen Parents 259

Shaping the Future of Services 262

SUMMARY 263

11. Children in Family Foster Care 265

Family Foster Care: History and Today's Foster Care System 266
- *Historical Beginnings 266*
- *Foster Care in Recent Years 267*
- *The Nature of Foster Care Today 268*
- *Types of Foster Homes 271*
- *Reasons Children Enter Foster Care 272*

Parents: Foster and Biological 275
- *Foster Parents 275*
- *Birth Parents with Children in Foster Care 281*

Children in Foster Care 284
- *Feelings About Placement and Separation 284*
- *Feelings About Birth Parents 285*
- *Feelings About Foster Parents 286*
- *Life in Foster Care 286*
- *Leaving Foster Care 286*

The Role of the Foster Care Social Worker 289

The Future of Foster Care 292
- *Political Influences 292*
- *Future Directions and Concerns 293*

SUMMARY 295

12. The Adoption of Children 297

The Evolution of Adoption 298
- *Definitions and Assumptions 300*

Issues and Changes in Adoption Today 304
- *Decreased Number of Adoptable Children 304*
- *Changes in Types of Children Available for Adoption 305*
- *Controversy over Agency-Assisted versus Independent Adoptions 306*
- *Access to Information and Openness in Adoption 309*
- *Transracial Adoption: Domestic and International 310*
- *Adoption Disruptions and the Need for Follow-Up 313*

Adoptive Participants 315
- *Birth Parents 315*
- *Children Available for Adoption 318*
- *Adoptive Applicants 321*

The Adoptive Process 324
- *The Homestudy 325*
- *Placement and Legalization 326*
- *Postlegalization Services 327*
- *Adoption Disruption 329*
- *The Role of the Adoption Worker 330*

The Search and Lifelong Services 331
Supporters of the Search 331
Who Searches 332
Search Outcome 332
Sealed Records 333
Consent Contracts 333
Lifelong Services 333
SUMMARY 334

13. Children in Residential Settings 337

Historical Perspective and Today's Residential Settings 337
Historical Perspective 337
Types of Residential Care Today 340

Children in Residential Settings 346
Meeting Community Needs 346
Meeting the Child's Specific Needs 347
Adjustment to Placement 348
Life in a Residential Setting 348
Components of a Residential Setting 348
Level System and Token Economy 350
The Influence of Peer Culture 351
Handling Crises in Residential Settings 352
Sexually Acting Out in Residential Care 354
Sexual Abuse of Children in Residential Care 356
Termination from Residential Setting 357
Hospitalization 358

Working with Families of Children in Residential Care 361
Motivation of Parents 361
Types of Family Treatment 363
Problems in Working with Families 363

The Role of Staff in Residential Settings 364
Residential Staff 365
Educational Staff 365
Clinical Staff 366
Other Staff Functions 367
The Frustrations of Staff 367

Trends in Residential Settings 368
Environment 369
Staff Issues: Training, Support, and Self-care 369
Integration of Services, Program, and Culture Changes 370
Family Involvement 371
More Effective Evaluation 371
SUMMARY 372

14. Our Children's Future 375

Issues for the Future 375
- *Children's Status 376*
- *Children in Poverty 377*
- *Children at Risk 377*
- *Complex Populations 379*
- *Children and Health 380*
- *Children and Education 380*
- *Children and Technology 381*

Preparing the Child Welfare Worker 382

Child Welfare in the Twenty-First Century 384

SUMMARY 385

Glossary 387
References 397
Credits 419
Index 420

About the Author

Cynthia Crosson-Tower, M.S.W., M. Div., Ed. D., is the author of numerous books, including *Understanding Child Abuse and Neglect*; *When Children Are Abused: An Educator's Guide to Maltreatment*; *Secret Scars: A Guide for Survivors of Child Sexual Abuse*; *The Educator's Role in Child Abuse and Neglect*; *A Clergy Guide to Child Abuse and Neglect*; *Confronting Child and Adolescent Sexual Abuse*; and *Homeless Students*. She has also authored the monograph, *Designing and Implementing a School Reporting Protocol: A How-To Guide for Massachusetts Teachers* (revisions co-authored by Anthony Rizzuto), for the Children's Trust Fund in Boston and a similar monograph for Catholic Schools published by the Archdiocese of Boston. She is also the author of *Only Daddy's Dog*, a children's book about service dogs for veterans with post-traumatic stress disorder (PTSD).

Dr. Crosson-Tower has over 45 years of experience in child welfare practice. She has worked in protective services, foster care, adoption, and corrections; with juvenile and adult courts and with the homeless; and in a variety of counseling situations. She was also a regional trainer for the Massachusetts Department of Social Services. Her book *From the Eye of the Storm: The Experiences of a Child Welfare Worker* chronicles some of her experiences in the field. She is Professor Emerita of Behavioral Sciences at Fitchburg State University in Massachusetts and has taught seminarians at Andover Newton Theological School.

Dr. Crosson-Tower is the pastor of a church and has broadened her writing and training to include clergy. She has counseled survivors of childhood trauma and perpetrators of child sexual abuse through Harvest Counseling and Consultation. Most recently, Dr. Crosson-Tower has been working with veterans of OEF/OIF through NEADS/Dogs for Deaf and Disabled Americans. She has been instrumental in developing a program for NEADS to place specially trained service dogs with veterans returning from combat with post-traumatic stress disorder. She is at work on a memoir chronicling her experiences in developing this program and had authored several children's books about service dogs.

Dr. Crosson-Tower now consults for other service dog programs and has consulted for Assistance Dogs International, the accrediting body for service dog organizations, as they seek to develop guidelines for placing dogs for veterans with PTSD.

Introducing the Contributors

As I began writing this text, with many years in child welfare practice under my belt, it became evident to me that there were too many aspects of child welfare and too many varied services for me to know all of them in depth. For this reason, I enlisted the contributions of colleagues who are experts in their fields and who were anxious to help me present a positive picture of these services to future practitioners. The following introductions will give the reader insight into these authors and their contributions to the field.

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Lynne Kellner, Ph.D., is professor of behavioral sciences at Fitchburg State University. She supervises graduate and undergraduate students in the field. She has more than 25 years of experience in community mental health, specializing in children and family services. Other research interests include resiliency in children, creating a model of treatment for male sexual abuse victims, and evaluating a Massachusetts-based welfare-to-work program. She has authored a number of Continuing Education courses for those in the mental health fields, including ones Adoptive Families, Childhood Trauma, and Ethics of Children's Health Care. Dr. Kellner is the New England Director for the Council on Standards in Human Services Education.

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My thanks and appreciation to all of the contributors.



1

Children: Our Most Important Resource

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Discuss the incidence of children in need of child welfare service today.
- Describe how children were treated throughout early U.S. history.
- Describe the early efforts that were made to help children whose needs were not being addressed.
- Explain the concept of child advocacy, how it originated and how it helps children today.
- Discuss the current picture of child welfare and how services are delivered to children today.

The fate of one child in the United States today can be the fate of all children. In the interest of serving all children, we must seek to help each individual child. It is this goal toward which the child welfare system strives.

THE NEED FOR CHILD WELFARE SERVICES TODAY

There is no denying that America's children need help. Each day, 2,500 babies are born into poverty and in 1,267 cases, that poverty is extreme. At least, 1,492 of their families have no health insurance.

CHAPTER OUTLINE

THE NEED FOR CHILD WELFARE SERVICES TODAY 1

A BRIEF HISTORY OF THE PLIGHT OF CHILDREN 2

Abortion, Infanticide, and Abandonment 4

Child Labor and Education 4

EARLY EFFORTS TO CARE FOR AND HELP CHILDREN 7

Out-of-Home Care 7

Childcare 8

ADVOCACY IN THE PROVISION OF CHILDREN'S SERVICES 9

PROVIDING SERVICES FOR CHILDREN TODAY 13

Today's Children 13

Services for Today's Children 14

Services in the Future 15

Becoming a Child Welfare Worker Today 16

SUMMARY 18

Each day, 65 babies die before their first birthday while 870 are born significantly underweight. It is not only poverty that affects our children. Each day, 761 babies are born to teen mothers who may not have the resources to care for them. As children grow and live their lives, they meet other stumbling blocks. In the United States, there are 1,836 confirmed cases of child abuse and neglect each day. This does not take into account the reports of child maltreatment where there may not be enough evidence to confirm it. In public schools, and despite state laws, 838 are corporally punished. Not surprisingly, 2,857 students drop out of school each day. Children and teens also come to the attention of the juvenile justice system. Each day, 884 are arrested for drug crimes and 167 for other violent crimes (Children's Defense Fund, 2014).

As we consider the problems that plague our youth, we become aware that these figures often differ depending on racial or ethnic background. Table 1.1 provides an overview of many of these problems as they are distributed by ethnic group.

If we look at the problems that face children day by day and compare them to the statistics of the last few years, some trends become evident. Although the number of white and African American children born into poverty has decreased slightly, the numbers of Hispanic, Asian American, and Native American children have increased. On the positive side, more children of all ethnic groups that were reported now have health insurance. The numbers of low birth weight among all babies have decreased and there appear to be fewer births to teens (Children's Defense Fund, 2012, 2014).

What is responsible for such changes? Are they indicative of changes in the population or of prejudicial treatment of certain groups? As a future child welfare professional, you need to consider these demographic shifts.

All of these children are our future—our most important resource. It is up to today's adults to intervene so that all children will have a better future. This is the challenge facing the child welfare system.

To understand our view of children and our responsibility to protect and provide for them, we must consider the history of children's services. A brief history follows. Individual chapters expand on the etiology of specific services.

Summary of This Section

- America's children suffer from a variety of problems including poverty, low birth weight, early death, and lack of health insurance.
    - Some children drop out of school, are suspended from school, are arrested, are abused or neglected, and are killed by guns.
    - The percentages differ between various ethnic groups.
    - These circumstances require societal intervention that is provided through child welfare services.

A BRIEF HISTORY OF THE PLIGHT OF CHILDREN

The concept of childhood as we know it is relatively new. At one time, children were seen as miniature adults with many of the responsibilities of adults but few of their rights. Novels of various periods often reflected children's plight. For example, Disraeli's novel *Sybil: The Two Nations* (1845) described how children were subjected to horrendous conditions (sleeping on dirty moldy straw in damp cellars amid waste, both human and

Table 1.1 **Comparison of Children's Problems in the United States by Ethnic Group**

	White			African American			Hispanic			Asian American			Native American		
	2008	2011	2014	2008	2011	2014	2008	2011	2014	2008	2011	2014	2008	2011	2014
The number of children every day who															
Die in infancy	51	52	30	24	25	19	NR	NR	13	NR	NR	2	NR	NR	1
Are born into poverty	781	811	737	755	607	597	867	955	1,153	79	57	66	53	23	44
Have no health insurance	672	725	633	312	332	104	1,098	944	408	NR	NR	49	NR	NR	19
Are born at low birth weight	75	447	407	224	233	211	186	198	173	NR	NR	61	NR	NR	10
Are born to teen mothers	819	846	331	292	312	199	382	402	285	21	21	15	22	24	18
Are suspended by public schools	7,552	7,236	5,233	6,792	6,916	6,191	3,303	3,726	3,453	335	351	189	238	267	129
Are arrested	2,982	2,722	4,408	1,345	1,296	1,274	NR	NR	NR	64	64	55	56	51	54
Are arrested for violent crimes	95	86	88	103	96	95	3	NR	NR	2	2	2	2	1	2
Are arrested for drug abuse	268	266	303	118	94	95	NR	NR	NR	3	4	5	4	3	5
Drop out of high school	1,856	1,270	1,066	439	936	763	761	NR	834	106	98	81	NR	62	67
Commit suicide	4	3	4	NR	1	1	NR	NR	1	NR	NR	NR	NR	NR	NR
Are killed by guns	NR	4	2	NR	4	3	NR	NR	1	NR	NR	NR	NR	NR	NR
Are abused or neglected	1,198	823	805	556	417	384	419	387	399	24	21	19	NR	20	21

NR = not reported

Source: Based on data from The State of America's Children (2014). Children's Defense Fund. Retrieved from http://www.childrensdefense.org/library/state-of-americas-children/each-day-in-america.html. © Cynthia Crosson-Tower.

animal). In the novel, a child was given drugs by his nurse and eventually left to die on the streets at age 2. Charles Dickens wrote of children apprenticed to cruel masters and kept in poorhouses where their needs were neglected (see *Oliver Twist*, 1987). David Copperfield was neglected by his stepfather and eventually sent to work in a dirty, dark warehouse (Dickens, 1981). In literature, numerous other accounts speak of how children were treated as chattel and abused and neglected because adults saw them as expendable.

Abortion, Infanticide, and Abandonment

Abortion did not originate with contemporary society, nor did contraception. If contraception was ineffective, abortion was the traditional solution. Numerous studies reveal that abortion was widely accepted in ancient societies. Unwanted children who were not aborted were often abandoned or killed. **Infanticide** was common. During the Roman Empire and the flourishing of the Greeks, infanticide, although prohibited by law, apparently was one response to poverty and the burden of too many female children. Despite admonitions by secular officials and clergy not to continue in the killing of children, the practice seems to have persisted in Western Europe as late as the early nineteenth century (Stone, 1977).

From historical references and popular ballads of early times, we also know that infanticide was one solution to bearing children out of wedlock. For example, the well-known old English ballad "Mary Hamilton" tells how a lady-in-waiting to the Queen (believed to be Mary, Queen of Scots) became pregnant by the royal consort ("the highest Stewart of all") and was driven to solve her problem by tying it in her apron and casting it into the sea to drown (Symonds, 1997).

Infanticide was used to control the population and ensure that the populace would remain strong and healthy. In their early histories, Hawaii and China practiced infanticide as a form of maintaining healthy populations. Hawaiians drowned sickly children and sometimes female children (ten Bensel et al., 1999).

Since there was no agency for their protection, practices such as infanticide were considered to be the prerogative of the parents who had the ultimate authority to determine the fate of their children. Occasionally, a child's death would be noted by the courts and the parent prosecuted. For example, in 1810 a woman was tried for admitting that she had killed her baby. However, a jury found her not guilty, possibly due to insanity (Myers, 2008). Before 1875, the only remedy for the killing of children was prosecution and yet parents were often exonerated. On the other hand, if children were particularly unruly, parents might be brought to the attention of a magistrate for not teaching their children appropriate moral behavior (Myers, 2008).

Sometimes infanticide took the form of abandonment. Parents unable to care for their children might leave them to die or to be found by someone else. Caulfield's (1931 as cited in Kadushin and Martin, 1988) remarked that in England in the 1700s, abandoning unwanted infants drew little comment or consequences. Even during the late 1800s, children were abandoned in the streets of New York City at an astonishing rate. Although we would like to think that abandonment is a practice of the past, the high incidence of drug addiction among parents of young children means that some children continue to be abandoned and even killed.

Child Labor and Education

During the seventeenth and eighteenth centuries, approximately two-thirds of children died before the age of 4 (McGowen, 2005; Myers, 2008). Those who did live were expected to work along with their parents. Farm children in a largely agrarian society did

chores to contribute to the family's livelihood. At one time, children were also indentured to learn trades. **Indenture** was an arrangement whereby a child would be given over to an individual who could teach the child (usually male) a trade. Some of these children were well-treated but others were not. In *Oliver Twist* (1987), Dickens depicted the plight of one such apprentice. Oliver was the apprentice to an undertaker who not only mistreated him but also exposed him to the fine points of death. Like Oliver's master, many people who used apprentices made them work long hours and in unreasonable circumstances.

The industrial revolution brought a new way of using children in the workforce. Children were more plentiful than adults and, due to their small hands and bodies, able to do jobs that adults were too large or cumbersome to do. For example, children were frequently employed in mining and chimney sweeping because they could enter tight places. Little thought was given to the effect of the soot or mine dust on their growing bodies. In addition, children could be paid very little. Because they were thought to have no rights, few people objected to the long hours they were expected to work, the conditions under which they labored, or their treatment in general. Often, parents who depended on their child's bringing in extra income dared not protest the child's maltreatment if they knew about it. Other parents felt that their children owed them the wages they earned, whatever the conditions.

It wasn't until the late nineteenth and early twentieth centuries that child labor was addressed in a significant way. Through the efforts of reformers such as Jane Addams, Homer Folks, and Grace Abbott, the National Child Labor Committee (NCLC) was organized in 1904 to undertake reforms on behalf of working children (Stadum, 1995; Whittaker, 2003; Reef, 2007). Through its numerous publications that reported field investigations, the NCLC appealed to church, women's, and college groups to advocate for the reform of child labor laws. The message was straightforward. Reformers believed that children could help with tasks around the farm or home but that they should also be allowed a childhood free from "unhealthy and hazardous conditions," "unsuitable wages," and "unreasonable hours that could interfere with their 'physical development and education'" (Trattner, 1970, 9–10).

The first White House Conference on Children in 1909 stimulated the establishment of the U.S. Children's Bureau in 1912. It was the Bureau's role to advocate for children. One of its first tasks was to further child labor reforms. The number of children in the workforce who were 10 to 13 years old had dropped from 121 per 1,000 in 1900 to 24 per 1,000 by 1930 (Trattner, 1970), but many children were still being used as migrant labor, and many were uncounted in the census. When the Fair Labor Standards Act of 1938 established rules governing wages and hours for all workers, Grace Abbott of the Children's Bureau lobbied to expand the act to ensure that children younger than 16 could not be used in certain industries (Stadum, 1995; Whittaker, 2003; Reef, 2007; Myers, 2008).

However, the economic needs of World War II strained the enforcement of child labor laws, and the NCLC changed its focus to vocational training for children leaving high school. This change in focus would culminate in the NCLC's becoming the National Committee on the Employment of Youth in 1957 (Trattner, 1970).

It would seem that early child labor laws would be applauded by all, but some families found that the enacted prohibitions meant that there was one less wage earner in the family. Recognizing families' needs, social workers questioned the new legislation's stringency. At the same time, poor parents were often portrayed as lazy individuals who would rather send their children to work in factories than become employed themselves. Rarely did the hardworking parents who labored along with their children to eke out a meager livelihood come to the attention of the media or public (Stadum, 1995; Myers, 2008).

States began to allow children to be employed if a severe family need could be documented. The NCLC opposed such exceptions, and by 1921, most states had eliminated this practice. The NCLC argued that allowing children to work for low wages actually contributed to family poverty by "driving down the pay for adults who should be the household supporters" (Stadum, 1995, 37).

Along with the argument against child labor came the push for mandatory school attendance. Thus, school attendance laws piggybacked the child labor laws while some parents questioned the need for formal education of children needed as wage earners. The first compulsory attendance laws in the 1920s addressed children under the age of 14; by 1927, most states had increased the age to 16. Still, if families could demonstrate an economic need, children were given a certificate that allowed an exception from school in favor of earning a wage. Even if a child did attend school, it was permissible for him or her to complete a full week's work after school hours (Stadum, 1995).

It often fell to the juvenile courts to verify a family's need to require their children to work. In some areas, this task fell to the Charity Organization Society (COS). It was the role of the COS (later called the Family Welfare Association) to advocate and coordinate services for families in need of assistance (Ambrosino et al., 2011). When COS workers refused to grant the requests of parents to have their children work instead of attending school, tempers flared and the debate became heated. To encourage children to stay in school, the COS began instituting "scholarships" for needy families that equaled what the child would have earned in wages. Reformers discovered that these scholarships increased children's likelihood of remaining in school. "Mother's pensions" were also given to a select group of women who were raising their children on their own. These payments became the forerunner of Aid to Families with Dependent Children (AFDC) (Stadum, 1995; Myers, 2008; Ambrosino et al., 2011).

Today, most states decree that children must remain in school until age 16. More recent legislation protects children from unfair labor practices and ensures that they have an opportunity for an education.



Policy Practice

Behavior: *Assess how social welfare and economic policies impact the delivery of and access to social services.*

Critical Thinking Question: What does the history of child welfare say about the evolution of the attention to the rights of children? How have policies evolved? How might knowing the history of child welfare inform your own practice?

Summary of This Section

- Prior to the twentieth century, children were seen as mini adults with similar responsibilities to their superiors.
- Children were considered to be the property of their parents and for the most part, parents had the ultimate say over the fate of their children.
- Infanticide, the killing of children, was an early solution to unwanted, malformed children or children who were not of a desired gender.
- Unwanted children or those for whom parents were unable to care of might also be abandoned.
- There was no agency until the late 1800s that was responsible for the protection of children.
- Children were also expected to work alongside of adults, and some children were placed by their parents in indenture—the practice of working with a master to learn a trade.
    - The Industrial Revolution increased the need for children in the workforce as their small bodies and dexterous hands and fingers were needed for certain tasks.
    - Early reformers expressed concern about child labor and other treatment of children resulting in the first White House conference in 1909. This resulted in important legislation to protect children.

EARLY EFFORTS TO CARE FOR AND HELP CHILDREN

Out-of-Home Care

Because children were originally considered their parents' property, parents were expected to take responsibility for their children unless they could not do so. Poor parents took their children with them to suffer the degradation of **almshouses**. Other children remained at home, and their parents received "outdoor relief," a form of in-kind assistance. Orphans and children who could not be kept by their parents were cared for by others, originally church-sponsored organizations. The first U.S. **orphanage** was the Ursaline Convent, founded in 1727. But orphanages were slow to develop. There were only 5 U.S. orphanages in 1800 and only 77 in 1851. However, once the idea took hold, orphanages quickly multiplied. By 1900, there were 400 (Smith, 1995). By 1910, 110,000 children resided in 1,151 orphanages (Smith, 1995). Orphan asylums, as they were sometimes called, might house a few children or many. Although these institutions were established primarily to care for dependent children, Holt (2004) chronicles the development of orphanages for Native American children that attempted to **enculturate** the children into white society (see also O'Connor, 2004; Coleman, 2007). The late 1800s also saw children being moved from orphanages and "placed out." Instituted largely by **Charles Loring Brace**, **placing out** gave children an opportunity to live with families in the midwestern United States (O'Connor, 2004). Children were transported by orphan trains to waiting parents, often on farms. Here the children were fostered or adopted becoming extra hands to work with the family (see Chapter 11 for more complete details). However, as the number of western farms declined, so did the demand for dependent children as free labor at the turn of the twentieth century (Hegar and Scannapieco, 1999).

For the children who remained in orphanages, life varied depending on an institution's type, administration, and particular environment. Corporal punishment was the norm, and little thought was given to children's developmental needs. Life in an orphanage gave children actual necessities like shelter and only sufficient food to prevent starvation. These children were seen as pathetic individuals who needed the charity of others (Thurston, 1930).

Early childcare institutions were also largely segregated. In fact, the only facilities for many African American children were jails or reform schools, even when they were not delinquents. In the early twentieth century, associations of African American women began to address the needs of African American children (Peebles-Wilkins, 1995). Mary Church Terrell (1899), the first president of one such organization, explained that the mission of these organizations was to build a foundation for the future by promoting morality, integrity, and strength in children with the hope that by molding children—the future of the world—with these values, such issues as prejudice would be eliminated.

Institutions specifically for African American children, such as the Colored Big Sister Home for Girls in Kansas City, Missouri, and the Carrie Steele Orphan Home in Atlanta, began to emerge (Peebles-Wilkins, 1995). As in the case of African American children, little was provided for Native American children. Whether or not they had parents to care for them, they often were sent to orphanages or boarding schools as a way of not only providing for their care but also enculturating them into white society (Holt, 2004). Childcare institutions were not fully integrated until the mid-twentieth century.

During the 1920s, the institutions saw the need to modernize slightly. Increased recognition of children's needs prompted attempts to provide more humane treatment and

more "advantages" to the residents. Punishments continued to be severe in some cases, in spite of reformers' criticisms of corporal punishment.

Another way to care for dependent children became the **free boarding home**. Here, children were placed with families who agreed to assume their care, initially for no compensation. Eventually, a fee was granted for room and board, and agencies began to study those wanting to provide homes. These "free homes" were a precursor of today's family foster homes (see Chapter 11).

Children in orphanages and boarding homes were expected to show gratitude for their care by being respectful, compliant, and generally well-behaved. Children who misbehaved were threatened with expulsion. Children who complied with the institution's rules could stay until their majority (Hacsi, 1995; Smith, 1995; Holt, 2004; McGowen, 2005).

With the recognition that children need families, the use of orphanages declined in favor of family foster care. During the 1940s and 1950s, child welfare advocates spoke of the limitations of institutional care for children. Lillian Johnson, executive director of the Ryther Center in Seattle, compared an institution for a child to a life jacket that keeps the child's head above water until he or she can be helped to find solid ground (Smith, 1995, 135). The number of children in childcare institutions dropped from 43 percent in 1951 to 17 percent in 1989 (Merkel-Holguin, as cited in Wolins and Piliavin, 1964; Smith, 1995).

Today it is rare to find an institution dedicated solely to providing care for dependent children. Instead children are cared for by providing assistance payments to their parents or in family or group foster care. Current institutions are reserved for emotionally disturbed or delinquent children (see Chapter 13).

Childcare

Parents were expected to provide their children's daily care. During the years of the at-home mother, this usually was not a problem. However, World War II and the advent of the mother who joined the workforce considerably changed this picture. Working mothers were confronted with a variety of challenges during World War II in that there was marked hostility toward mothers working outside of their home even in the service of defense. Numerous well-known critics, including Father Edward J. Flanagan of Boys Town, J. Edgar Hoover of the FBI, and other defenders of the father-led family spoke out against these women (Tuttle, 1995).

The advent of these working mothers, many of whom had husbands fighting at the front, necessitated that new programs be instituted for the care of their children. Signed by Franklin Roosevelt, the Defense Housing and Community Facilities Act of 1940, more popularly known as the **Lanham Act of 1940** provided, among other funds for communities, money for childcare centers. Despite suppositions that the end of war would see mothers returning home to care for their children, "Rosie the Riveter" found that she enjoyed her new freedom and her family's increased income. The era of working mothers had begun, and childcare outside the home increased (Stoltzfus, 2004). That trend has continued to the present. Many families currently depend on the mother's income to survive.

Summary of This Section

- Children whose parents were poor might be sent to poorhouses or almshouses along with their parents.
- Children with poor or absent parents might also be relegated to orphanages. The first orphanage was in 1727 but these institutions were slow to develop until the mid-1800s.

- In the late 1800s, Charles Loring Brace developed the practice of "placing out" or sending children on orphan trains to new homes in the midwestern United States.
- For those who remained in orphanages, life was not always easy.
- Orphanages were segregated well into the twentieth century. There were fewer orphanages for African American children and little or nothing for Native American children.
- Eventually free boarding homes developed—the precursor to today's foster homes.
- During World War II, more mothers were forced to join the workforce necessitating day-time care for their children. The Latham Act of 1940 provided funds for childcare.

ADVOCACY IN THE PROVISION OF CHILDREN'S SERVICES

Over the years, a number of agencies, individuals, and pieces of legislation have actively advocated the provision of services for children. One of the earliest agencies to advocate for children was the New York Children's Aid Society, founded in 1853. Through this organization, Charles Loring Brace began to address the needs of dependent children through "placing out" (see Chapter 11). If the numbers attest to success, this agency's efforts were extremely successful. By 1873, Brace's program had placed 3,000 children; in 1875, the peak year, 4,026 children found new homes in this manner (Hegar and Scannapieco, 1999; Popple and Leighninger, 2010; Ambrosino et al., 2011; Zastrow, 2013).

The 1874 case of **Mary Ellen Wilson** (see Chapter 7) elicited the efforts of Henry Bergh, then director of the American Society for the Prevention of Cruelty to Animals, and his colleague Elbridge Gerry, who advocated not only for Wilson but also for all the abused and neglected children by forming the Society for the Prevention of Cruelty to Children, the first agency with the specific mission of intervening in cases of child maltreatment (McGowen, 2005; Shelman and Lazoritz, 2005).

Another group of advocates in the latter part of the nineteenth and early twentieth centuries consisted of individuals associated with the settlement house movement. **Jane Addams**, **Julia Lathrop**, and others blazed the way for reform in child labor, the court system, and other matters affecting children.

In 1912, the **U.S. Children's Bureau** was established as a result of the first White House Conference on Children in 1909. Its creation marked the first recognition that the federal government had any responsibility in the provision of services for children. Lathrop became the first director and led efforts to institute programs to improve maternal infant care and decrease infant mortality. The Government Printing Office still carries one of the Bureau's first publications, *Infant Care*, which has undergone more than 20 revisions since its first printing (Johnson and Schwartz, 1996; Downs et al., 2008; Ambrosino et al., 2011).

The **American Association for Organizing Family Social Work** (later the Family Service Association of America) was founded in 1911, and the **Child Welfare League of America** was founded in 1921. Both organizations established standards for the provision of children's services and led the way in promoting research, legislation, and publications related to child welfare (Johnson and Schwartz, 1996; Ambrosino et al., 2011; Child Welfare League of America, 2011).

Although it is not always thought of as advocacy for children specifically, the **1935 Social Security Act** (SSA) established mothers' pensions (later, AFDC and Transitional Assistance) and mandated that states strengthen their child welfare services. The act also promoted the views that poverty is a major contributor to family problems, that children should be left in their homes whenever possible, that states should be allowed to intervene to protect family life, and that the federal government should play a larger role in overseeing child welfare services (Popple and Leighninger, 2010; Ambrosino et al., 2011).

The 1960s and the War on Poverty saw the development of **Project Head Start**. This program was based on research being done on child development and the effects of stimulation and poverty on children's ability to learn in school. Head Start strove to ensure that economically disadvantaged preschool children would receive medical care, nutritional services, and educational preparation to help them succeed in school (Vinovskis, 2005).

Another important advocacy agency for children, the **Children's Defense Fund** (CDF), was founded by Marian Wright Edelman in 1973. Deeply involved in the civil rights movement of the 1960s, Edelman felt that there was a need to help children throughout the country regardless of their race or class. The CDF encouraged parental involvement and change within the community. Early on, the CDF dedicated itself to various aspects of child welfare including: improving children's access to education, advocating for children with special needs, ending medical experimentation on children, increasing children's rights to privacy in the computerized age, reforming juvenile justice, and monitoring and improving foster care services.

Since its beginning, the CDF has also addressed child abuse and neglect, teen pregnancy, homelessness, and parenting issues.

In 1974, both the Title XX amendments to the SSA and the **Child Abuse Prevention and Treatment Act (CAPTA)** made major contributions to the provision of services for children. PL 94-142 (part of the Title XX amendments) ensured the education of all handicapped children (see Chapter 6), and CAPTA mandated reporting of child maltreatment, encouraged and provided funds for research, and mandated training for the recognition, prevention, and treatment of child abuse and neglect (Child Welfare Information Gateway, 2008; Ambrosino et al., 2011; American Bar Association, 2011) (for an excellent discussion of CAPTA, see Children's Bureau, 2014).

Perhaps a forerunner of today's emphasis on family preservation (see Chapter 8) and permanency, the **1978 Indian Child Welfare Act** sought to protect tribal rights and stop the frequent removal of Native American children from reservations to the homes of whites, a practice that betrayed their heritage and destroyed their kinship networks. This act may have prompted African American activists to insist that children from their cultural background also be kept within their own kinship and extended family systems (Pevar, 2004).

The 1991 **Indian Child Protection and Family Violence Act** (PL 101-630) further extended provision of services to Native American children. The act mandated the reporting of child abuse on Native American reservations. Prior to the act, there was potential for confusion as to whether abuse was handled by tribal councils or by the local child welfare agency. This uncertainty caused inconsistency in services (Pevar, 2004).

The **Adoptions Assistance and Child Welfare Reform Act** (PL 96-272) of 1980 further addressed permanency planning. This act discouraged placing children in foster care, required case plans, and mandated that reviews of services be done every 6 months. It also provided federal funding to assist the adoption of special-needs children. After this law was instituted in the early 1980s, the number of children in foster care dropped from an estimated 500,000 to an estimated 270,000. However, some think that the numbers of abused

and neglected children have risen since the act was instituted (Johnson and Schwartz, 1996; Ambrosino et al., 2011).

During the 1980s and 1990s, several pieces of legislation affected the provision of services for children, although they were not all directed specifically at children. **The Public Health Act of 1987** addressed teen pregnancy by establishing programs for pregnant and parenting teens. The Special Education for Infants and Toddlers Act enacted in 1989 enables developmentally delayed young children to receive services. The Developmentally Disabled Assistance and Bill of Rights Act of 1990 requires that developmentally delayed individuals, including children, receive services in the least restrictive setting. Despite the passing of such acts, the funds to implement them are not always available. In addition, ceilings have sometimes been placed on the funding allocated to meet client needs (Ambrosino et al., 2011).

In 1993, the **Omnibus Budget Reconciliation Act** established the **Family Preservation and Support Services Program**, which provided funds for states to develop family support and preservation programs. Although there had been amendments to CAPTA, this was the first major piece of legislation since 1980 to specifically address child welfare. This act was directed toward vulnerable families and attempted to strengthen services to parents in order to enhance parental functioning and protect children. The act was designed to be culturally sensitive and family-focused, with an emphasis on preserving the family unit (Downs et al., 2008). In addition to specific services such as foster care and adoption, child welfare agencies were encouraged to explore the resources of kinship and community care to meet children's needs (Children's Bureau, 2015b).

The Welfare Reform Act of 1996 also affected children and the services provided to them (see Chapter 3). In 1997, the **Adoption and Safe Families Act** was signed into law. This legislation was designed to advocate for the safety of children and promote adoption or other permanent homes (Levy and Orlans, 2014) (see Chapter 12 for details). This law represents the most significant changes in the foster care and adoption system to date. In 1999, the **Foster Care Independence Act** sought to improve services for children as they "aged out" of the foster care system.

In 2000, the **Child Abuse Prevention and Enforcement Act** (PL 106-177) also sought to reduce the incidence of child abuse and neglect. It authorized federal funds to states for prevention programs and for improvements to their criminal justice systems that would enable them to make more-accurate criminal history records available to child welfare agencies. The Intercountry Adoption Act of 2000 (PL 106-279) was aimed at improving adoption services.

The **Promoting Safe and Stable Families Act** of 2001 (PL 107-133) addressed the needs of the children of incarcerated parents as well as improved the services for youth who were aging out of foster care. In 2003, the Keeping Children and Families Safe Act (PL 108-36) served to amend and reauthorized CAPTA; it also addressed adoption services and family violence. Later amendments to Title IV of the SSA provided additional support to adoption and foster care (see the Adoption Promotion Act of 2003, PL 108-145; Fair Access Foster Care Act of 2005, PL 109-113; Safe and Timely Interstate Placement of Foster Children Act of 2006, PL 109-239; and Child and Family Services Improvement Act of 2006, PL 109-288).

Increased concern over child exploitation through abduction, child pornography, and access to children by offenders through the Internet led to the **Adam Walsh Child Protection and Safety Act** of 2006 (PL 109-248), which honored the memory of Adam Walsh, who was kidnapped from his Florida home in 1981 and later found murdered. His father, John Walsh, has become a strong advocate for legislation and services to prevent child abuse. (For a more complete summary of the above legislation, see the Child

Welfare Information Gateway page of the U.S. Department of Health and Human Services website.)

In October of 2008, the **Fostering Connections to Success and Increasing Adoptions Act** of 2008 (PL 110-351) amended parts B and E of Title IV of the SSA in an effort to further support relatives who are caregivers, improve outcomes for children in foster care, and enhance incentives for adoption. The law also addressed tribal child welfare providing for better foster care and adoption access.

On December 20, 2010, President Obama signed PL 111-320, a 5-year reauthorization of the federal CAPTA that had last been reauthorized in 2003. This reauthorization made minor changes related to the responsibility of parents for fetal alcohol spectrum disorder, permanency planning when parents have been sexually abusive, the case tracking required of child welfare agencies, and several considerations for homeless children (see American Bar Association, 2011 for more details).

The **Patient Protection and Affordable Care Act** (PL 111-148) of 2010 is recognized as an effort to provide medical care for all citizens of the United States including children. However, this law also had specific provisions for child welfare including the extension of Medicare coverage for former foster children until the age of 26, mandated case reviews for children aging out of the foster care system and increased services for teen parents.

The **Child and Family Services Improvement and Innovation Act** (PL 112-134) of 2011 fine-tuned some of the services provided to children through child welfare agencies including such issues as better coordination of children's health care services, monitoring the trauma caused to children by removal and subsequent placements, advocacy for expedition of permanent placements, promotion of better reunification plans when appropriate, and requirements for the number of social worker visits (for more information, see https://www.childwelfare.gov/pubpdfs/majorfedlegis.pdf).



Policy Practice

Behavior: *Apply critical thinking to analyze, formulate, and advocate for policies that advance human rights and social, economic, and environmental justice.*

Critical Thinking Question: What trends do you see in the legislation that influences child welfare practice? How has the intervention evolved in the field of child welfare? What do you feel has most influenced the services provided to children today? In what areas is policy still needed?

The **Preventing Sex Trafficking and Strengthening Families Act** of 2014 made some improvements in the provision of child welfare services in addition to building in safeguards for children at risk for sexual trafficking.

Current discussions about various issues of public policy greatly affect the provision of child welfare services. In addition, children are exposed to a variety of social problems that affect their well-being. The high incidence of drug use among both parents and their children influences child development. Drug use carries the threat that children will be exposed to HIV. Further, increased violence in our society makes children especially vulnerable to harm. The fact that many of our nation's homeless are women and their children means that even the basic needs of some children are not being met.

Summary of This Section

- One of the earliest agencies to advocate for children was the New York Children's Aid Society Founded in 1853. It was his agency that sponsored Charles Loring Brace's orphan trains.
- The dramatic beginning of child protection centered around the case of Mary Ellen Wilson, a neglected and abused child, in New York city in 1874.
- In the late 1800s, settlement houses were also instrumental in advocating for children and in the furthering of programs to benefit children.

- The American Association for Organizing Family Social Work (later to become the Family Services Association of America) was established in 1911.
- The Children's Bureau was established in 1912 as a result of the first White House Conference to address the need of children.
- One of the most active agencies today to benefit children, the Child Welfare League of America was founded in 1921.
- Other significant agencies emerged during the twentieth century, including Head Start in the 1960s and the Children Defense Fund in 1973.
- The twentieth century has also seen some significant legislation that impacts children. Some of the most significant has been the Child Abuse Prevention and Treatment Act (CAPTA) of 1975, the Indian Child Welfare Act in 1978, Adoption Assistance and Child Welfare Reform Act of 1980, the Family Preservation and Support Services Act of 1993, and the Adoption and Safe Families Act of 1997.
- In 2010, President Obama signed the reauthorization of CAPTA.
- The Patient Protection and Affordable Care Act (PL 111-148) of 2010 was designed to ensure that all citizens had adequate health care, but this legislation also contained directives for the improvement of child welfare services.
- Other legislation since 2010 has been the Child and Family Services Improvement and Innovation Act (PL 112-134) of 2011 and the Preventing Sex Trafficking and Strengthening Families Act of 2014.

PROVIDING SERVICES FOR CHILDREN TODAY

Today's Children

Today, minority children remain underserved. Although most children in foster care are African American, the traditional foster family is white. Black advocacy groups argue that placing African American children with white families robs the children of their cultural heritage (Hegar and Scannapieco, 1999). Despite the fact that the rate of minority children in the United States grows yearly, there is still prejudice and discrimination prevalent in the field of child welfare as in any other area of public service.

Over the last decade, there has been a marked increase in the number of immigrants in the United States and currently one-quarter of all children in the United States are either foreign born or have foreign born parents. The highest percentage of immigrants are Hispanic from Mexico and Latin American countries followed in number by Asians. The stresses faced by immigrant families attempting to acculturate to their new surroundings may increase their risk for needing child welfare services (Dettlaff et al., 2012; Children's Bureau, 2015a).

In addition to legal immigrants, there are approximately 11.2 million unauthorized immigrants in the United States in 2012. Approximately 7 percent of children in K–12 have at least one unauthorized immigrant parent (Krogstad and Passel, 2014). There is no way of estimating the number of children in this category who are below school age. Or how many of the total number of children will come to the attention of the child welfare system. Of those who are documented as already involved with child welfare agencies,



Human Rights and Justice

Behavior: *Engage in practices that advance social, economic, and environmental justice.*

Critical Thinking Question: How have the services provided for diverse groups differed? How do you feel this has impacted child welfare today? How do you see yourself engaging in activities that will benefit families from diverse economic and cultural backgrounds in the interest of social and economic justice?

67.2 percent are Hispanic, 14.8 percent are white (non-Hispanic), 10.0 percent are African American (non-Hispanic), and 7.5 percent are Asian (non-Hispanic) (Lincroft and Dettlaff, 2010; Dettlaff et al., 2012).

The diversity of the represented cultures now living within the United States has challenged the social service system. For example, a social worker in a large eastern city recounted the following story.

Case Example Learning About Diverse Populations

We have had a large number of Cambodian families in our city for several years. Because of this, our social workers received training in some of the cultural issues so that we would know how to deal with these families. Then quite a few Hmongs moved here. The Hmongs are Laotian hill people who have customs that are quite different from the Laotians themselves. They have what we might consider somewhat archaic ideas of courtship and child-rearing and helping them to integrate into our culture has been a real challenge. Understanding these families, along with the Vietnamese parents, the several Chinese clients, and the families from India and Pakistan we serve, has kept us very busy. The cultural variations among these folks are great and to treat them all the same does them a great disservice.

There is often a need for increased collaboration with other professionals and agencies who provide care to immigrant families. There may also be a lack of engagement between those in child welfare agencies and immigrant communities (Dettlaff et al., 2012). There is a need for better training for child welfare workers to meet the needs of these populations.

Services for Today's Children

Today, child welfare services emphasize trauma-informed practice, an approach that is based on the understanding that children who come to the attention of child welfare services have experienced at least one form of trauma and that the services offered to them and to their caretakers must be strength-based and emphasize physical, psychological, and emotional safety for the victims/survivors as well as for providers. The goal will be for those being served to gain a sense of control and empowerment that can lead to healing.

Services within child welfare strive first to support the family in its crucial role. If this is not sufficient, it may be necessary to supplement the family's strengths or resources. The last resort is for substitute care for children with the hope of some permanent plan—either reunification with their families or alternate homes (e.g., long-term foster care, kinship care, or adoption). Child welfare advocates agree that, whenever possible, the best place for children is with their families. Thus, families must receive assistance in solving whatever problems make it difficult to deal with their parenting role.

There is also increased emphasis on serving children with special needs in addition to trauma. In educational settings (see Chapter 6) and substitute care settings (see Chapters 11 and 14), practitioners recognize that the needs of children with a variety of disabilities require alternative methods of intervention.

Experts have become increasingly aware of how the services offered to children and their families affect the consumers that they strive to benefit. We have long recognized the importance of early development on children's later ability to function. We know from the studies of Bowlby (1982, 1988) and others that mother-infant bonding is important in the formation of the individual. Levy and Orlans (2014) emphasize the importance of

attachment between the child and the caretaker in the early stages of life. It is this base that will influence the child's development, relationships, values, and well-being.

Attachment is created through a consistent, reciprocal relationship between parent and child. The absence of such a relationship compromises or disrupts attachment, putting the child at risk for serious problems. *Attachment disorder* can be created by such circumstances as parental substance abuse, child abuse or neglect, teen parenting, family violence, poor environmental stimulation, separation, and poverty (Brisch, 2004; Blaustein and Kinniburgh, 2010). These are the circumstances that bring children to the attention of the child welfare system. So court intervention removes the neglected child of a drug-abusing mother who was battered by her husband from the only home the child has known. This child demonstrates many characteristics associated with attachment disorder: difficulty with trust, inability to be affectionate or empathize with anyone, intense anger, lack of compliance with caregivers, self-destructive behavior, destruction of property, cruelty, and hyperactivity. What does such a child need to heal? Most needed are consistency, compassion, and patience (Blaustein and Kinniburgh, 2010; Brisch, 2014; Levy and Orlans, 2014).

Enter the child welfare system. The already traumatized child is placed in a foster home, then another, and then another. The child is placed for adoption, but the placement fails and the child returns to foster care. Finally, convinced that this child is unable to make a transition to another family, social services then places him or her in residential treatment and thus exposes him or her to numerous residential caregivers, many teachers, and several therapists. With such inconsistency and interrupted relationships, how can we wonder why such a child does not improve?

However, we cannot totally condemn the child welfare system. Practitioners have spent years trying to make the system work for children (see Crosson-Tower, 2015), yet experts feel we are far from achieving that goal. Now it is up to the future generation of professionals to recognize the need for more consistency in the lives of troubled children. There are many ways to accomplish this consistency, as the following chapters will demonstrate. We have the knowledge to improve the lives of children and their families. It is now up to us to reevaluate and make the system work.

Services in the Future

It is impossible to predict this century's challenges to the provision of child welfare services because environmental influences (e.g., political climate and economics) constantly change. The unprecedented amount of legislation aimed at helping families that was enacted in the last 2 decades is beginning to have an impact on services. Yet, many unresolved issues from the past century involving children and their families continue to plague us. These include poverty, inadequate health care, domestic violence, child abuse and neglect, and substance abuse. The need for preventive and restorative services for children and their families will continue. Throughout its history, the United States has failed to meet this need. The federal government has funded services only if problems became serious and affected increasing numbers of people. The trend has been to seek one solution to the needs of those experiencing similar problems and to reuse unsuccessful "solutions" with a slight twist and then blame the victims when new programs again fail. For example, the Temporary Assistance to Needy Families programs developed through the Personal Responsibility and Work Opportunity Act of 1996 are really "workfare" programs. Some individuals succeeded in leaving welfare; others have not. Research to evaluate the effectiveness of such programs is only beginning.

What direction should child welfare services and related policy making take in the remainder of the twenty-first century? The goal is to develop and implement a national family policy based on programs and services that exist in other family-friendly industrialized nations. In effect, residual services would be replaced by institutional services available to those in need as problems arise, with no stigma attached. Both prevention and trauma-informed treatment would be emphasized (Ko et al., 2008). A bureaucratic structure would continue to be necessary for delivery of services. However, agencies would have the flexibility to individualize services based on clients' specific needs. Programs and services would be modeled after those that existing research indicates meet the service goals for families. Additional research findings would guide decisions about continuing, changing, or discontinuing services.

To accomplish this revision of services, effective lobbying of those with political power at the local, state, and national levels would have to occur. Lobbyists would need to be knowledgeable about research findings and realistic about costs. The tax structure would have to be changed to support comprehensive services that would involve higher tax rates for large, profitable corporations and equitable taxing of wealthy individuals. Funding for some services would be provided by employers or shared by employers and employees (e.g., health insurance, including coverage for mental health, and childcare centers on site or located in areas adjacent to several businesses). Comprehensive, effective preventive services are less costly to society compared with intervention after the fact (e.g., building prisons and providing necessary services to those incarcerated is more costly than preventing the problems that result in imprisonment). As a society, we need to accept that a small proportion of those in our society may need supportive services throughout their lifetime to function at the maximum of their abilities.

Becoming a Child Welfare Worker Today

Today's **child welfare worker** assumes many different roles in the provision of services. Each role may require a different type of training. The first child welfare workers were volunteers; it wasn't until the 1900s that child welfare became a professional field (Ambrosino et al., 2011). What might a child welfare worker do? The answer largely depends on the type of service that he or she provides and the type of agency in which he or she is employed. Table 1.2, based on the chapters that follow, lists some possible roles of a child welfare worker.

These possible roles require different levels of education. Some agencies will hire residential counselors or aides without a college education, but most prefer that a counselor or aide have an associate or bachelor's degree. Although some agencies will hire individuals who have a degree in an unrelated field, most prefer that social workers have a degree in human services, social work, or another field that prepares people for social service delivery. The more specialized the social worker's role, the more education required. Counseling often requires a master's degree in social work or counseling.

The daily tasks of a child welfare worker largely depend on the type of agency in which he or she works. Most child welfare workers perform their roles within an agency or some other bureaucratic setting. Such a setting can increase the frustration of the job because many bureaucracies, in order to function and ensure quality, require that staff follow numerous procedures and document them through electronic "paperwork." "The documentation can seem overwhelming at times," a veteran worker has stated, "but it all seems worth it when a child and his or her family are receiving the service they need."



Human Rights and Justice

Behavior: *Engage in practices that advance social, economic, and environmental justice*

Critical Thinking Question: How has the intervention evolved in the field of child welfare? What do you feel has most influenced the services provided to children today?

Table 1.2 **Examples of Child Welfare Roles**

Type of Service	Agency	Possible Job Title	Roles Performed
Family services	Family planning clinic	Counselor	Counsels on contraception, family planning, pregnancy, prenatal care, and so on
Family-support or preservation services	Early intervention	Home visitor	Provides support for parents, especially in at-risk families
Services for the homeless	Homeless shelter	Shelter staff member	Provides support and counseling with regard to budgeting, housing, childcare, and homemaking; advocates for families in shelters
	Housing agency	Advocate	Provides support, advocacy, or provides counseling for families seeking housing; helps identify housing and places families
Services for the substance abusers	Drug/alcohol agency	Counselor, outreach worker, educator	Provides support and counseling for drug-addicted or alcoholic parents or teens; provides substance-abuse prevention training in schools and the community
Childcare	Childcare center (private or federal, e.g., Head Start)	Teacher, aide, family worker	Provides services for children in childcare setting; does outreach to parents
Education	School	School counselor, aide, health educator	Provides a variety of services to remove barriers to children's learning, such as counseling, groups, and aid to special-needs children; functions as a liaison to parents
Counseling	Family service agency	Counselor	Provides counseling to families and children
Child protection	Child protective services	Child protection social worker	Provides case management to families at risk for child maltreatment
Court services	Juvenile court	Social worker, probation officer	Provides counseling or case management for children and families seen by the juvenile court
Services for teen parents	Agency for teens Family service agency	Counselor, residential staff member	Provides support, counseling, or case management for teen parents; serves as a residential staff member in homes for unwed mothers
Foster care	Child protection agency	Social worker	Provides home studies of potential foster parents; places and supervises children in foster homes
Adoption	Adoption agency Family service agency Child protection agency	Social worker in placement, home finder, recruiter	Provides home studies on potential adoptive parents; places and supervises children in adoptive homes
Residential care	Residential treatment center	Social worker, residential staff member	Supervises children in residential settings; provides counseling for children in care

Source: @ Cynthia Crosson-Tower.

Training is a vital part of child welfare. Unfortunately, some agencies have used a "learning by doing" method to train staff—to the detriment of the clients. Under Child Welfare Training, Section 426 of the SSA, the U.S. Department of Health and Human Services has funds available to nonprofit agencies and educational institutions for training staff in public child welfare agencies (Johnson and Schwartz, 1996). Many professionals think it is also advisable that staff have college training in order to provide adequate services for families and children.

The field of child welfare can be a challenging one, but the role of the child welfare worker also has numerous rewards (see Crosson-Tower, 2015).

Summary of This Section

- Serving children in the future requires the recognition that minority children are still underserved.
- The increasing number of immigrants—both legal and unauthorized will have an impact on the child welfare system requiring that child welfare workers become trained in diversity and cultural competence.
- Child welfare services today are driven by trauma-informed care, which involves the recognition that children in need of services have experienced a variety of types of trauma that must be addressed.
- The first goal in child welfare is to support the family whenever possible. When the family is unable to care for its children, other permanent solutions are sought.
- Attachment is the foundation of a child's ability to develop and form later relationships. Promoting secure attachment is vital to serving children.
    - The role and tasks of a child welfare worker are governed by the agency in which she or he is employed.
    - Child welfare workers will usually need at least a bachelor's degree and training for their specific roles.

SUMMARY

- Children of all ethnic groups are in need of services today due to variety of identifiable problems. These include poverty, low birth weight, early death, lack of health insurance, abuse and neglect, arrests, being killed by guns, and problems in school including suspension and dropping out. It is many of these issues that bring children to the attention of the child welfare system.
- Children were often not treated well in early history. They were considered property to do with as their parents willed. Infanticide and abandonment were not uncommon. Poor children might be relegated to poorhouses with their parents and others were sent to orphanages. Children were also expected to work alongside adults in jobs that were often dangerous or did not give them an opportunity to develop normally.
- Orphanages were the first solution for children whose parents could not care for them, but reformers felt that children should have homes. In the 1800s, Charles Loring Brace came up with a plan to transport children by train to the Midwest for adoption or fostering. Eventually free boarding homes were developed. During World War II, working mothers required care for their children and childcare was developed.

- Efforts to advocate—or identifying and working to develop services to meet the needs of dependent children—evolved slowly. In the later 1800s, the case of Mary Ellen Wilson brought to the public's attention the plight of abused and neglected children. Settlement houses too were instrumental in advocating for children. Out of these efforts came several agencies in the early 1900s. Since then, significant legislation has been passed to benefit children, one of the most significant ones being the Child Abuse Prevention and Treatment Act (CAPTA) of 1975 that has been reauthorized several times since.
- Serving children today necessitates the recognition that minority children are still underserved, and children come from diverse cultural backgrounds. Many children have been traumatized before they come to attention of child welfare agencies. For this reason, trauma-informed care is the driving concept in children's services today. While the first goal is to strive to support and help the family, it is the responsibility of the child welfare worker to advocate for the best interests of children. Child welfare agencies recognize the importance of attachment and strive to provide children with the best permanent place for them to grow and develop. Those interested in child welfare must usually have a bachelor's degree and can expect to work within an agency, the role of which will determine the worker's tasks and clientele.

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2

The Changing Family

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Give a demographic picture of today's family.
- Describe how the family can be seen as a system and the interrelated components of that system.
- Describe the types of families today and how development and emotional climate comes into play.
- Explain how culture impacts families and outline the main cultural groups and their characteristics.
- Discuss the stressors that might bring families to the attention of child welfare agencies and what helps them to cope.

CHAPTER OUTLINE

A PICTURE OF TODAY'S FAMILY 21

THE FAMILY AS A SYSTEM 24

Family Roles and Rules 25

Communication Patterns 25

Observation of the Family as a System 26

TYPES OF FAMILIES AND HOW THEY FUNCTION 28

The Emotional Climate of Families 29

The Family Life Cycle 31

THE IMPACT OF CULTURE ON FAMILIES 34

Families with Anglo-European Roots 34

Families with Native American Roots 36

Families with African American Roots 38

Families with Hispanic Roots 40

Families with Asian Roots 42

Families with Middle Eastern Roots 44

Family with Diverse Sexual Orientations 45

STRESSES ON FAMILIES AND HOW THEY COPE 47

Parental/Family Dysfunction 47

Role Definition and Inequality 48

Parent–Child Relations 48

Disability 49

A PICTURE OF TODAY'S FAMILY

The family is constantly changing and may look quite different from the picture we had of families in the past. Yet, throughout history as today, no institution has had more of an impact on the values of society than the family. The Federal Interagency Forum on Child and Family Statistics (2014) reports that in 2013, 64 percent of all U.S. children from birth to 17 years lived in two-parent families, 4 percent lived with their own unmarried, cohabiting parents, 24 percent lived with mothers only, 4 percent with fathers only, and 4 percent with neither parent. The study did not specify whether the parents in two-parent families were of opposite sexes. Approximately 24 percent of children lived in families with at least one

When Families Need Help 49
The Family as a Resilient Unit 50
SUMMARY 52

parent who was not born in the United States and 22 percent of children between 5 and 17 spoke a language other than English at home.

Among those children not living with either of their parents, 55 percent lived with grandparents, 22 percent with other relatives, and 22 percent with people who were not their relatives (n.p.).

Of the children living with two parents, 92 percent were biological or adoptive parents and only 8 percent lived with a biological or adoptive parent and a stepparent. Of those with a stepparent in the home, 70 percent lived with their biological mothers and a stepfather.

The majority (74%) of the two-parent families were white, 59 percent were Hispanic, and 33 percent were African American. Asian American and Native American families were not reported. Today, families may consist of a single adult; multiple generations; heterosexual or homosexual couples; or a mosaic of colors, values, and culturally diverse variations.

Numerous factors have contributed to drastic changes in the picture of the family. In his study, Galston (2007) suggests that the current generation of those in their early 20s—formerly the group from which one would expect children—has a different outlook than in past decades. Several decades ago, it was expected that one would marry in one's 20s and have children. According to Galston, marriage now ranks among the bottom four criteria that those in their early 20s feel are necessary for adulthood, with only 15 percent of those surveyed indicating that marriage at their age is important and 14 percent expressing an interest in having a child. Only 15 percent of those in their 20s see the need for finishing an education and only 26 percent believe that one must be fully employed to achieve adulthood. If these statistics are accurate, there is a significant change in the age at which people want to have children, the circumstances of parenthood, and the concept of family.

In addition to the decline in early marriage and the tendency among some racial and ethnic groups not to marry at all, marriages often do not last, leading to significant numbers of single-parent families and blended families.

The need for mothers to work often leaves increased responsibility for care to extended family members, especially grandparents. The growing number of same-sex couples and their legal right to marry in some states also have an impact on the type of families we see today. The ways in which couples meet and begin relationships has also changed, as individuals rely more and more on Internet socialization.

Today, a majority of children in the United States are born outside of marriage. One study suggested that 53 percent of U.S. children would be born to **cohabiting parents**. By the age of 2, 51 percent of the children's parents were still cohabiting, 18 percent are married, and 30 percent of these relationships had been dissolved (Galston, 2007). Many children will spend at least part of their childhoods with a single parent. A significant number of children will experience several changes in the composition of their family (Teachman et al., 2000). In addition, the word "family" takes on different meanings in terms of who interacts with the child and how.

Why has marriage—especially one-time traditional marriage of one man to one woman—become less common in the United States? Teachman and colleagues (2000) blame the changes on the rapid shift in the economic environment that faces families in the twenty-first century. Although employment opportunities have increased for young women, their male counterparts are plagued with more uncertain futures. This situation often leads to delayed marriage while the woman pursues her career goals and resists taking on a less-secure partner. Once married, the employment of both the husband and wife in a family forces a renegotiation of family tasks, roles, and expectations. The failure to forge a workable arrangement often leads to divorce. For lower socioeconomic groups,

new financial-aid regulations have also influenced family composition. In addition, new laws concerning the right of same-sex couples to marry has also had an impact on the composition of the family raising children.

Nonetheless, there is hope for the U.S. family. Family members are learning to adjust to the economic crises and to their own needs. For example, male partners may be seen in the role of primary caregiver more than in years past, and the leveling off of the divorce rate suggests that couples are successfully renegotiating the assignment of domestic duties. Single parents as well as lower socioeconomic groups continue to feel pressure, but some policy analysts also feel that the current tone in the federal government is more pro-family. Hopefully, continued policy changes will reflect that optimism.

No matter how the family is defined or configured, some form of family is responsible for protecting children and imparting to them the mores of the society in which they live.

In a world in flux, it is expected that the family will provide the context for the procreation, enculturation, and protection of children. When we think of the concept of family, we usually think of a group of people who choose to live together, or at least have regular contact, for the purpose of performing specific functions (Crosson-Tower, 2013). These **functions** can be broken down into a series of responsibilities. One such responsibility is **procreation**. It is not uncommon for a couple to procreate but, for whatever reason, decide not to remain together to parent the child. Whatever the family unit involved, it is expected that the family will then be responsible for the **socialization** of the child, helping him or her to learn to relate to other members of society, both peers and adults. Families are also expected to teach children the values of the society—that is, to **enculturate** them. By verbalizing to and modeling for children, the parental figures let them know what is deemed appropriate by the culture in which they live. In addition, families model appropriate gender-linked and cultural roles (Mason et al., 2002; Anderson and Taylor, 2007; Walsh, 2012b). Children learn from their same-sex caregivers what is relevant to their gender. Same-sex parents often find role models outside the family to help children with this gender identification.



Human Rights and Justice

Behavior: *Apply their understanding of social, economic, and environmental justice to advocate for human rights at the individual and systems levels.*

Critical Thinking Question: What might you as a social worker do to protect the rights of each of the members of a family? How might you see that individual members are served? Are there agency policies that might prevent some ethnic, cultural, or diverse groups from being properly served?

Families are also expected to *protect* their offspring, ensuring that these children grow to adulthood in the safest environment possible. Families are expected to provide *financial and emotional support* to their members. They are expected to meet the child's *other basic needs* such as food, shelter, clothing, and affection. Our culture also expects that the family will provide for the child's *medical and educational needs*. Finally, the family has the extremely important role of *interpreting the world to the child and the child to the world*. The following situation illustrates the interpretation of the child to the world.

Case Example Franz

Franz is a 12-year-old child with severe handicaps. His younger brothers protect and nurture him with diligence. Unable to speak, Franz has learned to communicate using a wooden board on which the alphabet is printed. To make his needs known, he points to the letters on the board, spelling out his requests. At very early ages, his three younger brothers learned to read his words and understand the hand signals he uses. "It is not unusual," recounts his mother, "to see Franz talking to a stranger surrounded by his brothers who are eagerly interpreting. The children seem to find it a way of connecting that meets everyone's needs."

Families who meet society's expectations are accorded the right to privacy, and they carry out their roles with minimal societal intervention. The functional family needs to deal directly with society only in encounters with the school and the medical community. It is the family that does not meet its obligations that comes to the attention of the child welfare system.

Summary of This Section

- According to the Federal Interagency Forum on Child and Family Statistics, the majority of children in 2013 still lived in two-parent families, while a smaller percentage lived with single parents.
- In addition, grandparents or other relatives are raising a significant number of children.
- Most of the two-parent families were white, followed by Hispanic and African American.
- There are multiple factors that explain the changes in family composition. These include the economy, the expectation around when and whether to marry, concerns over the divorce rate, and changes in the acceptance and legalization of same-sex marriage.
- The family assumes certain roles in society including procreation, socialization of children, enculturation, modeling of societal and gender roles, financial and emotional support, meeting of basic needs as well as medical and educational needs, and the interpretation of the world to the child and the child to the world.
    - To accomplish these goals, the family is allowed a good deal of privacy. Only when the family is not meeting the needs of its children does the child welfare system need to intervene.

THE FAMILY AS A SYSTEM

The family is a complex system that constantly changes. Within the system is a series of subsystems. The ***parent subsystem*** is made up of caregivers who are responsible for making decisions and regulating the activities of the family unit. It is expected that parents will protect and nurture their children and teach them the values of the culture so that they can grow to take their places in society. To do this, parents not only provide verbal cues to proper behavior but also **model** the behavior and attitudes that are expected socially (Goldenberg and Goldenberg, 2012; Strong et al., 2013).

The ***sibling subsystem*** is composed of the children in a given family and provides an arena in which children can practice relationships with peers. Siblings have an opportunity to compete, fight, negotiate, and learn from each other. Eventually they transfer these skills to peers outside of the family. In the healthy family, there are clear **boundaries** between the parental and sibling subsystems. Parents have specific roles, as do children. Family dysfunction can occur when generational boundaries become compromised. The sexually abusive family is characterized by a blurring of generational boundaries: The sexual relationship that is appropriate between adults crosses boundaries and involves the children. However, **generational boundaries** must also be fluid enough to allow members to have appropriate interaction. When boundaries are too rigid, children often feel abandoned and feel that their parents are not available to them emotionally.

In addition to these two main subsystems, families are composed of a variety of other units. For example, all the males of a particular family comprise a subsystem, as do all

the females. Extended families living together have other subsystem possibilities. For instance, there may be grandparent subsystems.

A family system must also maintain boundaries with the outside world. If these boundaries are poorly defined, the family may lose its identity as a family. If they are too rigid, the family becomes isolated from the world in which it operates.

Family Roles and Rules

Historically, family members have assumed a set of **roles** expected by society and an individualized set of roles dictated by the individual family. Often these overlapped. For example, at one time the father figure in the home was expected to be the breadwinner, and the mother figure had the role of maintaining the home. Although some families deviated based on their own needs, most families accepted these roles and governed themselves accordingly. Today there are no clear-cut, societally prescribed roles, partly due to the economic need for both parents to work outside the home. Therefore, families are more apt to find their own ways of taking care of the family tasks. In some families, the mother maintains a job outside the home while still regulating the household. Other families find ways to share the roles and tasks inherent in everyday life. The assignment of these roles itself can create stressors. Increasingly, women cite the need for parents to share responsibility for child rearing more equally so that women are not overtaxed in their roles as wives and mothers. New generations are increasingly conscious of this need to share in maintaining a home, but do not always know how to achieve such a balance. The way in which the family deals with these issues may be largely based on personality.

Some families find that their ethnicity imposes roles on them that they find difficult to maintain. For example, some cultures still see the man as the head of household and the primary breadwinner. So, while it might be easier and financially beneficial for the woman to work outside the home, the male may fear losing some of the respect previously given him.

The assignment of roles can be spoken or unspoken and is often quite complex. In addition, roles are not always functional. Children are sometimes cast into roles that do not foster healthy development. Parents who are themselves unable to accept responsibility and nurture may see their children as their caregivers, thus robbing children of their right to be taken care of and protected (Goldenberg and Goldenberg, 2012).

Roles are often supported by **family rules**, which are repetitive patterns of interaction that family members develop with each other. Rules are either spoken or unspoken and govern the way in which families communicate and perform. Rules that are unspoken in one family may be spoken in another. For example, in one family the females do the indoor tasks, such as cleaning and cooking, while the men do the outdoor tasks, such as mowing the lawn. In some homes, this is just understood; in others, it is clearly stated.

Rules may also support or cover dysfunctional behavior. In an alcoholic family, it might be understood that family members stay out of Dad's way when he is drinking or make excuses for Mom when her drug problem impedes her functioning. In sexually abusive families, siblings often know not to communicate with each other. This silence may be demanded by the perpetrator, who recognizes that the abuse can be kept secret if family members do not talk to each other about it. Rules dictate how family members will behave, feel, and think. Violating these rules can create conflict within the family.

Communication Patterns

Communication within a family system often is at the root of how the family functions. Communication is not always on the surface, nor do people always communicate through words. Gestures, postures, voice intonations, and facial expressions sometimes say more

than the words spoken. Culture also affects how families communicate. Some ethnic populations use communication patterns that are hierarchical. Elders are respected (as in Asian cultures) and the young must listen and learn from them. Partly due to cultural heritage, some families express their emotions freely, while in others, the show of emotions denotes a lack of strength or self-control. Family rules differ from culture to culture (McGoldrick and Ashton, 2012). Many cultures see the father as the family head and his word is not to be disputed. In this case, rules such as "Ask Father before making decisions" are paramount. In other cultures, the mother may be the chief decision maker.

It is important for those working with particular cultural groups to be familiar with their mores and values. Not taking the time to do so could result in an inability to help the family and could even insult them, as the following case illustrates.

Case Example From a Muslim Perspective

A Muslim family was referred to a family service agency by their son's school when the boy had become too difficult for school personnel to handle. The family came reluctantly, the mother encased in her traditional garb, including a veil over the lower half of her face. Interested in knowing how the family was functioning, the worker—unfamiliar with Muslim custom—made eye contact with the mother and asked her how she felt about their child's acting out. The whole family's reaction was immediate and the worker quickly realized that he had somehow offended them. It was not until he talked with another worker that he learned the cultural error of a man's making eye contact with a Muslim woman and communicating with her directly rather than through her husband.

To be effective, communication in families must be clear and open. Effective communication can often get lost in the stresses and demands of everyday life. It is often incomplete or unclear communication that brings families to child welfare agencies.

Observation of the Family as a System

One highly effective method of looking at the family as a system with its roles, rules, and communication patterns is through the use of genograms. A **genogram** is a diagram of the family's relationship system, in the form of a genetic tree. This usually includes at least three generations (Goldenberg and Goldenberg, 2012). Specific symbols are used to represent family members and the relationships between them.

One advantage of a genogram is that it can give both the helper and the family a quick and fairly comprehensive view of what is occurring in the family, what patterns are present, and how these are affected by previous generations. Genograms often help clients recognize that they are part of generations of dysfunction and that the patterns they now practice have been handed down from previous generations (McGoldrick and Ashton, 2012). Clients then are more effective in breaking these patterns for future generations.

The Hartowski family came to the attention of social services because Mr. Hartowski was sexually abusing his daughter. It is obvious from the genogram (see Figure 2.1) that child sexual abuse, in addition to other types of family dysfunction, has been present in several generations. Intervention is clearly needed in this generation.

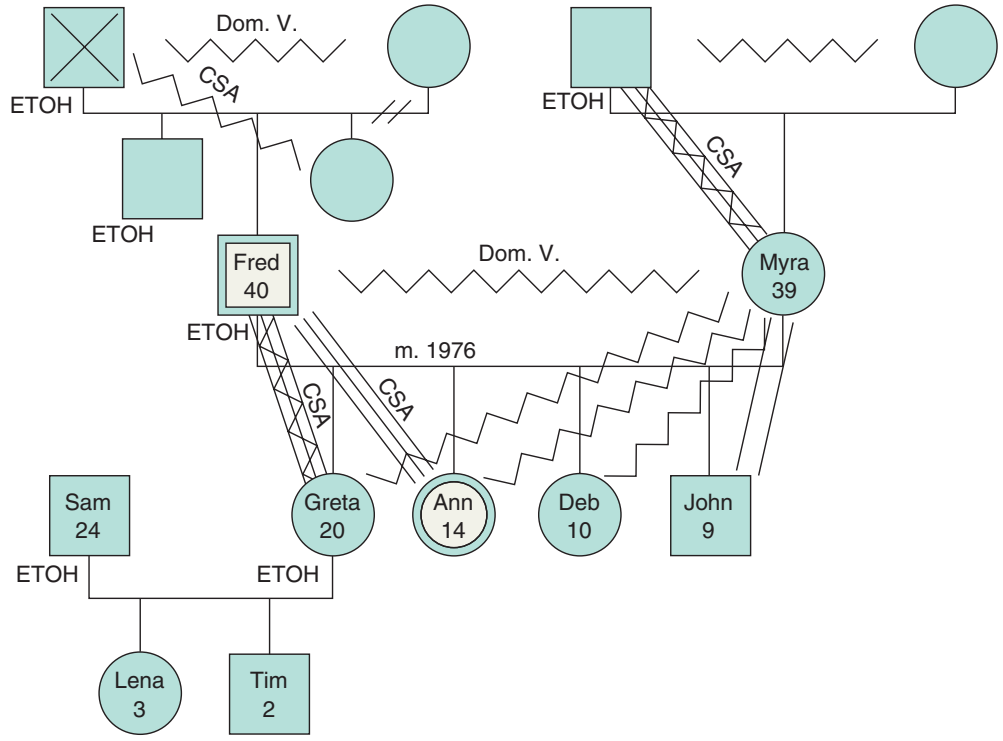


Ethical and Professional Behavior

Behavior: *Use reflection and self-regulation to manage personal values and maintain professionalism in practice situations.*

Critical Thinking Question: Draw a genogram of your own family. Does anything jump out at you? What steps might you take to ensure that your own influences from your childhood do not prejudice you in working with client families?

Figure 2.1 • The Hartowski Family



ETOH = alcohol abuse CSA = child sexual abuse Dom. V. = domestic violence

Source: @ Cynthia Crosson-Tower.

Watts-Jones (1997) cautions, however, that not all families fit neatly into a genogram. The kinship bonds of African American families, for example, make it difficult to use the classic biologically based genogram. Watts-Jones proposes a genogram for African Americans that takes into consideration kinship and functional ties.

Summary of This Section

- A family can be seen as a complex system divided into subsystems each with their roles and responsibilities. Two obvious subsystems are the parental subsystem and the sibling subsystem. There are other systems made up in a variety of ways (e.g., all the females in the family). Healthy systems are divided by boundaries. Some families have blurred boundaries that can be indicative of or support dysfunction. In addition, there are boundaries that the family also maintains with the outside world.
- Each family has a set of roles that members take within the system. Sometimes, these roles overlap. The roles may be influenced by society or originated by the family itself. Their ethnic origin may dictate or influence these roles.
- Roles are supported by the family rules—or what is expected of each member. Rules may be stated or implied and may also support or mask dysfunctional behavior.
- Communication patterns refer to the way in which a family transmits information and feelings from one member to another. Communication may be verbal or by way of non-verbal means such gestures, expressions, or voice tones. Cultural heritage has a significant impact on communication patterns.

- An effective method of demonstrating how a family functions both at this moment and over the last few generations is to construct a genogram, or a drawing of "genetic tree" depicting family relationships and interactions over several generations. Genograms can also be helpful in allowing the family to see how they are influenced by the past.

TYPES OF FAMILIES AND HOW THEY FUNCTION

The picture of family life varies greatly today. Some authors (Walsh, 2012b; Strong et al., 2013) divide families into four types: two-parent, **dual-wage-earner**, single-parent, and **reconstituted or blended families**. These variations are influenced by cultural diversity. A two-parent family within one cultural group might look quite different from a two-parent family in another cultural group.

The two-parent (man and woman), dual-wage-earner family most closely resembles early family concepts. Here, two parents strive to raise their mutual children, but economic necessity has required the female parent to enter the workforce. This family system grapples not only with common family demands but also with the time-management and role-assignment issues that are inherent when both parents are outside of the home for much of the day. **Role-assignment issues** have created the need for research and intervention and caused families to seek help. The family structure of father as breadwinner and mother as nurturer continues to be idealized, and it is not uncommon for families to have difficulty reconciling these notions with their needs. Today, the dual-wage-earner family may be one in which the parents are the same gender.

Single-parent families result from divorce, death, or the decision of the parents not to marry. The **single-parent family** is usually headed by the mother (although fathers as single parents are becoming more common as divorce courts attempt to cater to the best interest of the child). The single parent tries to assume the role of both parents.

The reconstituted or blended family is one in which there are two parents, one or both of whom have had children by another partner. When they marry, these parents bring with them their respective children, whom they then co-parent. They may also bear children of their own. Roles, rules, and communication patterns for such families may be challenging. Each adult brings at least two sets of role expectations: those of their family of origin and their first marriage/relationship. The children may compare their previous family with the new family system.

Additional family types include families by adoption and gay and lesbian families.

Case Example Rebecca and Denise

Rebecca and Denise have been partners for 10 years. After Rebecca's divorce, she was concerned about raising her two small children alone. Her early marriage to Ted had been the result of her pregnancy and was never very happy. When she met Denise at work, Rebecca was very attracted to her. Their relationship eventually became intimate. The two women had a commitment ceremony and settled down together to raise Rebecca's children.

Although gay and lesbian families had at one time been discounted as a viable family structure, they are increasingly common and accepted (Mason et al., 2002; McWhirter et al., 2006). Some might suggest that what is normal for a family is subject to interpretation.

Although some argue that parents of the same sex do not provide children with adequate gender models, others point out that the presence of two parents does give the child two adult role models, while children who grow up in single-parent families may witness excessive stress being placed on their sole parent. On the significance of families created by same-sex couples, Walsh (2012b) suggests that lesbian and gay families can teach society much about family life, including how roles and responsibilities are allocated as well as about strength and resilience. Despite the stigmas that these families must often overcome, they are forming families and carrying out appropriate roles and tasks to raise children (McGoldrick et al., 2015).

In years past, families often consisted of multiple generations. Today extended or **intergenerational family systems** still exist but are most common among minority or newly immigrated families. Although the children of these groups have more adult models with whom to identify, they may also feel the pull of the greater society to become independent of their traditional cultures. This can create stress within the family.

Whether or not the multiple generations live as one household, longer life spans resulting from modern medicine mean that children may still have living grandparents. These grandparents may provide role models very different from the children's parents. Grandma may not live in the child's home, but her influence may still be felt as she pursues her own active lifestyle. Grandma's later need for nursing-home placement may expose the child to another reality of aging. In other situations, the grandparent becomes the child's primary caretaker. There may be numerous reasons—including the parents' ages, career goals, military service, instability, or substance abuse problems—for grandparents raising children, and this type of family structure must be recognized in today's world (see Hayslip and Kaminski, 2008; Cox, 2013).

In an interesting twist, more grandparents are taking over the role of primary caretakers than ever before. Often referred to as **kinship caregivers**, grandparents and other relatives are currently raising more than 7 million children in the United States today (Monahan et al., 2013; Cox, 2013). This arrangement often occurs as a result of the parents' inability to care for their children due to substance abuse, incarceration, abandonment or illness, and the grandparent's desire to avoid the children's placement in foster care.

Families, therefore, can be defined according to their function (who does what household tasks, childcare activities, etc.), their legal structure (by virtue of marriage, birth, or adoption), the perception or expectations of family members (live-in partners, long-term relationships, kinfolk, etc.), or biological relationships. Obviously these may overlap: Legal structures may dictate rights and inheritance as well as acceptance. The fight for the rights of gay and lesbian couples to marry that has reverberated in the media until the legalization of such unions became a reality. Same-sex relationships further argue for defining families by virtue of the function of each of their members.

The Emotional Climate of Families

Each family functions differently, depending not only on the composition of that family but also on the backgrounds, personalities, and past experiences of the members. Ideally, caregivers provide their children warmth, consistency, and stability. As mentioned in Chapter 1, children bond with their caregivers in a process called **attachment**. Through the nurturance they receive and the process of attachment, children learn that they are lovable and that the world is a friendly place. Attachment also enables children to reach out beyond the microcosm that is their family and forge relationships with others (Olsen et al., 2010). Unfortunately, not all children have the experience of being accepted, nurtured, and encouraged by their parents.

Also, even if there is some nurturing, there may also be rigid control and restriction that prevent the child from feeling good about himself or herself. Different types of attachment styles produce varied results in children's behaviors. Those who develop secure attachment will fare better than those who do not.

Attachment can be seen on a continuum from secure attachment to nonattached. *Secure attachment* is characterized by the child's closeness to and trust of the primary caretaker. This child feels secure even in situation where he or she might sense vulnerability. For example, a child would notice when his mother left a room, but when she returns he goes to her and is able to connect easily. The child's sense of individuality is balanced with the togetherness with caretakers. The caretakers of this child have been affectionate and attentive, meeting his or her needs so that the child feels confident that he or she will be cared for in the future. *Ambivalent attachment* is characterized by a child who becomes anxious when the caretaker is not present but then resists the attention when they are reunited. This child is hesitant to explore his or her environment and is easily frustrated. The child is responding to a caretaker who is inconsistent, sometimes attentive but often neglectful. In *avoidant attachment*, the child is resistant to closeness with the caretaker, who is distant or unengaged. The child does not use the caretaker as a safe base and sees the caretaker as unavailable, unresponsive, or rejecting. This infant is needy and can be clingy but is actually frustrated, angry, and can even be aggressive.

The child with *disorganized attachment* has never learned to trust and does not tolerate closeness to the caretaker who is extremely erratic and often frightening or abusive. This child is often fearful and cannot be comforted easily. He or she may even appear fearful around the caretaker and otherwise exhibits unpredictable behavior. Some children are unable to attach or bond at all—often because they have experienced such trauma or rejection that the world does not feel like a safe place to be. Some experts refer to these children as *nonattached* while the more classic term is *attachment disordered* (Brisch, 2012; Levy and Orlans, 2014).

Although attachment begins in infancy, McWhirter and colleagues (2006) outline several types of child-rearing styles that may affect the emotional climate of a home throughout a child's life. Children respond to these styles in various ways. Whereas the high-support (warmth) style encourages attachment and the low-support (hostility) style tends to inhibit it, the other styles vary in their effects, depending on the individual child. For example, in a permissive family, one child may develop a healthy sense of independence while another responds to the lack of rules with rebellion and unsafe behaviors.

Often because of their own dysfunctional childhoods, some parents fail to give their children adequate and consistent nurturing. As a result, the children may develop *attachment disruption* or ***attachment disorder***. This is the inability to respond to comfort, form relationships, or cope with stress (Blaustein and Kinniburg, 2010; Brisch, 2012; Levy and Orlans, 2014). These children may develop conduct disorders, control problems, aggressive or withdrawn behaviors, or antisocial personalities. Typical characteristics of attachment disordered children include:

- Superficially charming or engaging
- Indiscriminately affectionate with strangers although the feeling lacks depth
- In reality, they are not affectionate, tender, or cuddly
- Fail to make eye contact
- Destructive to themselves and others with seemingly no conscience
- Cruel to animals
- Habitually lying or stealing

- No impulse control
- Lack of cause-and-effect thinking
- Unusual eating patterns
- Inability to get along with peers
- Preoccupied with fire
- Inappropriately demanding
- Incessantly chattering or asking nonsense questions
- Learning difficulties
- Abnormal speech
- Preoccupation with fire
- Sexual acting out (Brisch, 2012; Levy and Orlans, 2014)

Such children often come to the attention of the child welfare system. Therefore, it is vital that we understand the family, the supports it needs to properly nurture, and how we can help the children that the family has failed.

The Family Life Cycle

Like every other system, families change continuously. They also may follow somewhat predictable and definable life cycles.

McGoldrick and Shibusawa (2012) suggest that there are specific stages to the family life cycle. First, young adults emerge into their own independence and leave home to be on their own. The tasks here are for them to differentiate from their family of origin and develop emotional and financial stability. Second, these adults meet others and join through marriage or union as partners necessitating the realignment of the other relationships in their lives. Third, children require further adjustment not only to the new family members but also to extended family, friends, and the community. Fourth, as the children grow into adolescence, the family is challenged to learn to be flexible with boundaries and allow for the growing independence of their offspring.

Fifth, when the children are launched on their own and the couple moves into mid-life, the family unit must adjust to multiple exits and possibly marriages. In addition, the family members may become caretakers for the older generation or may need to grieve their deaths. At the same time, the adults in the family may be exploring new careers and activities that are more suited to their changing roles. Sixth, there may be a period when the family in late mid-life is supporting both the older and the younger generations. And finally, the core adults recognize their own advancing age, death among friends and partners, and their own dependence on others. Families who experience a breakdown caused by a trauma such as death or divorce will probably not follow this developmental process. Herbert and Harper-Dorton (2003) outline stages of transition that can be applied to families as well as individuals: immobilization, minimization of the experience, depression, testing, and finding meaning in the event. Families faced with acute stress may first be immobilized.

Case Example Divorce in the Higgins Family

When Julia Higgins filed for divorce, her husband Herb and their three children seemed unable to respond. “It was as if we were all paralyzed,” recounted Herb. “We had been having troubles but I couldn’t believe it when I was served with papers. Neither could the girls, who were then ages 14, 16, and 19. I think they thought their mother had gone mad. They always thought we were so happy.”

Families will often then minimize the experience, as the Higgins family did.

Case Example Divorce in the Higgins Family (Continued)

Herb says, "Our daughters kept telling me 'Don't worry about it, Dad! Mom will come to her senses. This is just a whim of hers.' We all kept saying to ourselves that we didn't have to worry. Julia would realize that that was not what she wanted and drop the whole thing. But she didn't!"

Once they realize that the crisis is real, families often go into depression.

Case Example Divorce in the Higgins Family (Continued)

"Once we realized that Julia really meant to leave, we all slumped into a kind of depression," Herb relates. "We each appeared to be functioning okay, but there was this overtone of sadness and hopelessness. We bickered with each other and everyone seemed caught up in her or his own needs."

At some point, family members accept that the crisis is a reality and that they must let go of their hope for a happy, together family. There may be a period of testing when the family members strive to see if the new configuration is really what is wanted by all.

Case Example Divorce in the Higgins Family (Continued)

Herb remembers, "There was a time, soon after I decided that the divorce was inevitable, that our children seemed to be trying to fix things up again. They would invite Julia and me places together, despite the fact that she had a new boyfriend. When Dianna, then age 20, got her first apartment, she invited Julia and me to dinner together. It was awkward, but we both love her, so we made the best of it. I finally had to talk to the kids and say that their mother and I would not get back together and they had to stay out of it. They finally got the message."

As the change completes itself, the family once again seeks homeostasis by searching for the meaning in the event. The Higgins girls spent long hours in discussion about what had driven their mother away. They talked about how their father had always made the decisions and that his need to control might have been a factor. And finally, each individual internalizes the meanings of the crisis, as does the family system.

Case Example Divorce in the Higgins Family (Continued)

Herb says, "Each of my daughters seemed to have a different idea of why Julia had divorced me. I know that they thought my immigrant father's old-world attitudes had made me into a bit of a tyrant too, but I think there was more to it than that. Each girl was also affected differently by us being divorced. When they all eventually married, I could recognize in their choice of mates how they had interpreted what had happened in our family."

Families that experience the loss of a family member may join with other family units. Two years after the divorce, Herb Higgins remarried. His daughters, then ages 16, 18, and 22, had a difficult time with his decision. The two youngest, still living at home, found the adjustment challenging. Their new stepmother came to the union with four boys, ages 7, 9, 12, and 14. The girls feared that they would be placed in the role of babysitters and remarked about their stepmother's more permissive child-rearing

standards. By the same token, their oldest stepbrother, used to being "the man of the house," resented being bossed around by two older girls. As is often common in blended families, the first several years were a challenge. For these families, the initial developmental task is to realign relationships so that the family can function relatively smoothly (McGoldrick et al., 2015).

Culture, too, may have an impact on family development and change. Each culture has specific expectations of its members that affect the family system. There may also be variations depending on when a particular ethnic group immigrated to America (Lynch and Hanson, 2011; Walsh, 2012). For example, the way in which families from different cultures deal with specific developmental tasks of their children can differ greatly. For example, white children usually learn to dress themselves at age 3.7 years, African American children are 4 years old, and their Native American counterparts are only 2.8. Native American children are also allowed to stay alone in the evening earlier (9.9 years) than white children (14.4 years) and African American children (13.6 years). Native American children also care for younger siblings at an earlier age (15.7 years) than do white children (16.4 years) and African American children (16.5 years) (Joe and Malach, 2011, 121). Children from other immigrant cultures may be expected to tackle these tasks at earlier or later ages, depending on the values of the parents. These methods of dealing with children will affect the development of the entire family.

For the gay or lesbian family, the process of coming out to their families and friends may be construed as part of the family life cycle as well. When and how the parents disclose their lifestyle choice to individual families of origin affects their intergenerational relationships. These parents may have had to hide their true feelings from others as children. As a result, families may strive to create different family rules and roles that influence how the family functions and develops (see more about specific cultures in the next section).

Summary of This Section

- The configuration of families differs greatly. Some authors divide families into four types: two-parent, dual-wage earner, single-parent and reconstituted, also called blended families.
- With the legalization of same-sex marriage, gay and lesbian couples have been having and raising children.
- In the past, families were often intergenerational with several generations living together and raising the children giving the children more models to emulate. Although this is not that common today, more and more grandparents are raising children on their own. This is often the result of parental abandonment or incapacity.
- The emotional climate differs from family to family as well. An important piece of this is the child's ability to bond or attach with caretakers.
- There are several different types of attachment styles including secure attachment, ambivalent attachment, avoidant attachment, and disorganized attachment. Children who are abused or exposure to very dysfunctional caretaking may not be able to bond at all, a condition referred to as attachment disorder.
- There are specific stages of family life beginning when the young adult leaves the family of origin, meets and connects with another to create a family, introduces children into the family system, and eventually launches those children on their own. Each stage brings its own challenges and requires a variety of adjustments for the family unit.

THE IMPACT OF CULTURE ON FAMILIES

Families may have totally different roles, rules, and communication patterns depending on their cultures. The most statistically prevalent cultures are discussed here, but the child welfare worker should become familiar with the variations present in his or her client population. For example, one can discuss generalized characteristics of Hispanic or Asian American families, but within those two cultural groupings is a variety of individual orientations. Mexican families are not necessarily like Puerto Rican families, and Chinese families have different values from families whose origins are in India. Thus, one should digest the generalizations but seek more detailed information as necessary.

To determine how an individual family functions, one needs to consider several questions:

1. What is the family's culture of origin?
2. Is the family connected with a subgroup within that culture (e.g., some cultures have caste systems that have different expectations of individuals depending on their castes)?
3. What is the relationship of the culture or the subgroup to the wider culture in which it functions (prejudice and stigma play a role in how well families are able to integrate into the larger society)?
4. What are the family's individual characteristics?
5. What are the family members' way of adapting to the stresses of living in a family unit (Crosson-Tower, 2013)?

In addition, some cultures value individualism while others stress collectivism. These values shape social behavior. Those with more individualistic attitudes stress the attainment of personal goals, autonomy, competition, and independence. In contrast, collectivist cultures value cooperation, mutual obligation, and personal sacrifice for the good of the group. Individuals in such cultures have a high personal identification with their families and will sacrifice personal needs for family welfare. Because many families from collectivist cultures find the United States rooted in individualistic values, and therefore a difficult society into which to integrate, it must be assumed that at the root of the problem of a minority family may be role confusion based on the differences between their cultures of origin and this one (Atkinson, 2003). Yet all families have at one time experienced the difficulties inherent in America's being a "great melting pot" that does not duplicate any one culture, including the Native American culture that settled it and the European cultures that colonized it.

Families with Anglo-European Roots

When people consider culture, there is often no discussion of early immigrants with European heritage and how their values influenced the greater society of today. Such platitudes as "If you don't succeed, try, try again," "Where there's a will, there's a way," and "A penny saved is a penny earned" have become so embedded in Americans' mentality that we rarely stop to identify these sentiments as remnants of the philosophy of the early Anglo-European colonists (Hanson, 2011).

Reports of a rich, new world and disillusionment with their native lands brought early colonists from England, the Netherlands, Spain, Portugal, France, and Italy. They brought with them a desire to forge a new life and a set of values from their own lands. While they

interacted with the native people of their new land, they maintained their own traditions. They possessed a pioneering spirit, which was enhanced by breaking from the rule of England in the 1700s. The westward expansion resulted from this desire to reach out and forge one's own way. This need to settle and face numerous odds strengthened the rugged individualism that produced an undercurrent that still influences American values.



Diversity and Difference in Practice

Behavior: *Apply and communicate understanding of the importance of diversity and difference in shaping life experiences in practice at the micro, mezzo, and macro levels.*

Critical Thinking Question: How does one's cultural background influence how one communicates with others? How might you prepare yourself to help clients of different cultural backgrounds?

Values

The values of those with European heritage tend to include independence, self-directedness, assertiveness, acquisition, equality, freedom, and self-help (Hanson, 2011). In general, families with European heritage value individualism and value privacy. Equality is important to them and they believe that humanity is basically good. They tend to be informal but at the same time can be direct and assertive. They are future-oriented valuing achievement, action, efficient utilization of time, hard work, and materialism (Hanson, 2011).

The family is greatly affected by these values. Family privacy, for example, is highly valued by many individuals. They believe that families should be left to their own pursuits and allowed to raise their children as the parents see fit. In their view, outsiders should intervene only when parents maltreat or fail to provide for their children. Some critics of current child welfare practices feel that agencies are too quick to intervene in family life.

In the United States, every family member is encouraged to become an individual. The sentiment is that everyone should be able to pursue what is best for his or her growth and enjoyment. Equality is valued and it is hoped that each individual will be given equal opportunity to achieve.

To those from another culture, the European American often seems too informal, to the point of being uncultured or uncouth. Slang, casual dress, and open discussions of almost any topic are the norm. Americans value the future and what will happen tomorrow, as opposed to the historical or the happenings of today. Today is regarded in terms of how it will affect tomorrow (Hanson, 2011).

Communication and behavior are, among those with European roots, action oriented, direct, materialistic, and based on time constraints. Success is based on power and resources, especially money. Each individual is expected to do his or her best and is encouraged to flourish amid fierce competition.

Communication Patterns

Communication among those with European roots is usually relatively open and direct. Warmth toward others is expected. In general, social interactions lack the ritual aspects common in many other cultures. People are expected to be seen as equal and therefore they have equal rights to express themselves. Personal space is prized and many individuals expect about an arm's length in their physical closeness to others. Physical closeness such as hand-holding on the street or open displays of affection in public is unusual. It is considered polite to be on time and to keep one's commitments at all cost (Hanson, 2011).

The family interprets norms of communication in different ways, depending on the influence from other cultural groups and the individual upbringing of the parents. For example, some families have little or no ritual in greeting or in their everyday lives; others have more. The Watson family greets relatives and friends with smiles and even handshakes, but does not typically kiss or hug as a greeting. Their meals are taken informally and family members dine together only if they happen to be home at

the same time. The whites, on the other hand, greet each other with a hug and a kiss, rarely a handshake. They make a practice of eating the evening meal together, and it is expected that each family member will be present unless otherwise arranged with Mrs. White.

Religion and Spirituality

Religion is seen as something that the individual has a right to espouse or not espouse. Because religion and one's spiritual beliefs are considered private, they are usually not discussed. People expect a clear separation between church and state, giving rise to such issues as the cessation of prayer in public schools in many states.

The choice and practice of an organized religion is also up to the individual. Most families function within the framework of a Judeo-Christian belief system, with the majority ascribing to some type of Christianity. Although not everyone goes to church or synagogue, holidays that have religious origins, such as Christmas, Easter, and Chanukah, are celebrated by the majority of families (Hanson, 2011) although not necessarily with religious significance.

Families with Native American Roots

Native Americans lived in North America long before the European colonists arrived. Despite the changes forced on them over the years, many Native American values and customs have survived and are actually seeing a revival as others become interested in the old-world philosophy. Today, there are over 560 distinct Native American nations, each with its own customs and practices. Some individuals would prefer to be referred to be their tribe or nation (e.g., Comanche or Arapaho) rather than grouped together as Native American. Some find the terms "Native American" or "American Indian" offensive given that their cultures pre-date any others in America. For these critics, there may be a preference for the term "Native" or "First Nations" (Weaver, 2013). With respect to such feelings, and with the need for consistency within this chapter, this author will refer to this group of people as Native Americans.

Some Native Americans live on reservations and live as much within old traditions as possible. However, many people of Native American ancestry have been assimilated into the larger society and are indistinguishable from the general population. These families may practice a mix of their Native American rituals as well as hold the customs and beliefs of their non–Native American neighbors (Hildebrand et al., 2007; Lum, 2010; Joe and Malach, 2011; Weaver, 2013). One difficulty for Native Americans is learning to survive in two cultures. Unfortunately, this group of people is disproportionately poor (23.6%) but this may vary geographically (Weaver, 2013). The variations in their ways of life and customs are influenced largely by their geographic regions as well as the impact of non–Native American people on particular tribes. There are, however, some generalizations that can be made about Native American cultures.

Work with Native people necessities the question "How do they see their family?" Families are often multigenerational and it is not uncommon for grandparents to be raising the children. In fact, among such nations as the Cherokee of Oklahoma, 63.4 percent of grandparents are the primary caretakers, while in the Muskogee Creek Nation, the figure is 58.9 percent (Johnson, Gryczynski, and Wiechelt, 2007; Weaver, 2013). These significant rates can be attributed to a high rate of incarceration of females within some communities (Weaver, 2013). Native Americans may define "family" in the broadest sense including those who are not related by blood. How each family defines itself is important for their social worker to know.

Values

Native Americans consider sharing an integral part of the community and their way of life. Individuals share freely with others, even sharing child rearing as a community experience. Children have the run of the community, and each adult feels an obligation to interact freely with them through teaching, encouragement, and even discipline. However, learning among Native American children is largely experiential. For example, a child might be allowed to suffer some minor harm (e.g., burning a finger to learn not to touch something hot) as a way of learning by experience (Joe and Malach, 2011; Crosson-Tower, 2013).

Native Americans also believe in a oneness with nature that dictates an acceptance of natural occurrences and their impact on the individual. Thus, suffering as a result of natural occurrences becomes an integral part of growth (Hildebrand et al., 2007; Joe and Malach, 2011; Crosson-Tower, 2013). Children are taught to have a respect for nature, natural events, and the land, and a harmony with Mother Earth is at the core of many rituals and ceremonies.

Native American families also teach that it is important to control one's emotions. It is not unusual for Native Americans to seem stoic or even aloof to members of other cultures in the face of stressful events. The family keeps to itself, as does the individual, practicing the noninterference that has characterized Native American peoples for centuries. The Native American's form of protest is silence or withdrawal. Those in the child welfare field often mistake this behavior on the part of Native American parents as indifference (Lum, 2010; Crosson-Tower, 2013).

Case Example The Graywings

The Graywing family had moved off the reservation when the father took a job 50 miles from their reservation home. It was the first time in several generations that anyone from the Graywing family had lived off the reservation, and the mother and her four children were most uncomfortable with the idea, though this would never have been verbalized to anyone outside the family.

Several months later, the Graywing children came to the attention of the local child welfare agency when the youngest child, age 2, was found by a neighbor several blocks from the house. The child had been observed by another neighbor the previous day in an area even further away from the Graywing home. Talking about the events, the two women became concerned and felt that the agency should be notified.

When a social worker visited Mrs. Graywing, the mother seemed unconcerned. The next day, the neighbors again called the agency, saying that the same child had been seen on the railroad tracks. The worker again went to the house and, finding the Graywing children (ages 2, 3, and 5) alone, she took them into custody until the mother could be located. When the mother arrived home, she found a message from the worker, asking her to contact the agency immediately. Assuming that her children were somewhere in the neighborhood and resenting the agency's intervention, the mother discarded the note and did not call. The agency assumed that the children had been abandoned and placed them in foster care. It was not until a worker familiar with Native American custom was brought in on the case that the issues were resolved and the children were returned to their parents.

Native Americans view time differently than many other cultures do. To them, time is a rhythm and circular motion to it (Ho, 1987). For this reason, developmental milestones are difficult to determine. Time is measured not by the clock, but by the moon, the stars, and the seasons. Native Americans may also operate on their own time schedule, valuing congeniality more than rigidity, to the frustration of more punctual cultures or individuals (Hildebrand et al., 2007; Joe and Malach, 2011).

Over the years, the values of the Native Americans have been greatly misinterpreted. In fact, there have been movements to force Native Americans to conform to the values of other cultures. Off-reservation boarding schools in the late 1800s were one attempt to separate Native American children and enculturate them into Anglo culture. These schools had a far-reaching impact on those who attended them and have been much debated. Although today there may be more tolerance for ethnic diversity, Native American values may still come into conflict with those of other cultural orientations.

While basic values attributed to Native American people have been outlined above, it is important to note that not every individual who sees himself or herself as Native today adheres to these values. Poverty has taken its toll on their culture and with it violence, substance abuse, homicide, child abuse, and domestic violence. Violence among Native communities is 2.5 times the national rate (Weaver, 2013). Prejudice and oppression too has influenced the daily lives of Native Americans. But the pride in community and culture has motivated Native community leaders to seek solutions to these problems (Weaver, 2013).

Communication

Native Americans believe that each individual has a right to dignity and respect. As a result, there is little hierarchical communication; rather, everyone is considered to be on the same level. Cooperation is valued, and one tends to give in rather than compete.

Patience is also important to Native Americans, who believe that the universe is unfolding as it should. Although some outside the culture view this ability to rest and wait as laziness, Native Americans are comfortable with the recognition that what should happen will do so in due time.

Religion and Spirituality

A new interest in Native American philosophy on the part of those outside the culture has made many people more familiar with the belief in the healing power of nature. The Native American sees the need to remain in harmony with nature. Ceremonies and rituals dedicated to the reverence for nature punctuate Native American daily life (Hildebrand et al., 2007; Joe and Malach, 2011; Crosson-Tower, 2013; Weaver, 2013).

When working with diverse populations, it is important to recognize their traditions, also taking into consideration the impact that living in the United States today has had on the family members. Familiarity with courtesies appropriate to each culture will help the child welfare worker dealing within various populations.

Families with African American Roots

The customs and traditions of the African American family have been part of this country since its early history. The majority of African Americans have descended from slave ancestors who were brought to this country in the 1700s and 1800s. A small number of Africans also came over as free but indentured servants who were seeking a new life. Once freed, southern slaves migrated north in search of more and better opportunities. These migrants were largely ignored; only some work in the settlement houses of the late 1800s furthered their integration into the mainstream culture (Goode et al., 2011).

Experts suggest that residual effects of the early history of slavery have been passed down from generation to generation of African Americans. Leary (2005) called the impact on today's African Americans *Post Traumatic Slave Syndrome* or the condition present when a group has experienced multigenerational trauma, including centuries of oppression and prejudice. This author and others suggest that working with African

American families must take into consideration these residual effects (Leary, 2005; Aymer, 2013). Two of the most significant are what Leary terms vacant self-esteem—the African Americans tendency to devalue himself or herself—and ever-present anger or the tendency to externalize anger at situations in a way that is not always proportionate to the stimulus (Leary, 2005).

African Americans have experienced much prejudice, and bitter controversy surrounded their integration into predominantly white areas. From school desegregation and freedom marches to the efforts of the National Association for the Advancement of Colored People (NAACP) and other activist organizations, African Americans have sought to be more fully accepted by others in U.S. society (see Gadsden, 1999). Today, African Americans make up over 13 percent of the U.S. population (U.S. Census Bureau, 2015).

The African American family is more likely to experience poverty than its white and Hispanic counterparts. About 36 percent of all African American families live below the poverty line, in contrast to only 12 percent of white families and 33 percent of Hispanic families (Iglehart and Becerra, 2000; Goode et al., 2011; McGoldrick, 2012). African American families are also more likely to live in inner cities amidst crime, unemployment, and other stressors. Infant mortality is twice as prevalent among African American infants as it is among whites (Goode et al., 2011). Amid these realities, the African American family continues to persevere.

Willie and Reddick (2010) stress that one must look at African American families through the lens of socioeconomic class. Although they too face the problem of prejudice and inequality, these authors explain that the middle-class African American family fares much better than families who are working class or poor.

Values

Values that have brought the African American through a myriad of stresses are reliance on one another and shared religious beliefs. Extended family and friends, often referred to as "kin," provide mutual aid in a variety of situations, including childcare, financial aid, advice, and emotional support (Hill, 2003; Hattery and Smith, 2007; Hildebrand et al., 2007; Willie and Reddick, 2010; Goode et al., 2011; Aymer, 2013; Crosson-Tower, 2013). It is not uncommon for extended family or friends to take children whose parents are unable to care for them. Children are prized among African American cultures and their well-being is seen as the responsibility of the total family and even the community. Perhaps this strong sense of kinship originated in early tribal tradition and has been passed down through the centuries.

Within African American families, work is expected of all members. Today, it is the African American woman who is more able than her male counterpart to enter the workforce. Because women are often single parents, the children are expected to assume a substantial amount of the household tasks (Hill, 2003; McAdoo, 2006; Lum, 2010; Willie and Reddick, 2010; Crosson-Tower, 2013). The fact that African American children assume so much responsibility has often been construed by white child welfare agencies as constituting neglect on the part of their parents. The reality, as is true for many minorities, is that African American parents recognize that it is only through hard work and perseverance that their children will survive in this world. This early training prepares their children for the responsibilities of adulthood.

Because African Americans recognize that education can elevate one's status, they value educational opportunities. Elders are also seen as possessing knowledge that can be beneficial to the young, and oral tradition plays a large part in the African American culture (McAdoo, 2006; Hattery and Smith, 2007).

Communication

African American families are close-knit by nature. Children are given love and accepted into the family circle with warmth and understanding. Due to the emphasis on the extended family and friends, children move freely through the circle of adults and have a number of adult models with whom to identify. There is an emphasis on instilling in children a sense of pride in their identity. Although communication is valued within the culture, it may seem abstract to some outsiders. Analogies are often used to express feelings without explicitly identifying the feelings themselves. The African American family is very much in touch with their feelings but has a characteristic manner of expressing them.

Case Example Cora Lee

Cora Lee and her six children are a common sight at the Stafford Street School playground. The mother's loud, deep voice is often raised in hearty laughter as she watches her children play. She frequently brings her mother or one of several aunts, who also encourage the children and chuckle about their antics. Despite the fact that the children remain largely independent of their mother, Cora Lee seems very much in tune with their feelings. A fall from the jungle gym usually results in the child being scooped up against his mother's chest and hummed to while she continues to listen to her adult companions. In no time, the soothed child is off to play again with his siblings and peers.

Music often plays a part in the African American family's life. It is experienced rather than merely listened to and may be used to soothe, to play, and to accompany work (Goode et al., 2011).

Religion and Spirituality

Historically, the church has played a significant role in African American life. Religion and family are closely linked, and over the years the family has used its religious beliefs for comfort in the hostile white world. The church becomes a focal point, not only for emotional support but also for socialization. Ministers are seen as teachers, counselors, spokesmen, and even kinsmen (Aymer, 2013; Crosson-Tower, 2013).

The organized African church began in 1787 by Richard Allen and Absalom Jones in Philadelphia. Known originally as the Free African Society, the movement eventually gave rise to the African Methodist Episcopal Church (AME). About the same time, New York City saw the development of the African Methodist Episcopal Zion (AMEZ). Over time, the Baptist churches began to attract African Americans in increasing numbers. Today the Baptist churches represent a large percentage of the church-going population (Hattery and Smith, 2007; Goode et al., 2011).

Whether associated with an organized church or not, the African American family holds a strong belief that "the Lord will provide." To those not familiar with African American philosophy, the assumption that life will unfold as it is meant to may make African Americans seem fatalistic or uninvolved in their own destinies. Nothing is further from the truth.

Families with Hispanic Roots

To say that a family is "Hispanic," a term often interchanged with "Latino/a," does not fully acknowledge the diversity of the Spanish-speaking peoples living in the United States. Today Hispanics are the fastest growing minority in the United States. Between 2000 and 2010, this population has grown by 43 percent (Gonzalez and Acevedo, 2013). But this group is comprised of numerous cultures, each with their own values and traditions. The majority of

Hispanics are Mexican (63%), followed by Puerto Ricans (9%), Cubans (3.5%), Salvadorans (3.3%), and Dominicans (2.8%). The remainder are from other Central American, South American, or Caribbean countries (Zuniga, 2011; Ennis et al., 2011). Zuniga (2011) points out that more than three-fourths (76%) of the unauthorized immigrants in the United States are of Hispanic origin, with the majority from Mexico.

Values

The extended family plays a large role in the Hispanic community. The extended family, however, does not include only blood relatives but also friends and anyone else who shares a family's living space. Godparents or sponsors (*padrinos*) play a major role in the lives of children. *Compadrazzo*, or the practice of using these compadres in a variety of ways, is integral to Hispanic life. Compadres, whether they be godparents, relatives, or close friends, maintain close relationships with the children of the family, treating them almost as their own (Hildebrand et al., 2007; Zuniga, 2011; Gonzalez and Acevedo, 2013).

The traditional Hispanic family believes in male supremacy, strict role delineations, and female submissiveness. *Machismo*, the male's sense of honor, courage, and responsibility to his family, is extremely important in the Hispanic family, but a much misunderstood concept in the outside world. It is the father's role to keep the family together and to provide for them. The economic realities of the present may make it easier for the woman in a two-parent family to find work, making the man feel less powerful and placing extreme stress on the family as their adopted homeland tests their traditional views (Zuniga, 2011; Gonzalez and Acevedo, 2013). This family tension may lead to aggression or even violence as the male's machismo is threatened. Today, some Hispanic families may also be headed by single females, changing the balance of power and the family's way of operating. Yet, as her male children grow, the mother may be more likely to recognize her sons' power than will mothers of some other cultures.

Also central to the value system of Hispanic families are the concepts of *dignidad, respecto*, and *personalismo*. *Dignidad* acknowledges the importance and worth of each individual. *Respecto* incorporates a hierarchical view of relationships in which elders must be respected and the young look to the older for decisions and teachings. *Personalismo* refers to the Hispanic reverence for individualized, warm, and close personal relationships. The feeling is that each individual deserves personal one-to-one attention. Large impersonal bureaucracies are usually avoided by Hispanics for this reason (Zuniga, 2011; Gonzalez and Acevedo, 2013). Keeping these values in mind, workers dealing with Hispanic families do best if they use a friendly, informal, but respectful manner that encourages the clients' trust. Hispanic families need to see the helper as a professional whom they can respect, but one who does not look down on them or depersonalize them or their needs.

Communication

The concept of *respecto* governs much of the communication between Hispanic family members. Males and elders are given higher status than women and children, and therefore communication tends to take place with these individuals in key positions. Traditional roles are adhered to and both genders have particular things that are expected of them.

Children are considered to validate a marriage in the Hispanic family and they tend to be pampered and overindulged. The parent–child relationship actually takes precedence over the marital relationship when the children are young. Sons are revered and daughters are protected. Hispanic mothers teach their sons that it is their role to protect and provide (Hildebrand et al., 2007; Zuniga, 2011; Gonzalez and Acevedo, 2013).

Strong negative emotions, such as anger and aggression, are not acceptable in the traditional Hispanic family. Family members maintain close emotional ties based on respect

rather than the airing of personal grievances. For the Hispanic family, this tendency to respect and project congeniality toward others may cause them difficulty in the non-Hispanic world. For example, believing it disrespectful to disagree, Hispanic clients may agree to an appointment that they may not plan to keep.

Due to the fact that Hispanics are taught not to disagree or express negative emotions, they may turn stress inward and suffer from somatic ailments. Headaches, stomachaches, and other physical problems may indicate psychological distress.

Religion and Spirituality

Catholicism is the predominant religion of the Hispanic population and plays an extremely important part in family life. In the *barrio* (the Hispanic community), the church is the focal point for both social and inspirational events. Many families use *mandas* (a promise or offering asking for God's intervention) to call on their faith to direct their lives. Prayers to the Virgin Mary are also a common practice among Hispanic households. Today, not all Hispanics are Catholic. Almost one-quarter identify themselves as Protestant, and many as Evangelical or Pentecostal (Zuniga, 2011; Gonzalez and Acevedo, 2013).

Although it may seem contradictory to outsiders, Hispanic families also rely on folk healers to cure their physical ills and often their psychological problems as well. Their strong belief in the efficacy of these practices often makes them successful.

Families with Asian Roots

In recent years, Asian Americans have been one of the fastest growing minority groups in the United States. This growth seems to be a result of the Asian refugees and immigrants who have entered this country since the Immigration and Nationality Act Amendments of 1965 and the withdrawal of the United States from Vietnam in 1975 (Chan and Chen, 2011). Although Asians and Asian Pacific Islanders are usually grouped together, there are probably more differences from culture to culture than in any other grouping. Asia encompasses China, Japan, Vietnam, Cambodia, Laos, India, Thailand, Burma, Malaysia, Singapore, the Philippines, Sri Lanka, Pakistan, and Korea, and each of these countries represents vastly different traditions and ways of life. In fact, these cultures are so complex that it would take volumes to consider them in any depth. Here, we can only consider Asian cultures in the most superficial manner.

Values

Like the Hispanic family, the traditional Asian family is one with clearly defined roles based on male dominance and a hierarchical structure. Although most Asian women have entered into the workforce, many Asian families still adhere to traditional gender roles. The older generation is especially revered. Parents command respect and must be obeyed. The family behaves as a unit, a close-knit group, and individuals are not expected to be autonomous. To do so would be a rejection of family values. In turn, the family values a "middle of the road" position that emphasizes harmony with others (Chan and Chen, 2011; Chung, 2013).

Shame plays a major role in dictating the behavior of adults and in disciplining and molding the behavior of children. Honor should be brought to the family at all cost, by doing one's best, behaving respectfully, and refraining from doing wrong. *Face* refers to the ability to hold one's head high, knowing that one has behaved honorably. Asians talk of *saving face*, or maintaining one's honor, as paramount to the family. Family honor is greatly valued and family members will go to great lengths to save face. Shame is used so much in child rearing that non-Asian agencies may question if this practice is emotionally abusive (Hildebrand et al., 2007; Ling, 2007; Chan and Chen, 2011; Chung, 2013).

It would be unthinkable, for example, to sexually abuse children in Asian families, an attitude that makes the incidence of sexual abuse in this population extremely low. Such behavior would bring great dishonor to the family. In many Asian communities, a bride's virginity is a high priority. The Vietnamese woman, for example, is expected to be a virgin when she marries, and the loss of her virginity may mean that she is prohibited from marrying. Similarly, daughters from Indian families are married whenever possible to someone who will improve their families' social status. The young woman is expected to come to her new husband pure and virginal. Thus, a father would not sexually abuse his daughter lest he endanger her (and his) chances of attaining a higher social status or caste.

Harmony is highly valued in some Asian families, especially when the family operates under a Confucian philosophy. The group is paramount, and the needs of the individual are secondary to the desires of the group. Self-esteem is dependent on how well one fits into and is accepted by the group and how well one avoids conflict with the group. Most Asians do not wish to stand out from others and will often take a seemingly benign or middle-of-the-road position to avoid being noticed as separate from the group (Chin, 2005; Hildebrand et al., 2007; Chung, 2013). These values make life especially difficult for the family when adolescents in their efforts to fit in with non-Asian peers, seek more independence and find the standards of their family to restrictive. In turn, the rebellious attitude of their offspring can lead to Asian parents berating themselves for failing to be competent parents (Chung, 2013).

Communication

Because of the need to be part of the group and the value of harmony, communication among Asians conforms to a rigid set of rules. Since the elder is held in highest regard, communication begins at the top and filters down to others. One is not expected to be direct, as in Western cultures, but calm, respectful, and congenial. A "yes" from an Asian family member may not mean that he or she will do as requested, but only indicates that the person has heard you. It may also mean that he or she would not dishonor you by disagreeing. This cultural value is especially difficult for non-Asians to comprehend and can cause problems between Asians and workers in Western agencies who are not familiar with this fine point (Min, 2005; Ling, 2007; Lum, 2010; Chan and Chen, 2011).

Among themselves, Asian family members practice respect and recognize that honoring the family is paramount, because their self-esteem is based on how honorable each family member is. Further, Asians are not likely to conflict with other family members because they are so intent on the protection of harmony.

Religion and Spirituality

Religions among Asians differ greatly. Confucianism, Taoism, and Buddhism, as practiced in China and Korea, emphasize respect for one's ancestors, filial piety, and the avoidance of shame (Lum, 2010). Buddhism emphasizes "four noble truths": life is suffering; suffering exists because of people's overattachment to the world; suffering can be extinguished by giving up this attachment; and one does this by attending to one's views, speech, and thoughts, and through meditation (Chin, 2005; Chan and Chen, 2011). Confucianism has no specific doctrine other than a belief that people must be in harmony with the world and others in it. Taoism seeks to cultivate inner strength, selflessness, and harmony, and stresses being on the path toward spiritual truth. Koreans also practice Shamanism, although this is more prevalent in rural communities than in larger urban areas. Shamanism involves relationships among people, spirits, and the universe and how these interrelate in one's life (Chan and Chen, 2011).

Hinduism and Islam, which involve more of a moral code than actual worship of deities, are also practiced in some Asian countries. All of these Asian doctrines emphasize the

concept of harmony with others and some form of fatalism or philosophical detachment. Possibly because of the fact that many Asian cultures have been buffeted by a variety of political events beyond their control, many Asian peoples treat events as if they are inevitable. This means that the Asian family may be less likely to seek help from outside agencies because family members assume that the crisis they are experiencing is their "lot in life" and therefore must just be endured (Rasheed et al., 2003; Crosson-Tower, 2013).

Families with Middle Eastern Roots

The Middle East includes Asian and African countries with distinct and different cultural orientations. These political states are usually identified as Iraq, Jordan, Saudi Arabia, Kuwait, Bahrain, Egypt, Sudan, Turkey, Iran, Oman, Israel, Yemen, and the United Arab Emirates (Sharifzadeh, 2011). These cultures are sometimes included with Asian groups, but to do so is to overgeneralize and do both types of cultures a grave disservice.

Immigration of people to the United States from the Middle East increased in the late 1800s when Arab tradesmen came to this country seeking new opportunities. From the 1890s to the 1930s, Armenians, who were being persecuted by the Turkish government, fled to the United States for sanctuary. Since that time, there continues to be an influx of Middle Easterners seeking refuge, freedom, and opportunity.

Today, this group is often referred to as Arab Americans although not all immigrants from the Middle East see themselves in this group. The Census of 2010 estimated that there were about 1.6 million Arab Americans in the United States, although the number has grown over the last few years. It is difficult to determine the exact number of immigrants as many are mistrustful of efforts by the government to estimate their numbers (Abu-Ras, 2013). Those who immigrate to the United States have often experienced hardships in their countries or origin and also in the process of immigration. In addition, the events of 9/11 have made some Arabs feel as though they are suspect in this country. Thus, they may continue to feel the resulting isolation, which can translate into difficulty accepting help from the social service system.

Values

There is a marked difference between educated Middle Easterners from large urban areas and those from more rural settings. More highly educated people have more familiarity with Western culture and therefore an easier time assimilating in the United States. Many have learned English early and this also helps their integration into U.S. culture.

The family is of primary importance in Middle Eastern cultures. Multiple generations, often as many as three, tend to live and work together. The family structure is patriarchal and adheres to strict religious rules. The family values the collective achievement of its members and holds these achievements up in pride and as a form of identity. Extended family members often perform functions that formal organizations or agencies would provide for other cultural groups. Those who have immigrated to the United States try to bring kinsmen over and surround themselves with large families that provide support and encouragement. Having children is considered the essence of being. Boys are highly valued and the birth of a male child is a cause for celebration. Neglect of one's children is considered to be a serious violation in these cultures, and the internal sanctions for such parents are more threatening than those of a protective service agency (Sharifzadeh, 2011).



Diversity and Difference in Practice

Behavior: *Present themselves as learners and engage clients and constituencies as experts in their own experiences.*

Critical Thinking Question: How would you keep up to date about the populations in the community in which you practice social work? What steps might you take to ensure that their needs are met? How might you learn more about how specific ethnic communities see themselves and their needs?

Communication

Because Middle Eastern societies are patriarchal, the hierarchy of communication begins with the oldest males. Mothers are seen primarily as the nurturers of their children and their proximity to their children is expected to be very close. Babies are usually kept in the same room, if not the same bed, as their mothers, and Middle Eastern mothers tend to be much more permissive with their children than their Western counterparts.

Case Example Metah Halvanian

Metah Halvanian came to the attention of the protective service agency when the kindergarten her son attended reported that they were concerned that "there was something going on at home." The boy had few boundaries or inner controls and spoke of sleeping with his mother. When the worker investigated, she found an extremely devoted and overindulgent mother who was horrified that she had come to the attention of an agency. She openly told the agency that her 5-year-old son still slept in her bed because her husband worked long hours and she felt that it was best for the boy. As the mother and worker talked, the boy freely roamed the house and interrupted frequently. It soon became obvious that he had as much, if not more, control than his mother. It took some time before the school guidance counselor, working with the family, was able to acclimate the child to the more structured school setting.

Individuation of children is an issue that may cause some problems for Middle Easterners as they attempt to integrate into their adopted culture. The emphasis on interdependence may cause conflicts for children as they strive to acclimate to the Western school system (Akhtar and Esposito, 2006; Sharifzadeh, 2011).

In communication, outsiders may find the Middle Easterner confusing. For example, a direct "no" is considered impolite. Instead, the Middle Easterner is likely to say "maybe" or a weak "yes," either of which can indicate agreement or that he or she does not want to seem disrespectful. Some cultures of the Middle East also respect professionals to the point that it is considered to be impolite to give the impression of disagreeing with a professional's opinion or recommendation. Therefore, the family may seem to comply when, in fact, they disagree. In addition, it is not acceptable to express one's own needs, and family members may actually deny that they want something (Sharifzadeh, 2011). It may require a worker who is familiar with the family's culture to work successfully with a Middle Eastern family.

Religion and Spirituality

To the Middle Easterner, religion is not a private and personal issue. It occupies a central position socially, culturally, and politically. Islam was one of the earliest religions in the Middle East and continues to be the region's most widely practiced religion today (Akhtar and Esposito, 2006). Judaism and Christianity are also part of the religious mosaic. The Eastern Orthodox and Catholic churches comprise the largest number of non-Muslims. Judaism is concentrated in Israel. Iran is also known for its populations of Bahais and Zoroastrians, which are now decreasing (Sharifzadeh, 2011). All of these faiths influence the customs of their followers and the ways in which families carry on everyday life.

Family with Diverse Sexual Orientations

As the number of gay, lesbian, bisexual, and transgender (LGBT) families increases, there is also increased research on determining the values and roles in such families. How the families of origin of the adults in the new LGBT family have responded to the coming

out of their children may impact family life for the new LGBT family. Extended families are important and their acceptance or rejection can be significant in the adjustment of the LGBT nuclear family (Mallon, 2013).

It is difficult to determine the demographics of LGBT families given that the parents in such families have often been socialized to hide their orientation. Some families live openly within their communities while others may hide their mutual child rearing activities as an LGBT couple under the cloak of rooming together. It was not until 2010 that the U.S. Census Bureau counted same-sex marriages and found that there was a 50 percent increase in the number of these families from 2000 to 2010. An estimated 650,000 same-sex couples live in the United States today with approximately 19 percent that report children under 18 in the home. Of these, 27 percent are female couples and 11 percent are male (as reported in Gates, 2013).

It is difficult to determine the values of LGBT families in that the adults making up these units comes from all different races and cultures. However, there are some factors that may be universal. For example, achieving parenthood when one is gay or lesbian may require more intentional planning than for other family groups. Studies also indicate that both parents are more equally involved in raising their children, and are often more child-focused. Many same-sex couples report losing some of their friends and outside contacts as a result of their parenting activities. When they socialize, it tends to be with like-minded same-sex families (Green, 2012).

Studies on same-sex parenting couples have suggested the presence of *heterosexual gender role strain* especially among gay men. This refers to the fact that society expects that woman are the primary caretakers in child rearing and gay fathers find themselves trying to cope with their status in ways that make them feel competent (Green, 2012).

Raising children in a same-sex relationship also requires making opportunities for children to be exposed to other gender models. As one lesbian mother explained:

> My partner, Jan and I felt strongly that our son Bobby needed male role models. We were fortunate in that a close male friend loved kids and assumed a grandfather role, taking Bobby places and exposing him to things that might not occur to Jan and I.

Another issue that can be either a support or a stressor for LGBT families is their relationship with the adult's families of origin. Some grandparents, while initially having difficulty with their adult children's life style, nonetheless want to be involved with their grandchildren and therefore learn to adjust to the fact that these children are being raised in an LGBT family. Other families of origin cannot make that adjustment and the alienation may become a source of conflict for the LGBT family.

Stigma is often a stressor for same-sex couple families. Not only is the larger society still grappling with same-sex normalcy but being LGBT may elicit rejection from a variety of religious groups and cultures. Finding acceptance within a religious group may be necessary for some couple, while others cope without it. By the same token, adults from cultures that shun homosexuality may feel isolated and rejected (Green, 2012; Mallon, 2013).

Working with LGBT families requires an understanding of the challenges and strengths of this group just as another cultural variation.

Summary of This Section

- A family's culture of origin can have a significant impact on how the family functions in terms of its values, roles, rules, and communication patterns. The culturally aware child welfare worker will be better able to help his or her clients.

- Families with Anglo-European roots tend to value independence, self-direction, assertiveness, freedom, and equality. Communication is relatively direct but individual families may communicate differently depending upon the family in which they were raised. Religion is a personal choice that is left with the individual.
- Families with Native American roots value community and sharing and often child rearing is shared with the whole community. Families are close to nature feeling that there is a rhythm to life. Family members may seem stoic, controlling their emotions and keeping to themselves—behavior that may be incorrectly interpreted as indifference. Spirituality is based upon nature giving rise to rituals that are a part of the family tradition.
- Families with African American roots are often influenced by their history as many have descended from former slaves. Families rely upon one another and extended family members or 'kin' play an important role in family life. Hard work is valued along with shared responsibility and aspiration toward education. Family members are in touch with feelings and may express them to one another openly. Religion plays a significant part in family life.
- Families with Hispanic (Latino) roots are diverse with Mexican, Puerto Rican, and Cuban families as the most prevalent. The extended family is important with godparents (*padrinos*) playing significant roles. Families base their value system on *dignidad, respecto,* and *personalismo. Respecto* governs communication, which may inhibit strong negative emotions from being expressed. Religion, which often plays a significant part in family life, tends to be Catholicism although there are increasing numbers of Pentecostals.
- Families with Asian roots can be diverse coming from a variety of different countries with diverse traditions and values but it is possible to generalize to some extent. Asian families have clear hierarchical structure with male dominance. Respect and obedience is expected of members and the closely knit family unit complies as it values harmony and dislikes conflict. Religions vary depending on geographic locations and traditions but Confucianism, Taoism, and Buddhism are the prominent faiths.
- Families with Middle Eastern roots are also diverse in their geographic and traditional origins. Many are of Arab descent. The family is valued and multiple generations may live and work together. These patriarchal families value collective achievement. Religion—predominantly Islam, Judaism, and Christianity—is central to family life.
- Today, families may also be made up of lesbian, gay, bisexual, or transgender adults (LGBT) raising children. Although it is difficult to identify a specific profile of such families, there are some similarities. Having children is an intentional act, and as a result, the parents often center their lives around the raising of these children. Roles are more likely to be individualistic and not along gender lines. These families may deal with stigma and issues of acceptance from their families of origin.

STRESSES ON FAMILIES AND HOW THEY COPE

Parental/Family Dysfunction

Kadushin and Martin (1988) suggested a framework for ascertaining why families must seek help. They say that services are required when there are difficulties in parental functioning in the following areas: unoccupied parental role, usually through death, illness,

imprisonment, mental illness, or abandonment; parental incapacity due to illness, ignorance, emotional immaturity, mental retardation, or substance abuse; role rejection, when a parent chooses to neglect, abandon, or abuse the child; interrole conflict, when there is conflict in the family about roles; transition issues, when a family is trying to cope with some type of transition, either developmental or environmental; and child incapacity issues, such as a family trying to cope with a child's disability.

Role Definition and Inequality

There has been much discussion about family roles in this era, when it is the norm in two-parent families for both parents to work outside the home. When more women began to work outside the home, the dominant assumption, especially among higher socioeconomic groups, was that the father would assume more household responsibilities to offset the stress on his partner of working and maintaining a home. Ironically, as the number of the women in the full-time workforce reaches an all-time high, there continues to be an inequality in the performance of household chores, with women performing these chores two-thirds more often. In addition, the attitude that household tasks are optional for men but required for women remains prevalent in much of the country today (Coltrane, 2000). Men in higher socioeconomic groups are more likely to share household tasks. In addition, an interesting shift takes place when children join the household. During pregnancy, tasks may be shared, but once the first child is born more of these begin to fall to the mother. Studies show that wives rate the equality of household tasks as significant factors in perceptions of fairness and marital satisfaction, but husbands do not (Coltrane, 2000). The resulting depression and fatigue of the mother burdened with a significant weight of responsibility for such tasks may create stress for the family unit.

Environmental factors may also have an impact on a parent's ability to perform his or her role. Today, many American parents are very much aware of the effect that serving in the military has on family life. With the war in Iraq continuing, parents of both genders may find it necessary to leave their offspring in order to fulfill their military obligations. Even if only one parent must be absent, the realignment of roles and the anxiety over involvement in combat or other dangerous situations can have an impact on family life. Since 9/11, children too have become much more aware of the threat of death to their parents in times of terrorism or war.

Parent–Child Relations

As the American family is threatened by economic strain and divorce, relations between parents and their children have come under scrutiny. As parents feel more stressed, they have less energy, time, and patience to give to their children (McWhirter et al., 2006). Rules and roles become more flexible and less defined to cope with the changing demands on the family structure. Mothers complain that they have less time with their children, more disagreements, fewer enjoyable times with their spouses, and less involvement in their children's schools, sports, and other activities than their parents did with them.

Relationships between stepchildren and stepparents are another stressful issue for many families. Reconstituted families are faced with the joining of two families with different sets of rules and expectations. As the parents strive to negotiate their own relationship, parental roles may come into conflict. Who will discipline whose children is often a source of contention. Who controls the family decisions and who does what tasks in the house create other areas in which negotiation is necessary. Not all families are able to weather these storms of adjustment successfully.

Another issue of parent–child conflict may confront the newly immigrated family. Parents who hold cultural expectations of their children that differ from what is expected of American children may discover that, as their children become integrated into the school system and form relationships with peers, they are influenced by a new set of values.

Case Example Conflict in a Vietnamese Family

A family who recently immigrated from Vietnam expected that their teenage daughter, Hien, would respect the traditions with which she was raised. The family anticipated that she would not see boys alone and would wait until the family believed that she should be allowed to have contact with the opposite sex. But the boys in Hien's high school class found her attractive and appealing and were soon asking her to go out with them. Knowing her parents' feelings, she initially refused. But it was also important to her to fit in with her new friends, and they all seemed to be dating. Hien began to see boys after school and to sneak out of the house. When her father discovered what his daughter had been doing, he was extremely upset and felt that the family had lost face.

Disability

Disability or illness on the part of the parent obviously creates stress for the family. What many of us do not realize is how much stress the disability of a child within the family can place on the family system. The following older teen explained about living with his sister who was born with spina bifida.

Case Example Deborah

"The birth of Deborah changed our family's whole life," he says. "When she was first born Mom and Dad spent a lot of time in the hospital. We were left with grandparents and other relatives. We weren't neglected. Mom and Dad tried to explain to us and spend time with us, but their priority had to be Deb. Even after she came home, things were never the same. She always had to be the center of attention. She had so much medication and had seizures. We all learned to go into a 'crisis mode.' That meant that when she was in crisis and Mom and Dad had to be there for her, we kids learned to be very self-sufficient. One of my brothers really resented her, though, and that was hard for all of us. I think the stress destroyed my parents' relationship, too, because after about 10 years they got divorced."

Families with special-needs children learn to accommodate in a variety of ways, but often not without some type of support or outside intervention.

When Families Need Help

Services provided for families can be divided into three categories: supportive services, supplementary services, and substitute services. *Supportive services* are home-based services that help the family to care for, protect, and nurture its children. They strive to empower the family to help themselves. Such services might include counseling, early intervention, and protective services. The last category might be confusing, as one often thinks of protective services as removing children from their parents. In reality, separation of children from parents is the last resort. The first goal of protective services is to discover and enhance parental strengths to help the parents cope and not abuse or neglect

their children. Only when this is not possible are other interventions used. *Supplementary services* are used when the parent–child relationship has begun to be impaired or needs additional help. Financial assistance, childcare, and homemaker services are examples of supplementary programs. *Substitute services* are used as a last resort. They substitute the care that the family of origin is not able to provide either temporarily or permanently. Such services are adoption, foster care, and residential treatment.

Although this is one way to categorize services, some find that it is inadequate. Services may actually overlap and parts of service provision can be categorized in different ways. Services may also be divided into categories, depending on who provides them. There are public agencies under federal, state, or county governments; voluntary nonprofit agencies supported by community funds; private for-profit agencies supported by client fees; and corporate-sponsored agencies.

How services to families are categorized is not as crucial as how well the services meet families' needs. It is vital in the study of child welfare services that the potential professional be familiar with the wide range of services available and how these can be used to benefit clients. The most important aspect of helping is to empower. Empowerment enables families not only to solve today's problems but also to gain insight in facing the problems of tomorrow.

The Family as a Resilient Unit

It is clear that there will continue to be a variety of stressors that challenge the family of the future. The family will persist in feeling the stress that our current *economic situation* enhances. Family members will continue to be faced with the challenge of how to meet family needs while both parents work or, in the case of single-parent families, when the only adult must work outside the home. As more parents face unemployment, families will need to find ways to compensate. Working parents will continue to be faced with the necessity of finding adequate childcare arrangements in an already overstressed market. Both parents will need to find creative ways to negotiate with employers over such issues as maternity/paternity leave, flex time, and shared vacations. Families will continue the struggle of making decreasing paychecks meet the demands of increasing prices.

Relationship changes will not only challenge the family unit but will also create new and often creative new systems. While at one time, adults who married expected to be with their partners for a lifetime, that is no longer the case. Approximately 50 percent of all marriages will end in divorce and these adults will often go on to find others and develop new family units that bring with them new challenges.

Perhaps as a result of these changing family configurations, a paramount need in today's society may well be services to *resolve the residual effects of family conflict*. Divorce and family instability have a profound impact on children, who grow into adulthood with resulting scars that may make it difficult for them to form their own families. Thus, those in the helping professions are increasingly recognizing the importance of providing an opportunity for teens and adults to understand the role their families played in their emotional conflicts. Granted, family dysfunction has always been with us and many young adults have sought to make sense of traumatic childhoods. But as we recognize more fully the impact of family unrest on children's development, services and resources seem more vital.

Currently, groups dedicated to understanding family dysfunction, books on the subject, and therapists who specialize in helping adults to "make peace with the past" strive to meet this need.

Despite all the challenges that they face, many families demonstrate a resilience that is inspiring. The trend in helping services today is to identify the quality and source of **family resilience** and to build upon it. Resilience is the ability to withstand and bounce back from adverse situations and challenges that life presents (Walsh, 2012a). The act of having withstood adverse situations often producing trauma and making some sense of the experience in order to go on, promotes growth in individuals and in families. Divorce, death of a member, coping with disability in another, and a variety of environmental assaults can be the fodder for renewed strength, new insights, and an enhanced ability to cope. Stressors for a family are often cumulative events or experiences over time (e.g., the effects of poverty), and some might even be generational as in the case of racial prejudice.

Walsh (2012a) suggests that the processes of family resilience fall into three areas: belief systems, organizational patterns, and communication/problem solving. Each of these has sub-categories.

Those families that find *resilience from their belief systems* may have learned ways to make meaning out of adversity. For example, one Cherokee grandmother told her grandson who was facing unfair treatment at school and was bent on revenging the wrong, "We have two wolves battling inside us. One is evil, and carries on his back anger, hate and revenge. The other is good and carries peace, love, understanding and forgiveness. Which wolf will you feed?" The old adage, that "we gain strength form testing it" is another way of making meaning and coping with adversity.

Some families nurture a characteristically *positive outlook* that helps them to reframe their trials so that they see hope for the future. Other families use their *spiritual orientation* and beliefs to help them to cope (Walsh, 2012a).

A second category of processes leading to family resilience is the family's *organizational patterns*. Some families possess a *flexibility* that allows them to organize their resources, rebound, and adapt. This may result from clear and mature leadership within the family unit, or cooperation that breeds a sense of safety. For example, the birth of a severely disabled child threatened to cause undue hardship for one family. However, the parents rallied and explained to their children the need to a "new normal" within the family that required a more equitable division of labor to accommodate the needs of all. The now adult children of the family credit the mature response of their parents who gave them clear goals and helped them to adjust to get the family through the difficult years leading up to and following their sibling's death.

The *connectedness* of some nuclear families as well as the *ability to mobilize extended family members and community supports* provides the impetus for some to survive and thrive (Walsh, 2012a).

And finally *communication and problem solving skills* lead to family resilience. When families are able to provide *clear information* to each other and not hide their feelings, resentments, and experiences under cloaks of denial, all members benefit. In addition, when families are able to achieve *open emotional expression* by sharing painful feelings, demonstrate empathy toward one another and tolerate differences, they are helped in their adjustment to problems. Many of these families often use humor or recognize the need to share pleasurable experiences as a way of taking the emphasis off of the pain. And finally, families that communicate well often practice *collaborative problem solving* in that all members of the family unit are able to work together in shared brainstorming, decision making, goal setting, and planning to meet setbacks together (Walsh, 2012a).

The challenge for social workers is that amidst the myriad of family problems that some clients present, it may be difficult to recognize their strengths. But understanding from where resilience can be gleaned and what characteristics on which to focus, the helper is much better able to empower families toward positive outcomes.

Summary of This Section

- Families are in need of services when they are unable to fill their role of rearing children in an optimal manner. This may be a result of an unoccupied parental role, parental incapacity, interrole conflict, transition issues, and child incapacity issues.
- Role definition or inequality occurs when there are no clear expectations of family roles and conflict results. Parent–child relations may also be strained when roles and boundaries are unclear.
- When families require assistance, these services fall into three areas: supportive services that are home-based and serve to strengthen the family's ability to function, supplemental services used when the parent is not fulfilling his or her role but might be able to do so with help, and substitute services used as a last resort when parents are unable to care for their children.
- Families often have strengths that can be built upon to empower them. Recognizing resilience, defined as the ability to persevere and overcome hardship, is an important piece of a strength-based approach to family case-management and treatment.
    - Families find resilience in their belief systems, their organizational patterns, and their ability to communicate effectively and solve problems together.

SUMMARY

- Families are changing and may look very different from those in the past. Today, children live with two parents who may be of different or the same sexes, married or living together, or may be raising the children alone as a single parent. Some children are being raised by extended family members, most often grandparents.
- The family is a system composed of a series of subsystems and organized by generational boundaries, roles, and rules. Families have unique communication patterns that are sometimes dictated by culture. Genograms are a method of getting a picture of not only the family composition but also family interactions and patterns.
- The different family configurations—two-parent, dual-wage-earner, single-parent, and reconstituted or blended families—all have emotional climate. The well-being of children is often determined by how the family members, especially the primary care taker—are able to bond with the child in infancy. Bonding or attachment may be secure, avoidant, ambivalent, or disorganized. Families each have a life cycle that begins when the two adults emancipate from their families of origin and progress through the birth, growth, and launching of their own children.

- Culture has a significant impact on how families function. The predominant cultures of Anglo-European, Native American, African American, Hispanic, Asian, and Middle Eastern all have distinct values, communications systems, and spiritual beliefs. In addition, same-sex families are a developing culture of their own.
- There are numerous stresses for today's families including an unoccupied parental role, parental incapacity, inter-role conflict, transition issues, and child incapacity issues. Each has its own unique way of coping. Services to families fall into three categories: supportive, supplemental services, and substitute services used as a last resort when parents are unable to care for their children. But families have strengths that must be tapped into by the helping system. The family's ability to overcome difficulties is often referred to as resilience, the roots of which can be found in their belief systems, their organizational patterns, and their ability to communicate effectively and problem solve together.



3

Children and Families in Poverty

By Lynne Kellner and Kathleen Craigen

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Define the demographics of children and families living in poverty.
- Describe the causes of poverty and how children and families are affected.
- Explain the impact of poverty on children and their families.
- Outline present and future efforts to alleviate poverty.

CHAPTER OUTLINE

DEMOGRAPHICS: WHO ARE THE POOR? 55
Defining Poverty 55
Demographics 57
Geographic Distribution of Poverty 58
Family Composition: Child's Age and Family Structure 58
Cultural Membership and Risk of Poverty 59
CAUSES OF POVERTY 61
The Great Recession and Employment Difficulties 61
Child and Family Homelessness 61
Parents' Education and How Children Are Affected 62
Disabilities 63
Immigration 64
Additional Causes of Poverty 65
IMPACT OF POVERTY 66
Impoverished Environment 66
Health, Development, and Education 69
EFFORTS TO ALLEVIATE POVERTY 73
Prevention Services and Assistance Programs 74
Opportunities for Youth 78

DEMOGRAPHICS: WHO ARE THE POOR?

Defining poverty is not as easy as one might think. Broadly, it can be defined as the lack of economic resources for a person or family to attain a minimum standard of living (Giffords, 2014). However, this does not address the complexity of human experience. For example, is it considered poverty if a family can afford housing, clothing, and food but is economically devastated when the family car needs extensive repairs or is unable to buy holiday gifts for the children?

Defining Poverty

Statistics on poverty are derived in multiple ways. The federal poverty level is an example of **absolute poverty**: a fixed dollar amount based on the size of the family that is necessary to attain basic goods and

Why Poverty Endures 79
Shaping the Future of Poverty Prevention and Services 80
How to Reduce Child Poverty Right Now 82
SUMMARY 85

services, such as food; it does not include the cost of rent, transportation, childcare, or home heating (Giffords, 2014). Additionally, it should be noted that federal poverty guidelines as established by the Social Security Administration in the early 1960s were based on the assumption that the family would only be in poverty for a short period of time and cut backs to basic foods would be temporary. Therefore, guidelines were established to provide enough money for a family to buy food that the Department of Food and Agriculture considered adequate for a healthy diet on an emergency, short-term basis (Fisher, 1997). Unfortunately, many families subsist on these baseline diets for years. The dollar allocation for food budget was not intended as a healthy long-term measure, and it does not account for holidays when a family might have guests or want to have special holiday food. Table 3.1 shows the poverty thresholds for 2015.

Relative poverty is a more subjective term that describes people technically above the poverty line but who experience deprivation due to having less economic resources than those they consider peers (Giffords, 2014). Relative poverty compares the income and needs of a family to that of other typical families; adjustments are made for such expenditures as childcare, health insurance premiums, and geographic location. It also includes income from government benefits (Citro and Michael, 1995). A family that has additional financial burdens may experience relative poverty even if it looks like "on paper" they should have enough money. For example, a family that is providing support to an aging, ill grandparent might find themselves with a number of ongoing expenses, such as transportation and incidentals that the elder might enjoy. Over time, this can add up.

An alternative measure to poverty, the **Self-Sufficiency Standard**, has been devised to identify the income necessary for a working adult to achieve economic independence for one's family. This standard also takes into account the local cost of living; clearly some parts of the country are much more expensive to live in than others, particularly for housing. The Self Sufficiency Standard also takes into account any tax credits for children or earned income that might reduce the amount of money the wage earner needs to make a

Table 3.1 **Poverty Thresholds for Families by Household Size**

Number in Household	Yearly Income
1	$11,770
2	$15,930
3	$20,090
4	$24,250
5	$28,410
6	$32,570
7	$36,730
8	$40,890

Source: DeNavas-Walt, Carmen, and Bernadette D. Proctor, U.S. Census Bureau, Current Population Reports, P60-252, *Income and Poverty in the United States: 2014*, U.S. Government Printing Office, Washington, DC, 2015.

Table 3.2 **A Comparison of Self-Sufficiency Standards in Several U.S. Cities**

Poverty Level	City	Hourly Wage	× 40 Hours/Week	× 52 Weeks = Yearly Income
$20,090	Boston, MA	$28.83	$1,153.20	$59,966.40
$20,090	San Francisco, CA	$26.97	$1,078.80	$56,097.60
$20,090	Philadelphia, PA	$22.26	$890.40	$46,300.80
$20,090	Cleveland, OH	$20.21	$808.40	$42,036.80
$20,090	Denver, CO	$19.43	$777.20	$4,041.44
$20,090	Atlanta, GA	$18.37	$734.80	$38,209.60
$20,090	Portland, OR	$14.83	$593.20	$30,846.40

Source: Based on Center for Women's Welfare, and U.S. Department of Health and Human Services (n.d.) Center for Women's Welfare. (n.d.). *The Self-Sufficiency Standard: What a Difference a Measure Makes*. University of Washington School of Social Work. Retrieved from http://www.selfsufficiencystandard.org/self-sufficiency-standard-0. © Cynthia Crosson-Tower.

reasonable living. Thirty-seven states have developed self-sufficiency standards tailored to the needs of families of varying compositions, including number of adults in the household and the age of the children. Younger children require more expensive childcare, while it costs more to feed and clothe an adolescent. Consider the 2009 self-sufficiency rate per hour for a parent with a preschool child and a school-aged child as shown in Table 3.2 (Center for Women's Welfare, 2015). Note how the self-sufficiency standards differ from the "one-size-fits-all" federal poverty guidelines for 2015 in the various cities.

The hypothetical family of a parent with a preschooler and school-aged child falls under the poverty line at $20,090 regardless of location. However, the Self-Sufficiency Standard reveals that the family would need a higher income to be financially independent, which varies considerably based on location. One can see that the hourly rate needed for economic independence without public assistance in Boston is nearly twice that for families living in Portland, Oregon. The caseworker is advised to consider the context in which the family lives. This will help to determine the family's real needs, based on rent structure, local cost of living, and expenses associated with various stages of children's lives. It is more comprehensive to look at the Self-Sufficiency Standard than to simply look at "one-size-fits-all" poverty thresholds.

Demographics

The number of children living in poverty following the 2008 recession is staggering. Twenty-two percent, or 16 million children, live in families below the poverty line (National Center for Children in Poverty, 2014). This is an increase from 18 percent pre-recession (Jenkins, 2015). At the same time, the total number of children under 18 has remained consistent, growing only by less than 1 percent (National Center for Children in Poverty, 2015b). Of those in poverty, 40 percent (7.1 million in 2012) lived in **extreme poverty**, defined as less than 50 percent of the poverty level, or under $11,746 annually for a family of four. If we look at **low-income families**, defined as no more than twice the poverty threshold, 44 percent of American children qualify (National Center for Children in Poverty, 2015b). Child poverty rates in America far exceed those of any other age

group. In 2014, 13.5 percent of adults aged 18–64 and 10 percent of elders lived in poverty (U.S. Census Bureau, 2015). One reason for higher rates of child poverty is that while the expenses related to caring for children is high, children are seldom able to contribute financially (Krase, 2014).

One in five children born in America has a chance of being poor. Even as the world's largest economy, the United States has the second highest rate of relative child poverty among 35 industrialized nations. The country with the lowest child poverty rate is Finland with 3.6 percent of children living in households with incomes below 50 percent of the National Median Income. The United States has a rate of more than six times this, at a staggering 23.1 percent (Children's Defense Fund, 2015).

Rates of child **homelessness** also grew following the recent economic downturn, partly as a result of parental employment problems. Families comprise 36 percent of the homeless population, and unaccompanied youth under 18 comprise another 8 percent of the homeless (Office of Community Planning and Development, n.d.). In the 2011–2012 academic year, 1.2 million public school students were homeless, a rise of 73 percent since the recession (Children's Defense Fund, 2015, 4–5).

Geographic Distribution of Poverty

There are higher rates of overall poverty in the southern states (16.5%) and western states (15.2%), compared to the Northeast (12.6%) and Midwest (13%). One contributing factor is immigration patterns, since many immigrants settle in the southern and western states, particularly those in low-paying agricultural jobs (DeNavas-Walt and Proctor, 2015). Mississippi has the nation's highest child poverty rate in the country at 31 percent and New Hampshire has the lowest at 9 percent (National Conference of State Legislators, 2012). Children who grow up in cities are most likely to be poor, while those in the suburbs are the least likely; youth in rural areas fall in between (Churilla, 2008). Suburban children often are of families with more economic means. Lack of available resources such as transportation and job opportunities accounts for some of the variations among geographic areas.



Evaluation

Behavior: *Select and use appropriate methods for evaluation of outcomes.*

Critical Thinking Question: How might using different measures of poverty (i.e.: absolute poverty level, relative poverty, and self-sufficiency standard) influence one's assessment of a family struggling financially? How might it determine which services to offer the family?

Family Composition: Child's Age and Family Structure

Family structure is correlated with child poverty; perhaps this reflects the resources available to the child in the home. Children of married couples are least likely to live in poverty. While two-parent homes may provide more flexibility in employment and childcare arrangements, it is interesting to note that children in two-parent homes in which the adults are unmarried have higher poverty rates than those of married couples (47% for different-sex partners and 29% for same-sex partners). This, however, may not simply reflect marital status; younger couples, who are less financially solvent, may not marry. Additionally, in families in which the couple is not married, the child(ren) may only be the biological child(ren) of one partner. Step-parents may not be as invested in the care of the children, particularly if the relationship is new or ambiguous. Interestingly, single mothers are twice as likely to live in poverty as single fathers (48% vs. 22%) perhaps reflecting gender biases in employment or differing reasons why fathers and mothers become single parents (National Conference of State Legislators, 2012). In 2014, women still only earned 79 percent of what men do for

Table 3.3 **Poor and Low-income Children by Age Group**

Child's Age	Percent of Age Group Considered Low Income	Percent of Age Group Considered Poor	Likelihood of Living in Poverty Compared to Elders Age 65+
Under 3	47%	25%	Nearly three times
Under 6	48%	25%	Nearly three times
6–11	45%	22%	More than twice
12–17	41%	19%	More than twice

Source: National Center on Children in Poverty. (2015a). *Child Poverty*. Columbia University, Mailman School of Public Health. Retrieved from http://www.nccp.org/topics/childpoverty.html. © Cynthia Crosson-Tower.

the same job (DeNavas-Walt and Proctor, 2015, p. 7). Additionally, single mothers are more likely to have low-wage or part time jobs, often without benefits (Mather and Widom, 2010). One reason for this is that single mothers may need to take more time off to care for their children, thus negatively impacting their upward mobility in the workforce. When single parents receive **child support**, it significantly lessens the chances that the child will fall below the poverty line (National Conference of State Legislators, 2012).

Younger children are more likely to live in poverty than older youth. The number living in poverty gradually decreases from 47 percent for children under 3 to 41 percent for ages 12–17 (Jiang et al., 2015b). When parents do not work outside the home, even if the family receives financial supports, these usually only account for the basic needs and leave the family vulnerable. Reasons a parent may not work include the discomfort leaving young children with outside providers, common among some cultural groups, or lack of access to affordable childcare. Without a job that provides a living wage, the family is often strapped and unexpected expenses, such as the child needing additional clothing or school supplies, can force a family into some difficult decisions of what to buy. See Table 3.3 below for a breakdown of poor and low-income children by age group in America.

Cultural Membership and Risk of Poverty

Children of color and ethnic minorities are disproportionately more likely to live in poverty (see Table 3.4). One in three children of color is considered poor, and nearly half of all states had black child poverty rates of 40 percent or more (Children's Defense Fund, 2014, p. 4). In comparison, only 13 percent of white children live in poverty (Kids Count Data Center, 2015). Younger children of color are significantly impacted; 70 percent of black, and 65 percent of Hispanic, infants, and toddlers live below the poverty line (Jiang et al., 2015a).

Children of immigrants experience higher rates of poverty, particularly when their families have been in America for shorter periods of time. One in three children of immigrants live below the poverty line (Child Trends Databank, 2014b). Newer immigrants have higher poverty rates than more established ones (38.5% vs. 27.2%). Currently, about three in four of immigrant children who live in poverty are of Hispanic origin; most settle in urban areas.

Table 3.4 **Race and Ethnicity of Children in Poverty, 2014**

Race/Ethnicity	Percent of Children Under Poverty Line	Percent of Low-Income Children
Black or African American	38%	65%
American Indian	36%	63%
Hispanic or Latino	32%	63%
Two or more races	22%	
Asian and Pacific Islander	13%	31%
Non-Hispanic White	13%	31%

Source: Based on Kids Count Data Center (2015, September). *Children in Poverty by Race and Ethnicity*. Annie E. Casey Foundation. © Cynthia Crosson-Tower.

Summary of This Section

- Twenty-two percent, or 16 million children, live below the poverty line, an increase of 4 percent since the beginning of the Great Recession.
- Forty percent of poor children live in extreme poverty or less than 50 percent of the poverty level (less than $11,746 annually for a family of four).
- Forty-four percent of American children are considered low-income: their families' income in no more than twice the poverty threshold.
- Absolute poverty is a fixed measure of how much a family of a particular size needs to attain basic goods and services, such as food; this does not include the cost of rent, transportation, childcare, or home heating.
- Relative poverty, a more subjective term, refers to those technically above the poverty line but who feel deprived due to having less economic resources than others in the United States.
- The self-sufficiency standard identifies the income necessary for a working adult to achieve economic independence for one's family; it accounts for the varying cost of living in different geographic areas.
- The southern and western states have higher rates of poverty than the midwestern and northeastern ones.
- Children of married couples are least likely to live in poverty.
- Generally, children are less likely to live in poverty if their parents have a higher education status and are employed full time.
- Children of color and ethnic minorities are disproportionately likely to live in poverty than their white counterparts.
    - Children of immigrants have higher rates of poverty; nearly one-third live in poverty with higher poverty rates among new immigrants. Currently, about three-fourths of immigrant children living in poverty are of Hispanic origin.

CAUSES OF POVERTY

There are multiple life circumstances that can cause children and families to become poor or keep them trapped in the **cycle of poverty**. American children often live with adults and rely upon them for economic support. Therefore, it's vital that the causes of both adult and child poverty are explored. This section describes the different ways in which adults and children become poor or remain poor such as the Great Recession, homelessness, disability, immigration, and more.

The Great Recession and Employment Difficulties

Child poverty has not rebounded to the pre-recession rate of 18 percent despite improvements in economic indicators such as employment and the stock market (Child Trends Databank, 2015). These economic indicators are often used to analyze the impact of the **Great Recession of 2008** but do not necessarily capture the subtleties in the economics of child and family poverty. Despite rebounds in the stock market, which has generally performed well although inflated, the market's resiliency does not positively impact the poor as much as the wealthy. A look at employment rates also shows that it is not a direct indicator of getting people off the poverty rolls. In 2014, the employment rate caught up to the 2007 pre-recession level, but poverty rates continued to climb from 12.5 percent in 2007 to 15.1 percent in 2014 (Batra, 2015, 22). Although these are general poverty rates, they include many young parents, consequently affecting child poverty.

The recession also followed one of the worst business cycles in recent history; the slump from 2000 to 2007 provided little cushion for businesses to fall back on when the great recession hit. In order to keep their businesses going during the recession, some employers made changes to their hiring practices and these are not reflected in overall employment statistics. For instance, some employers responded to the need to reduce their costs during the recession by cutting wages and/or hours of their employees; in 2009, the average household brought in $5,000 less than it did in 2000 (Batra, 2015).

At the same time, the cost of living did not go down. For most families, housing is the single largest expense; rents and home prices have become increasingly out-of-control for poor and low-income families. About 5 million of the neediest low-income families receive federal rental assistance to help them afford a place to live, such as public housing vouchers for private rentals. Unfortunately, due to funding limitations, only one in four needy families with children receive such assistance (Children's Defense Fund, 2015).

During difficult economic times, marginalized people are competing for the same resources as the majority. Employment is one of them. Consequently, the recession exacerbated the employment difficulties for racial and ethnic minorities; roughly one in four Hispanic or African Americans fell into poverty after the recession (Economic Policy Institute, n.d.). Immigrant families also had increased difficulty finding work as employment opportunities were cut back (DeNavas-Walt & Proctor, 2015).

Child and Family Homelessness

Families become homeless due to a number of difficulties, such as lack of affordable housing, extreme poverty, decreasing governmental supports, family disruption after conflicts or intimate partner violence, substance abuse, or after losing their homes due to disaster (National Association for the Education of Homeless Children and Youth, n.d.; National Coalition for the Homeless, 2014).

Intimate Partner Violence

Intimate Partner Violence, which disproportionately affects women, can be a precipitating factor for families to fall into poverty. Unsure how they will survive, some women remain with an abusive partner because of the need for financial support and/or health insurance. One may wonder why a person would stay with an abusive partner, but the decision to leave can be complicated. Leaving one's home abruptly results in unpredictability on many levels. Some additional burdens may include needing to find a new place to live, eating out due to a lack of kitchen facilities, and/or transporting children to school rather than relying on school buses. Additionally, some victims need to take time off from work to obtain medical care, enroll children in school, find housing, and attend court appearances. For these reasons, about 50 percent of women who suffer domestic abuse or sexual assault lose their jobs; intimate partner violence is a significant cause of homelessness among women with children. In an effort to address this problem, the Violence Against Women Reauthorization Act (VAWA) expanded important housing protections for survivors of domestic violence (Imbery, 2014). Mandatory paid sick time would help such women to get over a short disruption in employment and work toward economic stability.

Runaway and Homeless Youth

Adolescents who leave their homes often face significant uncertainty on the streets and risk of entering poverty. Youth who run away often do so to escape physical and/or sexual abuse, parental neglect or substance abuse, and/or extreme family conflict (National Association for the Education of Homeless Children and Youth, n.d.). Parents are likely to ask a child to leave or push them out of the home if they cannot afford to care for them or provide for specific mental or disability needs. Additionally, children transitioning out of foster care or institutional facilities are more likely to experience limited housing options, become homeless, and remain homeless for longer periods of time. It is estimated that one in seven youth between the ages of 10 and 18 will run away; approximately 75 percent of which are female (National Conference of State Legislators, 2016).

> **LGBTQ youth** (lesbian/gay/bi-sexual/transgender) who encounter severe family conflict and disapproval of their sexual orientation are at risk of homelessness as well. It can be difficult to find shelter given that there are few beds for LGBTQ youth, and all too often if they find shelter, they have to contend with denigrating remarks from other residents and/or staff. Compared to homeless heterosexual youth, LGBTQ youth have higher rates of physical and sexual abuse, mental health problems, and unsafe sex practices (National Alliance to End Homelessness, 2015). LGBTQ youth are more likely to exchange sex for housing and shelter and have higher instances of abuse and violence at homeless shelters and on the streets (Homeless and Runaway Youth, 2013). They are twice as likely to attempt suicide than their heterosexual peers. More welcoming shelters and training for staff to meet the unique needs of these youth is necessary (National Alliance to End Homelessness, 2015).

Parents' Education and How Children Are Affected

Education and employment status of parents is correlated with child poverty; generally, parents with higher education completion and full-time employment are better able to provide for their children. Low parental educational level is considered a primary risk factor for children growing up in economically strapped homes. 50 percent of children with parents who have only a high school diploma are likely to be low income (National Center for Children in Poverty, 2014). While 86 percent of parents without a high school diploma or GED head

Table 3.5 Disparities Separating Children Based on Mother's Education

Children Living with Mothers Who Had Not Graduated from High School	Children Living with Mothers Who Had a Bachelor's Degree	Child Outcome
53%	4%	At or below the federal poverty level
84%	13%	Low income
$25,000	$106,500	Median family income
48%	11%	Parent not working full time, year round
16%	49%	Proficient in reading in the 8th grade
16%	52%	Proficient in mathematics in the 8th grade
63%	36%	Not enrolled in pre-kindergarten at ages 3–4
40%	2%	Did not graduate high school by age 19
9%	6.8%	Low birthweight
16%	4%	Not covered by health insurance

Source: Based on Hernandez, D., and Napierala, J. (2014, July 1). *Mother's Education and Children's Outcomes: How Dual-Generation Programs Offer Increased Opportunities for America's Families*. © Cynthia Crosson-Tower.

families in poverty, parents with some college education head only 31 percent of families living in poverty (Jiang et al., 2015b). Children who live with a mother who has not graduated from high school, specifically, experience economic disparities compared to those who live with mothers who have a bachelor's degree (see Table 3.5). As with many poverty indicators, there is an overlap with other variables. This is the case with maternal education and marriage status. Women who have completed a baccalaureate degree are roughly two and a half times more likely to marry than those who did not receive a high school diploma: 5.67 percent and 2.34 percent respectively in 2012 (Fry, 2014). See the chart below that outlines the differences between children who live in homes with mothers of different educational attainments.

Disabilities

The future for a child born in the United States with significant disabilities, or for a child who is raised by a person with a disability, seems to be rather bleak with little hope of escaping poverty. The poverty rate for working age adults with a disability is nearly two and a half times that of others without a disability. Recent research also indicates that persons with disabilities make up almost half of the working age adult population who live in poverty in America for at least 1 year; for those who endure longer-term poverty, two-thirds have a disability. This is largely due to the fact that individuals with disabilities are significantly less likely to be employed and have earnings, are at risk of experiencing job loss, and often face barriers to education and skills development. Having a disability or caring for a child with a disability are causes of economic hardship and many families are forced to go without basic needs such as food, shelter, and medical insurance (Vallas and Fremstad, 2014).

Families containing at least one member with a disability are more likely to be poor and receive benefits such as Social Security and public assistance (National



Diversity and Difference in Practice

Behavior: *Apply and communicate understanding of the importance of diversity and difference in shaping life experiences in practice at the micro, mezzo, and macro levels.*

Critical Thinking Question: Disability is a natural part of diversity. How might social workers positively impact persons with disabilities facing adversity and living in poverty? What can be done at a micro level (directly with the individual or family)? What can be done at a mezzo level (neighborhoods and institutions)? What can be done at the macro level (entire communities and systems of care)?

Center for Disabilities, 2009). Although a variety of systems are in place to aid individuals with disabilities such as **Social Security Disability Insurance (SSDI)**, **Supplemental Security Income (SSI)**, and many state and locally funded assistance programs, there are substantial differences between the median earnings of those with and without disabilities. According to the 2010 U.S. Census, a person with any type of disability had a median monthly income of $1,961 ($23,532 annually), while someone without a disability had a median monthly income of $2,724 ($32,688 annually) (Brault, 2012). In addition, a child who lives in a household that is headed by someone with a disability is less likely to be consistently employed as an adult and is more likely to be arrested before the age of 20 (Ratcliffe, 2015). The data expresses that disabilities and poverty are correlated but many anti-poverty agendas are not directly addressing a means to alleviate the economic stressors of having, or caring for someone who has, a disability.

Immigration

Although people have fled to the United States for centuries in hopes of improving their status in life, today's immigrants are faced with a vastly different economy that those even a few decades ago. European immigrants who came after the Industrial Revolution were able to find jobs in factories that allowed them to support their families. But manufacturing jobs have decreased significantly; it is estimated that manufacturing jobs will account for only 7 percent of all employment in the United States by 2020 (Henderson, 2012). Many immigrants are young families and the lack of a strong work history can make it difficult for young parents to gain employment that is sufficient to support their families. Additionally, since many immigrants come from countries with poor economic conditions, they often bring fewer financial resources with them (Aizenman, 2008). Despite these challenges, immigrant parents tend to have higher rates of employment than poor children of native-born parents (Wight et al., 2011).

Latin America, particularly Mexico and Central America, has been plagued by political unrest, low wages, and high poverty rates. This has resulted in a number of families, and sometimes children, coming to the United States in hopes of escaping working in dead-end, often demanding or dangerous, jobs that offered little hope of economic self-sufficiency (Becerra et al., 2014). Many immigrants take low-wage positions, often without benefits, just so they can survive (Becerra et al., 2014). Frequently, they settle in communities with fellow immigrants. While this provides support during the relocation process, it also makes it harder to learn English and acculturate into the dominant culture that affords more economic opportunities (Becerra et al., 2014). An extreme case of such isolation can be found along the Texas-Mexico border, one of the poorest areas in the United States. An estimated 500,000 Mexican immigrants and their families live in about 1,800 **colonias**, rural subdivisions that operate outside the benefits of incorporated towns and cities. Without the financial support from municipal government, these colonias often lack necessities such as potable water, sewer systems, and social services (Ortiz et al., 2006).

Many immigrant families hesitate to get involved with the social services system; language barriers and unfamiliarity with services can inhibit their willingness to access help. This is especially true of families with undocumented members. Latino families often

share childcare across generations; however, when extended family provide for a child though informal arrangements, the family does not receive services through the state's child protection agencies as they would in state-subsidized foster care. Consequently, families that provide unofficial kinship care often suffer financially, as evidenced by the fact that 19 percent of multigenerational families fall below the poverty line compared to the national average of 12 percent of all families (Vespa et al., 2013, 9).

Immigrant families often face unique challenges, both pre and post-immigration, as in the case of the many Central American children illegally attempting to enter the United States in the last few years. The sharp rise in unaccompanied children from Guatemala, El Salvador, and Honduras attempting to cross our borders began in October 2011 (Jones and Pondkul, 2012) and reached over 60,000 in the year of 2014 alone (Torres, 2015). Children will attempt to walk, get rides in trunks of cars, train cars, semitrailers, or access underground tunnels in order to cross the border in hopes of a better, but uncertain, life (Dirks-Bihum, 2014). Despite the associated risks, some parents believe the benefits outweigh the risks and urge their children to flee the toxic social conditions of their homelands such as the influence of youth gangs and drug cartels, lack of opportunities stemming from increased poverty, poor harvests and unemployment, vulnerability to sexual victimization, and lack of protection from law enforcement (Jones and Pondkul, 2012).

Immigration has become a much debated political issue, and decisions are sometimes made without the well-being of children in mind. Each day about 1,000 adult immigrants are deported, many of them are parents of American-born children. Since the children are United States' citizens they are left behind, often experiencing long-term adjustment problems as a result (Advincula, 2014).

Additional Causes of Poverty

In addition to these examples, other instances in which children and families may fall into poverty or remain within the cycle of poverty include, but are not limited to, divorce, lack of individual responsibility, parental illness or disease, natural disasters, **marginalization** by society, crime and violence, death, agricultural changes, war, famine, drought, and parental substance abuse (Shah, 2014). Often a child or family suffers a variety of hardships that result in their low economic status and make it difficult to escape.

In the timeline based on the case of Malcolm that follows, see how many factors you can identify that have contributed to the ongoing cycle of poverty.

Case Example Malcolm

Malcolm, weighing in at 4 pounds and 7 ounces, was born prematurely to a single mother who lived below the poverty line. They lived in the Chicago projects in subsidized housing and received SNAP benefits. Malcolm's mother could not afford much because the associated expenses stemming from his complicated birth (frequent trips to the doctor, special foods, etc.), as well as losing her part-time job, debilitated her financially. Early on, the child exhibited complications with cognitive development. He attended a lower-quality public school and it wasn't long before he began to fall even more behind. His mother could not afford a tutor and his school did not have enough staff to commit to after school programming. Additionally, Malcolm suffered from asthma and stayed home from school a lot because he struggled to walk there every morning. Malcolm dropped out of high school and never received a high school diploma or GED. As a young adult, he searched and applied tirelessly for jobs but he struggled to find any place that was hiring someone without a high school education. He took to

selling drugs so he could provide consistent food and shelter for himself and his mother. When Malcolm went to prison for drug distribution 3 years later, he found out that his fiancé was pregnant. Malcolm Jr., weighing in at 5 pounds 3 ounces, was born prematurely to yet another single mother who lived below the poverty line.

Summary of This Section

- The cycle of poverty is a seemingly endless perpetuation of poverty through generations; a lack of social and economic capital traps children in poverty much like their parents.
- The Great Recession of 2008 devastated America's economy largely disproportionately affecting citizens of the lower classes and the nation's children.
- Although employment rates have reached levels of pre-recession times, the percentage of poor people in the United States continues. Lack of affordable housing and increases in the cost of living contribute to low-income families having difficulty.
- Intimate partner violence, disproportionately affecting women, often leaves women and children in emotional and financial crisis due to difficulties with health, school, employment, and unstable housing.
- Adolescents who run away from home are at a higher risk for becoming poor or homeless.
- Individuals who identify as LGBTQ often leave home due to conflict and disapproval about their sexual orientation, but will often face adversity on the streets or in shelters.
- Parental education attainment and employment is correlated with child poverty; maternal education, particularly, plays a large role in children's outcomes.
- Due to the substantial medical expenses associated with disabilities, families with at least one disabled person are at a higher risk of being poor and will often rely on federal assistance programs such as SSDI and SSI.
- Immigrants, often bringing few financial resources with them to America, are finding it difficult to obtain gainful employment to provide for their families.
    - There has been an increase in immigration of unaccompanied children.
    - When illegal immigrant parents are deported, their American-born children are allowed to remain in this country and often face adjustment problems.

IMPACT OF POVERTY

Poverty impacts every facet of a child's life. Children who live in poverty have higher rates of social, emotional, and behavioral problems, and experience poor physical and mental health. Those who sustain poverty younger in life, or live in deep and persistent poverty, experience the most negative outcomes (National Center on Children in Poverty, 2015a).

Impoverished Environment

Children born into poverty often have to contend with a number of hardships that those of greater economic means do not face. In today's political climate of focusing on personal responsibility, it is important to remember that

children have little choice about the lives they are given, whether poor or affluent. Children do not choose their parents, what country they live in, what neighborhood they grow up in, and how much money their family makes. People who have experienced poverty at any point during their childhoods are three times more likely to be poor at the age of 30 compared to people who were never poor as children. The longer a child is poor, the greater the risk of adult poverty. Other times, children who are not born into poverty are still at risk for experiencing poverty at some point during their childhood (Children's Defense Fund, 2014).

It's not just money that matters. The uncertainty of whether one's needs will be met can lead to negative effects on children, such as dropping out of school, poor health, and poor adult outcomes. Parents need resources, both financially and socially, to provide an enriching environment for children to thrive and grow. Parents who face chronic economic hardship are significantly more likely than their affluent peers to experience stress and depression. Living in an environment such as this can lead to chronic family stress and decreased resources, both at home and within the larger community, for the child's social, emotional, and academic functioning (National Center for Children in Poverty, 2014).

Chronic stress can lead to parents developing poor coping habits and consequently impact their children. When children experience strong, frequent, or prolonged adversity—such as physical or emotional abuse, neglect, chronic hunger, caregiver substance abuse or mental illness, exposure to violence, or the accumulated burdens of family poverty—the stressful environment can be toxic. If this **toxic stress** continues and is not mitigated by adequate adult supports, it can literally rewire the child's brain. Young children's brains adapt to their environments and as the brain matures, the child who has not been exposed to significant trauma or deprivation typically becomes competent in regulating internal reactions and integrating environmental information. However, without a safe environment, the child's brain may not be supported in developing these functions (Painter and Scannapieco, 2013). Since children rely on their parents to provide for them, a child who does not receive such nurturance may internalize themes of helplessness and abandonment (Zilberstein, 2014). This results in the child having difficulty regulating emotions and behaviors, developing a negative self-image, and experiencing difficulty in interpersonal relationships. The long-term impact of this ongoing stress can be a lack of social competence, decreased ability to succeed in school, unstable employment, adult poverty, and involvement in the criminal justice system (Kisiel et al., 2014).

Housing Problems and Child Homelessness

Substandard or unstable housing, or homelessness, can have detrimental consequences on children's development. Unfortunately, the number of families experiencing "worst-case" housing needs increased from 6 million in 2007 to 8.5 million in 2011, including 3.2 million families with children. Only one in four needy families receive housing subsidies (Children's Defense Fund, 2015). Children who live in homeless shelters with their parents may not be given sufficient attention by the agencies serving them. While temporary shelters provide a place to eat and sleep, the structure and regulations of many shelters do not support children's developmental needs. Given that the job of most shelters is to help adult guests find jobs or training programs, and/or obtain entitlements, children's needs may be overlooked. The parents may be emotionally taxed already and have difficulty providing emotional comfort to their children.

Homeless youth who have run away, are living on the streets, or staying in shelters have an increased likelihood of participating in high-risk activities such as unsafe sex practices, intravenous drug use, and drug dealing. Forty percent of African American and 36 percent of Caucasian homeless youth sell drugs to make money for basic needs. These

youths are also at a higher risk for medical problems such as anxiety, depression, poor health and nutrition, and suicide. Lack of resources, such as medical records and proof of residence, restrict school enrollment. Additionally, limited transportation contributes to homeless youth receiving an inadequate education. These overall difficulties related to school have led to a 75 percent dropout rate and lack of financial resources for homeless youth (Homeless and Runaway Youth, 2013).

If the child or parent experienced interpersonal violence or other traumatic events precipitating the move to the shelter, living in uncertain, harsh conditions can exacerbate existing post-traumatic symptoms (Donlon et al., 2014). Families that need to move to another town or city to find a shelter may be cut off from natural social networks and experience disruption in family routines. Children may need to adjust to new school systems. Many shelters do not allow families, particularly fathers, and the children may experience this as another loss. Depending on the regulations and policies of the individual states, some children may be placed in foster homes while their parents go to adult shelters.

Ironically, while school may provide the safety, structure, and opportunities that could help stabilize a homeless child, many children are in so much external crisis that it is hard for them to benefit from these resources. Frequent changes in school location often leads to a decline in academic achievement, lower school engagement, and impaired peer relationships. This may be especially difficult for young children who thrive on consistency; they often suffer early language and cognitive delays (Donlon et al., 2014). The impact of a lack of consistent home continues as children age, and seems to be more detrimental than just that of poverty. Homeless children in grades 3–8 have poorer math and reading achievement compared to those from families living in poverty but maintaining a steady household (Cutuli et al., 2013).

Impact of Intimate Partner Violence on Children

Children are often the "silent" or "hidden" victims of intimate partner violence (IPV). Preoccupied with concerns for personal safety, the abused parent often has difficulty attending to the child's distress and is emotionally unavailable (Thornton, 2014). When dealing with family violence, youth of all ages often experience anxiety and depression, increased aggressiveness, lack of interest in friends and school, and behavioral problems. Younger children may manifest their distress through sleep problems, such as nightmares and bedwetting, and often engage in bullying. Adolescents tend to rebel, become truant, abuse substances, and have academic difficulties (American Academy of Child and Adolescent Psychiatry, 2013). Additionally, without the benefit of having witnessed the skills necessary for building healthy relationships, adolescents are statistically at risk of becoming involved in violent or abusive dating situations (CDC, 2014). Children who live in homes with IPV are often subjected to physical and psychological abuse as well (American Academy of Child and Adolescent Psychiatry, 2013).

Child Maltreatment

Neglect is the most common form of child maltreatment, comprising 78.3 percent in 2012, but the least substantiated because its effects are not always apparent (U. S. Department of Health and Human Services, 2013, 20) (see Chapter 7). Typically, **neglect** involves an omission of appropriate care rather than the commission of a hurtful act. However, the role of poverty should be considered when a family is not providing for its child(ren) since they are intricately intertwined. Poverty exacerbates the risks to child safety due to the risks associated with inadequate housing and/or homelessness and the difficulty parents have meeting the basic needs of the children. These stressors may contribute to parental mental health issues, and increased tension between the couple may lead to domestic violence. Some parents may try to escape a sense

of a dire future, although ineffectively, by turning to drugs and/or alcohol. A parent may feel depressed, fearful, and overwhelmed. In this state, the parent may not supervise or discipline effectively or respond to the child's emotional needs in a nurturing manner. Although using substances is not an effective coping mechanic, perhaps the child welfare worker should explore whether poverty, rather than substance use, was the precipitating problem.

Minorities have been overrepresented in the child welfare system, just as they are among the rates of children and families living in poverty. Structural racism, inadequate access to services, and housing challenges that many minorities face contribute to this inequality. However, it should also be noted that most families living in poverty do not come into the child welfare system. A number of protective factors have been found to help support resilience in poor families, including maternal employment, parents who were competently parented themselves, strong support from extended family, and informal support networks (Duva and Metzger, 2012).

Health, Development, and Education

Poverty has a detrimental effect on children's development. Children in poor families are five times more likely to be in fair or poor health than children in non-poor families. They have more severe health problems and fare worse with the same problems. Adverse childhood experiences impact health throughout a poor child's life. The more adverse experiences, the greater likelihood of health problems in adulthood including heart disease, diabetes, substance use, and depression (Children's Defense Fund, 2015).

Health Insurance and Access to Health Care

Ninety-five percent of children in the United States now have health insurance. While new options under the Affordable Care Act (ACA), commonly called Obamacare, has resulted in more children having coverage, immigration status, or the lack of available options through their parents' employment still prevents some children from being insured (Children's Defense Fund, 2015). Poor children are less likely to have access to affordable quality health coverage. Nearly 1 in 6 poor children lacks health insurance compared to about 1 in 12 non-poor children (Children's Defense Fund, 2015). Minority children are more likely than whites to lack health insurance coverage (1 in 7 Latinos, 1 in 11 African Americans, 1 in 15 whites) (Children's Defense Fund, 2014). Immigrant families are less likely to have health insurance and receive benefits such as food stamps. The lack of these supportive services may negatively impact the child's health (Wight et al., 2011).

People who have disabilities face additional challenges if they are also poor or of low income, including increased risk of poor health and quality of life. (Research indicates that persons with disabilities experience barriers to proper health care such as lack of transportation, communications skills, and insurance. Additional studies show that the cost of medications deterred 29 percent of disabled persons from taking their medication or refilling their prescriptions (American Psychological Association, 2015).

Health Conditions

Socioeconomic status impacts children before they are even born, as we can see in the complications minority children suffer. Lack of adequate health care for mothers prenatally has significant consequences. The March of Dimes (2014) notes that 19.8 percent of uninsured women give birth before 37 full weeks of gestation, placing their babies at risk of complications. Babies born to African American mothers are two times more likely to be of low birth weight and to die within the first year of life (U.S. Department of Health and Human Services, 2015, 25–26).

Minority children are 1.5 to 2 times more likely to suffer from **chronic health conditions**, such as asthma, diabetes mellitus, obesity, hypertension, dental problems, ADHD, mental illness, and cancer (Children's Defense Fund, 2014). Although these illnesses do have genetic components, Price and colleagues (2013) found that disadvantaged socioeconomic status, lack of social supports, difficulty accessing quality health care, and additional stressors contributed to the poorer outcomes for children of color. Parents struggling in low-income jobs may find it harder to take time off from work to keep frequent medical appointments or to travel some distance to more advanced health care centers. The living conditions of poor children may also play a role in their illnesses. Poor inner city children are exposed to respiratory irritants, such as poor air quality and indoor pathogens such as cockroach and mite feces, that are common in low-quality, low-income housing units (Fleg, 2008).

Mental Health

Children's mental health is also impacted by poverty; those who experience pervasive poverty have increased rates of externalizing behaviors and suffer from learned helplessness at age 17 (Evans and Cassells, 2014). The cumulative risk factors associated with poverty take their toll over time, especially those of violence exposure, family stress, and substandard housing. As young adults, those who grew up in poverty generally have poorer mental health than peers who had not experienced so much poverty. Although families may enter services, particularly counseling, for reasons other than poverty, their financial difficulties often complicate their situation.

Food Insecurity

Food insecurity in children leads to an increase in physical, emotional, and behavioral problems (Children's Defense Fund, 2015). About 20 percent of children in this country are living in homes that are considered food insecure (Feeding America, 2015). Children who experience **food insecurity**, or lack of consistent access to food, are at risk of developing health and developmental problems. As infants they are more likely to develop insecure attachments; this makes sense considering that food is such a part of emotional nurturance. As preschoolers, they have more behavioral problems than food-secure peers. In elementary school, food-insecure children have higher levels of anxiety and depression, lower math and reading achievement, poorer social skills and self-control, and lower attention spans. They are also more likely to have chronic health conditions and suffer from iron deficiency anemia. As teens, they are more likely to be depressed and suicidal. Food insecurity is associated with lower reading and math scores (Child Trends Databank, 2014a).

Although this might seem counter-intuitive, children in poverty are also twice as likely as those from higher income families to be obese (Food Research and Action Center, 2010). Good food can be expensive, and poor families may try to stretch their budgets by buying cheaper, high-calorie foods. Many low-income neighborhoods do not have full service supermarkets with a better selection of food than smaller, often more expensive, local markets. Some families do not have transportation, or cab fare, to go to the larger supermarkets (Krase, 2014). Many school districts have cut back on physical education classes as they focus more on academics in our test-driven society, thus depriving children of a chance to burn off calories during the school day. Poorer communities may not have playgrounds and other recreational areas, at least ones that parents consider safe for their children to visit (Powell et al., 2005). Additionally, families struggling to get by do not have the expendable income to sign children up for community sports leagues.

While some may argue that one's appearance is a personal preference, it is clear that obesity is a health issue. Children who are obese, compared to those considered of normal

weight, have higher rates of bone and joint problems, sleep apnea, high blood sugar levels, social stigma, and poor self-esteem. Seventy percent of 5- to 17-year-old obese children have one risk factor for cardiovascular disease such as high cholesterol or blood pressure. As adults, they are increased risk of cancer, heart disease, type 2 diabetes, stroke, and osteoarthritis (Centers for Disease Control, 2015).

Education

We have seen that parental educational level is a protective factor against family poverty, and education is often the key to children being able to rise out of poverty before beginning their own families. A child with parents who have achieved beyond a high school education, however, are 30 percent more likely to graduate from high school than children with parents who do not have a high school education. Additionally, poor children are less likely to enter school ready to learn and have the skills to graduate from high school partly because poor parents may have trouble providing as many stimulating experiences as those with more money. In poor families, parents spend less time reading or talking to their young children, and consequently the children are exposed to many fewer words each week than children in more affluent families. One study found that by age 4, high-income children had heard 30 million more words than poor children. Preschoolers from poor homes are less likely to achieve school readiness skills, such as recognizing letters, counting to 20, or writing their first names than more affluent children (Children's Defense Fund, 2015).

Members of poor, marginalized populations have an increased risk of poor educational outcomes. Unfortunately, children in poor communities often suffer the disadvantages of substandard school systems. Children who were poor for half of their childhood were 90 percent more likely to enter their 20s without ever completing high school (compared to those who had never been poor). The younger a child is when he/she experience poverty, the worse the impact (Children's Defense Fund, 2015). Children with disabilities in America are less likely to attain a proper education. The 2010 U.S. Census revealed that 8.4 percent of America's children under the age of 15 are diagnosed with a disability; many reported trouble completing regular homework assignments and received special education services (Brault, 2012). Children of foreign born parent(s) face unique challenges that poor children of native-born parents often do not. Cultural and linguistic differences may play a factor in the decreased rates of high school completion among children of the foreign born (Wight et al., 2011).

Poverty and Teen Risk Factors

Teens who grew up in poverty have higher rates of negative outcomes. Those growing up below 200 percent of the poverty line are twice as likely to get pregnant or impregnate someone (Sloup et al., 2009). One might find it counter intuitive that the poorest teens would choose to have families so young, but it is important to understand that when teens feel unable to achieve middle class goals and lack a sense of social mobility, early parenthood affords them adult status and a sense of accomplishment (Raley, 2008). (See Chapter 10 for a broader discussion on teen pregnancy and parenting.)

Poverty is a common denominator across racial and ethnic lines among youth who choose to join gangs. Several risk factors associated with poverty place young people at risk, including poor educational systems, dangerous neighborhoods, family stress, and possible histories of child abuse. Although gang membership has many negative consequences, the decision to join one is often an attempt to gain a support system and a sense of protection, to acquire more material rewards, to obtain status in the community, and

to rebel against legal and community norms. Having an older family member in a gang is also a risk factor. Girls who join gangs are disproportionately victims of childhood sexual abuse; they may be seeking protection from abuse at home. The vast majority of youth who join gangs do so between the ages of 11 and 15, with the peak at 13–15 years old. Given that they are still developing, there are many frequent negative outcomes associated with gang membership, including limited educational and job opportunities, increased family stress, increased substance abuse, the likelihood of being drawn into neighborhood crime, and long-term health consequences (Ritter et al., 2013). Consider the case study below of Eduardo; what are some of the factors that may have contributed to his decision to join a gang?

Case Example Eduardo

Although Eduardo's family was making a fairly successful adjustment to the United States after moving here from the Dominican Republic, adolescence became a turning point. As his classmates began to talk about colleges, he questioned whether he had the academic background needed to succeed at that level. An older cousin had joined a gang, and Eduardo was jealous of his new possessions, including a new sports car. Eduardo's mother urged him to keep away from his cousin, saying it was "bad money" since it was earned selling drugs. Eduardo seemed to be able to resist his cousin's efforts to join the gang until an unfortunate incident happened when he was 14. The local police made an error in attempting a drug bust and knocked down the door of Eduardo's family when their target was actually on the next block. Eduardo, his mother, and younger brother were handcuffed while the police ransacked their apartment. Since his mother spoke little English, Eduardo begged the police not to handcuff his 10-year-old sister who was diagnosed with Autism. After an hour of searching, the police found no drugs and left the apartment in shambles. The next time his cousin tried to recruit him into the gang, Eduardo figured, "Why not, the police already think I'm a dealer. And how else am I going to get the things I want in life?"

Chronic Stress and Trauma

The chronic stress that many low-income families experience can tax the parent–child relationship. All families experience stress, but poverty amplifies the negative effects of many different kinds of stresses. An unexpected car repair or missed time at work can place the family in a precarious situation. Parents dealing with poverty have higher than normal rates of depression, anxiety, alcohol abuse, and physical health issues. The continual stress results in physiological arousal, thus contributing to more reactive responses to the world, and perhaps their children, leading to ongoing parent–child conflict. In turn, children respond with higher rates of behavior maladjustment (Wadsworth and Rienks, 2012).

Unfortunately, families in poverty also carry a number of other risk factors, such as child maltreatment, parental mental health and substance abuse issues, partner violence, substandard and unsafe living conditions, ineffective parenting, and social isolation (Schmid et al., 2013; Child Welfare Information Gateway, 2014). Therefore, the child welfare worker should consider the possibility that the child may be experiencing post-traumatic symptoms that are interfering with functioning. The child who is having trouble paying attention in school may be responding to hunger, lack of academic preparedness, or intrusive post-traumatic symptoms. Adopting a trauma-informed lens allows the child welfare worker to determine if reactions to external situations or ongoing maltreatment might also play a role in the child's functioning and make appropriate referrals for services.

Trauma-informed care conceptualizes the person's behavior and symptoms as adaptations to trauma and considers the age, the developmental level, and the specific trauma history of the child in developing interventions (Briere and Lanktree, 2012). Low-income and minority families often face additional barriers to obtaining prompt and culturally sensitive mental health services, such as lack of transportation, resources, or finding clinicians who can speak their language (Santiago et al., 2013). Therefore, by the time they access treatment, the child may have been suffering for some time with reverberations throughout the family.

Summary of This Section

- Children who live in poverty have higher rates of social, emotional, and behavioral problems, and experience poor physical and mental health.
- Children who experience poverty at a younger age, or live in deep and persistent poverty, experience the most negative outcomes.
- Minority children are disproportionately poor; they are also 1.5 to 2 times more likely to suffer from chronic health conditions, such as asthma, diabetes mellitus, obesity, hypertension, dental problems, ADHD, mental illness, and cancer.
- Lack of resources such as transportation and parental flexibility at work can compromise access to quality health care for poor children.
- As a result of the Affordable Care Act (Obamacare), 95 percent of American children now have health insurance.
- Children growing up in poverty experience more mental health issues, including externalizing behaviors that can lead to legal involvement, than their more affluent peers.
- One in five children experience food insecurity. Due to the difficulty of providing a balanced diet for a family on limited finances, they also are more likely to be obese than their more financially stable peers.
- Children who grew up in poverty are more likely to become teenage parents, join gangs, and experience educational difficulties.
- Parental stress and lack of resources contribute to higher rates of child neglect than among other socioeconomic groups.
- Intimate partner violence not only impacts a child's mental health, but it may lead to homelessness if the children and victimized parent need to leave their home.
- Given the stressors that families living in poverty experience, caseworkers are encouraged to be familiar with trauma-focused theory.

EFFORTS TO ALLEVIATE POVERTY

People have attempted to address the problems associated with poverty for centuries; some have tried to help poor children and families and some have penalized them (see Chapter 1). Many of the programs that exist today that target poverty can be traced back to the **War on Poverty**. Although the early 1960s was a time of prosperity, there was growing acknowledgement that poverty had been shielded in the slums and various rural areas. President Kennedy first became concerned with alleviating poverty primarily in Appalachia; however, President Johnson is credited for declaring the War on Poverty in 1964 and expanding the focus to include African Americans. The War on Poverty

attempted to change the "**culture of poverty**" through education, job training, and empowerment skills. It was believed that providing resources and opportunities would enable those in poverty to become financially secure and join the middle class. Programs such as public housing, employment and training opportunities, expanded welfare benefits, affirmative action, Head Start, Upward Bound, Neighborhood Youth Corp., Job Corps, and Legal Services were initiated to provide such resources. Although well intentioned, the War on Poverty coincided with the War in Vietnam, and resources were switched from domestic programs to the military. Without the services to support efforts to help the poor, the War on Poverty faded into the background of the national consciousness (Copeland, 1994; Farmbry, 2014).

Prevention Services and Assistance Programs

Some programs are aimed at serving high-risk families before they enter poverty while others support those struggling with poverty or attempt to stop the cycle of poverty. Referral to **concrete services**, such as food pantries, childcare vouchers, and occupational and housing referrals may be the first step the case manager can take to alleviate family stress. Community-based agencies administer many programs to provide support during situational crises and to counter risk factors that have been found to lead to family poverty, such as teenage pregnancy (see Chapter 10), intimate partner violence, family preservation services (see Chapter 8), foster care, and parental substance use. Supportive counseling and psychoeducational programs, and case management to coordinate multiple services are common responses to support low-income families (Whitelaw Downs et al., 2009). It is important when working with economically disadvantaged families to consider the larger sociopolitical context of the family, including ethnicity, acculturation process, and values such as the relative merits of independence versus dependence (Lindsay et al., 2014). It is always important to examine one's own biases and values when encountering those from a different background.



Diversity and Difference in Practice

Behavior: *Apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies.*

Critical Thinking Question: What are some of your personal biases or values that may affect your ability to work with families living in poverty?

It can be helpful for the family to access support and services from as many domains as possible. Some families benefit from local resources such as church food pantries and thrift shops; but they may achieve greater stability through various government programs. The following programs were instituted to alleviate the negative outcomes of poverty, especially for children and families. States are usually reimbursed by the federal government for providing services, which allows individual states to determine how to best serve the needs of its population based on a number of factors, including cost of living. These programs can be divided into three general categories: financial assistance; health related; and educational and childcare services. See Table 3.6 for a list of some of the federally funded assistance programs offered to eligible families in the Unites States.

Wraparound Services

The **Wraparound Services** model embodies an intensive, holistic framework to address the complex needs of families struggling with multiple problems, as many in poverty do. The goal of wraparound services is to help families develop problem solving skills and coping mechanisms, and to gain a sense of self-efficacy by building the family's support system through a tailor-made service plan. Family members, including children old enough to participate in discussions, are given "voice and choice" so they can articulate

Table 3.6 **Government Programs to Support Children and Families in Poverty**

Program	Eligibility	Goals/Services Provided
Financial Assistance		
Temporary Assistance to Needy Families (TANF)	Less than poverty threshold for household size and participate in mandatory work program	Cash benefit program for basic needs
Earned Income Tax Credit (EITC)	Working families with income between $36,900 to $50,300 depending on family size and composition (two-parent families have higher income limit)	Tax credits, decreasing as income raises
Child and Dependent Care Credit	All income groups	Tax credit for a proportion of the amount spent on childcare
Personal Responsibility Work Opportunity Reconciliation Act (PRWORA)	All income levels, but mandatory for low-income, single-parent families seeking most governmental assistance	Child Support Enforcement; assist families in collecting child support from absent parents
Childcare Subsidies	Low-income families	Subsidized childcare programs; allows parents to work
Health Related		
Supplemental Nutrition Assistance Program (SNAP)	Families at roughly 130% of poverty level, with some variation for geography and family resources	Electronic debit card that allows families to purchase food items (excluding alcohol, pet food, and prepared foods)
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	Pregnant women and children under 5; income at or below 185% of poverty level	Can redeem foods determined necessary for proper nutrition; received nutritional information
National School Lunch Programs	Households below 130% of poverty line receive free meals; households from 130% to 185% of poverty level receive reduced-cost meals	Provides breakfast, lunch, and snacks
Healthy, Hunger-Free Kids Act	Public School Students	Increased meal reimbursements to schools so they can prepare healthier meals
State Child Health Insurance Programs (SCHIP)	Families whose income fall below state-set thresholds	Covers hospital stays, primary care, and specialist visits
Family Medical Leave Act (FMLA)	Job security program for all income groups	Mandates certain employers to guarantee job when worker has to take leave for family medical reasons
Persons with Disabilities		
Social Security Disability Insurance Benefits (SSDI)	People of all ages who are unable to work due to a disability that has lasted or will last at least 12 months and have earned enough Social Security Credits and are unable to work because of a disability that has lasted or will last at least 12 months or end in death	Provide assistance to individuals with disabilities

(Continued)

Table 3.6 **Government Programs to Support Children and Families in Poverty (*Continued*)**

Program	Eligibility	Goals/Services Provided
Childcare and Educational Programs		
Early Intervention	Developmentally delayed children under 3	Services include physical, occupational, and speech therapies; parent education and support
Head Start	Preschoolers living under the poverty line; some programs may expand eligibility	Improve social, emotional functioning and increase school readiness
Race to the Top	High poverty and low-performing public school districts	Improve quality of education; equalize disparities in education across school districts
TRIO Student Support Services	Must be a current or prospective student pursuing an associate's or bachelor's degree and one of the following: low-income, first-generation college student, or disabled	Increase college retention and graduation rates of students
Housing		
Housing and Urban Development (HUD) Public Housing	Limited to low-income families based on annual gross income, U.S. citizenship, or eligible immigration status	To provide decent and safe housing environments for eligible low-income families
Housing Choice Voucher Program (Section 8)	Limited to very low-income families; the family is responsible for finding their own housing with an owner that agrees to rent under the program	Provide assistance to very low-income families to provide safe, sanitary, and decent housing
Support Services for Runaway and Homeless Youth—Basic Centers	Must be less than 22 years of age and are either homeless or have run away from home	Provide emergency shelter services, reunite youth with their families, or locate appropriate alternative placements

Sources:

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understandings of their problems, what they want from providers, and then which service options to accept. Services are individualized, family-driven, culturally competent, and community based. They are delivered from a strengths-based perspective and include natural supports as well as agency ones. One of the professionals working with the family takes the role of the care coordinator to assure that the plan is being implemented and to monitor its effectiveness (National Wraparound Initiative, 2015). Identify the elements of the wraparound model in the services that the Saintal family receives.

Case Example The Saintal Family

Angeline Saintal's guidance counselor referred her family to counseling because of difficulties communicating with her mother and concerns that Angeline seemed to think that her teacher was going to hit her. Mrs. Saintal attended the first counseling session without her husband, explaining that he could not take time off from work. She brought Angeline, age 7, and her two other children, 5-year-old Chantale and 2-year-old Junior. She was very respectful toward the counselor, Susan, but confused and fearful as to why she was there. Susan explained what she knew from the Guidance Counselor and said that her role was to help the family articulate their perspective on what is happening with Angeline's schooling and to help them identify any supports that they might need. By asking questions about family history, Susan learned that the family had immigrated from Haiti 4 months ago. Mrs. Saintal spoke English but could not read it. Angeline had attended first grade in Haiti and had done well, but now she was struggling with reading and math. She also complained that the other children would tease her about her lunches, which often included blended shakes of ingredients uncommon in the United States, such as various vegetables, cornbread, and even spaghetti. Additionally, the teachers continuously questioned her about only having a shake and no "real lunch." These high-calorie shakes were considered meal substitutes in Haiti, and Mrs. Saintal did not want her daughter to get sleepy after lunch so she preferred to pack this lighter lunch alternative.

Angeline said that she felt "stupid" in class since she had trouble following the lessons in English; she feared her teacher, like in Haiti, would express her displeasure with physical punishment. Susan and Mrs. Saintal met with the teacher and guidance counselor together to explain the differing expectations on discipline in American and Haitian schools. Susan asked the teacher if there was another way besides the written daily agenda that Mrs. Saintal could find out what was going on in the classroom; she intentionally did not say that Mrs. Saintal could not read English. The teacher, however, understood the request and offered to put a brief summary on a voice mail message that all parents could access at the end of each day.

Mrs. Saintal had made some friends through her church, but she still felt a bit isolated and confused about American ways. She would have liked to get a job, but did not know how she could with two young children to care for. She also had concerns about Junior, who was not speaking even though he was over two. Susan helped Mrs. Saintal identify her needs and first look at her natural support systems. There were a number of women in her church who had come from Haiti and were further in assimilating to American ways. Susan helped Mrs. Saintal come up with a number of questions she could pose to these church women so she could get a better perspective on her own immigration process.

Susan helped Mrs. Saintal access Early Intervention services for Junior and a subsidized childcare program for Chantale so she could attend English classes. Mrs. Saintal thought this was a good start, since she would need to improve her English to attend a Certified Nursing Assistant program she had heard about. These applications were confusing for Mrs. Saintal, given her lack of fluency in reading English, so Susan asked her if she would be willing to work with a Family Services Coordinator who could come to her

house and help her with them. It was much easier to work on the forms with the children occupied with their toys at home than it was in Susan's office.

Mr. Saintal suffers from a rare blood disease; sometimes he is too exhausted to go to work. When he is ill, the family struggles to meet basic necessities. Mrs. Saintal was ashamed to go to a food pantry, so Susan negotiated with the Director of the Food Pantry to allow Mrs. Saintal to volunteer there a couple of hours a month and then privately collect the food she needed when the food pantry officially closed. Mrs. Saintal viewed this as a chance to meet more of her neighbors and as a way to avoid the embarrassment she felt of others knowing that the family had financial problems.

Creating Self-Sufficiency

Many groups have used information provided by the Self Sufficiency Standard to advocate for more economic stability for those in need, and the various states have responded in different ways. New Jersey raised its minimum wage, and Maryland added tax credits for low-income families. Alabama instituted a progressive taxation structure that increased the income level at which people must pay taxes; Pennsylvania increased childcare co-payments for low-income families. The federal government has adopted the Self-Sufficiency Standard as eligibility criteria for many job training programs and other services, thus making them more available to those above the poverty line but who are still struggling to get by (Center for Women's Welfare, n.d.).

Opportunities for Youth

Homeless youth face many obstacles to attending and thriving in school. The **McKinney-Vento Act**, first passed in 1987, mandates school districts to have homeless liaisons to help youth and their families access appropriate services and to coordinate with the child's home district to provide a continuation of schooling. Children who lack a fixed, regular, adequate nighttime residence are considered eligible for services; this includes those living in shelters, transitional housing, cars, campgrounds, or motels (National Association for the Education of Homeless Children and Youth, n.d.).

Case Example Ian's Struggles with Homelessness

After years of witnessing his parents' alcoholic binges and fighting, 16-year-old Ian decided to buy a big car with the money he had saved from working at Burger King and live in it. He parked the car on his parents' property and occasionally entered the house to shower, but otherwise Ian had little contact with his parents and virtually no support from them. Intellectually gifted, Ian focused his energies on his schoolwork, and despite his hardships, he was able to secure acceptance to a state college. His dorm room provided the first stable housing he had had in almost 2 years.

The federal government has instituted several job training and education programs that target adolescents and young adults to help reduce the negative impacts of poverty, including Job Corps. Job Corps is a free educational and training program for low-income youth ages 16–24. Many have had academic or personal difficulties. Students can commute or live in a residential setting while they complete a high school diploma or GED and simultaneously obtain job skills. Upon graduation, they are given help in securing a job and assistance to their transition to independent living (U.S. Department of Labor, 2015).

Why Poverty Endures

Given the number of programs that have been implemented to fight poverty, one might ask why it is still such a problem. Through the 1960s, poverty declined: Between 1959 and 1973, the overall poverty rate declined from 22 percent to 11 percent (Edelman, 2014). Three factors contributed to our country's ability to make such a significant impact in reducing poverty: (1) the good economy of the times, (2) the impact of the civil rights movement and consequent hiring of more African Americans, and (3) the introduction of programs that provided new opportunities and a safety net for the needy. Edelman (2015) argues that without the programs established in the 1960s and the current Affordable Care Act that poverty rates would probably be about double what they are now.

However, we live in different times now and an analysis of historical changes reveals some of the underlying factors contributing to the enduring high rates of poverty. Edelman (2015) suggested eight societal changes that have occurred since the early 1970s that have significantly contributed to high rates of poverty. These include:

1. *Shift to low-wage jobs.* After World War II, a high school diploma was sufficient to get a well-paid unionized job that would allow one to support a family. But with the 1973 oil crisis, companies moved many manufacturing jobs overseas as a means to create their products more cheaply. As technology advanced, manufacturing jobs also decreased. The new jobs that emerged were primarily in the service sector, which historically have paid less, thus impacting upward mobility. The median pay for a full-time job now is $35,000, barely more than it was in 1973, despite significant costs of living increases over the decades. Consequently, about 60 percent of households living in poverty are comprised of people who do work.
2. *Changing family structure.* Although, this is a controversial issue, statistics show that two-parent households are less likely to fall into poverty. While famous people may tout becoming single parents, they seldom have the same worries about providing for their children as many American families do. While social mores have changed and single parenthood is much more acceptable, the economic structure of the family is more resilient when there are two parents. If there are two adults in a household, and one loses a job, the other may have steady employment or be able to find one. Two adults allow for more flexibility with childcare, which can be a limiting factor in obtaining employment or can be prohibitively expensive for the working poor. Some politicians simplify this issue by advocating that single mothers should get married. However, that does not account for the complexity of human experience (i.e., cases of intimate partner violence) or address the underlying causes of why single mothers have such a difficult time making ends meet, even in comparison to single fathers.
3. *Deteriorating public education.* Education has become more important than 40 years ago; most good jobs require at least some post-secondary education. At the same time, our public schools have been underperforming for decades, particularly those in the worst neighborhoods, which are often attended by children of color and poor children.
4. *Mass incarceration.* There are currently over 2 million people in prison, disproportionately men of color. Stricter drug enforcement policies have resulted a greater likelihood of prison for minor offenses. Both the war on crime and the war on drugs resulted in more people from poor communities receiving prison

terms. While poverty may increase a person's chance of engaging in petty crime as a means to obtain needed resources, time in prison also increases one's chances of living in poverty upon release.

5. *Rise of segregated neighborhoods.* One of the unintended consequences of the Fair Housing Act was that middle class African Americans started moving out of poverty-ridden neighborhoods beginning in the 1960s. Poverty became concentrated in these neighborhoods when only those who could not afford to move were left behind in substandard housing. At the same time, jobs were more difficult to find (see # 1 above). This created a perfect storm for increased crime, violence, drug use, and school dropout rates. African Americans were not the only ones affected. White communities that had flourished on manufacturing experienced similar challenges. As economies fell apart, families struggled to get by and were unable to help with higher education expenses for their children. Consequently, the first generation of Americans that did not believe they would have a better life than their parents emerged.
6. *Increased deep poverty.* The Welfare Reform Act of 1996, under the Clinton Administration, significantly changed the role of the individual states in determining qualifications for receiving assistance. Before Welfare Reform, 68 percent of children in poor families received assistance; now about 27 percent do. So why the difference? Now that the states, not the federal government, have the authority to determine eligibility and benefits, half of the states serve less than 20 percent of the children living in poverty. Wyoming provides TANF to only 4 percent of families in poverty. Consequently, the number of families on SNAP has increased from 26.3 million in 2007 (pre-recession) to 48 million currently. This is because SNAP is legally mandated for all Americans, whereas TANF is not. Without the safety net that TANF can provide some families, there has been an increase in deep poverty, or those living at less than one-half the poverty line.
7. *Institutional racism and discrimination.* Although illegal, discrimination continues on many fronts. This impacts job opportunities that are so essential for lifting out of poverty.
8. *Worsening gap between rich and poor.* Our economy has doubled in the last 40 years, but income levels for the bottom half of the population have stalled. Those with the most money are often shielded. Everyone knows that Bill Gates and Mark Zuckerberg have exorbitant fortunes, but there are many more instances of income disparity in this country that are more hidden. For instance, the top 25 hedge fund managers collectively have more income than all the kindergarten teachers in the United States put together.

Shaping the Future of Poverty Prevention and Services

In the preamble to its Code of Ethics, The National Association of Social Workers (NASW) states that the purpose of the profession "is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (National Association of Social Workers, 2008, 1). With this mandate, one might ask, "So, what is the answer?" to reducing child poverty. Given the extent of the problem, it is necessary to consider solutions from multiple perspectives, including changing public policy, civic action, and volunteer work.

Public Policy

In trying to alleviate poverty, one cannot assume that the solutions of the War on Poverty of the 1960s will be fruitful. Public policy needs to respond to the societal changes in the last 40 years and recent economic realities within an increasingly technological world. While policy makers and the public may focus on changing welfare entitlements, alleviating poverty is far more complex than any one solution. We need to consider the working poor and not just welfare recipients, who are trying to support families in times of significant challenge. The nature of jobs has radically changed, as noted before. It is incumbent upon policymakers to determine a way to create more jobs that afford a decent income; this is particularly important given sharp rises in the cost of housing, energy, and higher education. In order to do this, we must improve our educational institutions and increase access to them for low-income students.

We must help support safe and healthy communities through both law enforcement and public health measures. We must demand a fair justice system that will not disproportionately imprison minorities. Strong community-based human services agencies need to be available for families in crisis so that a state of despair does not become a way of life. Government programs need to continue, and most likely increase, the safety net for families that cannot meet basic needs (Edelman, 2015).

One of the problems with anti-poverty programs is that they can be fragmented. This leaves recipients getting confusing or partial information and having to navigate multiple agencies. The Obama Administration has instituted a Promise Neighborhood grant program to help the most distressed communities, including Indian tribes, to create communities that will increase positive developmental and educational outcomes for their children. Communities develop a continuum of care that integrates the expertise of various agencies and programs in a well-articulated collaborate working relationship. Programs are highly individualized and grants are awarded to urban and rural communities, and Indian tribes; each develops its own vision and recruits area constituents, which may include nonprofit organization including faith-based ones, and institutions of higher education. The ultimate goal is to provide the support and resources that will enable children to successfully navigate life from cradle to career initiation (Promise Neighborhoods, 2015).

Civic Action

Occupy Wall Street was an effort that began in September 2011 to bring attention to economic disparity in this country; protesters camped out in cities across the country. Although the movement is barely visible today, it helped create a language around economic disparity: the 1 percent and the 99 percent. It raised awareness of the injustices of personal economic power and has splintered into a number of focused causes, including raising the minimum wage and the addressing the student debt crisis. The movement inspired tens of thousands of fast food and Wal-Mart workers across the country to march and demand higher wages, and a number of employers and states are beginning to do. National attention has also shifted to the student loan crisis; in January 2015, President Obama proposed allocating $60 billion to help make community college free for all Americans for 2 years. Although, the likelihood of this proposal passing the Congress is questionable, lawmakers and the public alike are now aware of and discussing the issue (Levitin, 2015).

Volunteering

The **Corporation for National and Community Service** (CNCS) is a federal agency comprised of four programs that focus mainly on disaster services, education, veterans and military families, and economic opportunity. By investing in thousands of nonprofits,

faith-based groups, and local partners across America, CNCS volunteers make a positive difference in the lives of millions of individuals every day. Fellow Americans serve at over 60,000 locations nationwide and address some of the most pressing challenges facing us today such as illiteracy, homelessness, hunger, and disasters (Corporation for National and Community Service, n.d.). One does not have to become a part of CNCS, however, to make a difference in one's community.

A well-known national volunteer-based program that strives to support individuals in need is the American Red Cross. Focus areas for the Red Cross are disaster relief, support to military families, blood donations, health and safety services, and international services. Many Red Cross programs will provide referrals and resources to children and families in poverty who need additional aid. There are many ways to volunteer with the Red Cross in your community, especially after local disasters that may leave people homeless or with few resources (American Red Cross, 2013).

In addition to getting involved in national programs like the ones mentioned above, there are plenty of ways for a person to make a difference in fighting poverty within their own community. How can you have a positive impact on your community and fight poverty?

- Become aware of the problems facing your community and educate yourself by watching the news, and reading a newspaper or online articles.
- Educate and inform others of the issues that you are passionate about. Recruit your friends and family to help you help others.
- Help to raise money for a local nonprofit organization through personal donations or fundraisers.
- Donate or collect items for local nonprofit organizations such as winter jackets for children and families living in homeless shelters.
- Purchase your produce locally at farm stands and farmers markets to help support other members of your community.
- Volunteer your time at local soup kitchens or community centers.
- Mentor and teach children at after school programs or in shelters.
- Donate your food leftovers to a local shelter or food bank.
- Join a campaign that is fighting poverty.
- Donate a portion of your rewards points from your credit card to affiliated nonprofits and other helpful organizations that fight poverty.

How to Reduce Child Poverty Right Now

While new ideas are necessary to alleviate child poverty, some of the programs that have been implemented have been helpful. The Children's Defense fund suggests that expanding a number of current programs would reduce child poverty by 60 percent in a short period of time, black child poverty by 72 percent and would improve economic circumstances for 97 percent of children in poverty. Table 3.7 presents these recommendations, the impact on child poverty rates, and the annual cost of implementation (Children's Defense Fund, 2015).

While some argue that implementing all these programs would be costly, the total cost of all the proposed recommendations would total 2 percent of our gross national budget. Implementing all of these recommendations would cost about $77.2 billion, or 15 percent of the $500 billion annual costs associated with the negative outcomes of children who grow up in poverty (Children's Defense Fund, 2015).

Table 3.7 **Investing in Solutions to End Child Poverty**

Focus	Suggestion for Improvement	Reduction in Child Poverty	Cost
Housing subsidies: only one in four needy families with children receive this assistance because of funding limitations	Expand by targeting families that live below 150% of official poverty guidelines and do not already receive housing assistance; increase funding.	20.8% (lifting 2.3 million children out of poverty)	$23.5 billion
SNAP benefits: currently averaging less than $1.40 per person per meal	Increase benefits by 30% to align with the U.S. Department of Agriculture's Low-Cost Food Plan.	16% (lifting 1.8 million children out of poverty)	$23.2 billion
Child tax credit: partially refundable tax credit that provides families with $1,000 credit for each child under the under 17 to help offset the costs of raising a child	Make the credit fully refundable so that low-income families can benefit from the full $1,000 regardless of income.	12% (lifting 1.3 million children out of poverty)	$12.4 billion
Subsidized job programs: build skills among the unemployed and underemployed	Provide minimum wage jobs for 30 weeks for unemployed and underemployed individuals ages 16–64 in families with children, possible renewal if unable to secure unsubsidized employment in 4 weeks.	11% (lifting 1.2 million children out of poverty)	$22.9 billion
Earned income tax credit (EITC): refundable tax credit only available to those with earnings	Remodel to create incentive for low-income families with children to work.	9% (lifting 1 million children above the poverty line)	$8.2 billion
Minimum wage: a parent with two children working full time at the federal minimum wage of $7.25 an hour would earn $4,700 below the poverty level	Increase minimum wage to $10.10 (and $7.07 for tipped workers).	4% (lifting 400,000 children above the poverty line)	$15.2 billion
Childcare subsidy: affordable quality childcare; demands currently exceed the supply	Expand program to provide assistance for all poor and low-income families.	3% (lifting 300,000 children out of poverty)	$5.3 billion

(*Continued*)

Table 3.7 **Investing in Solutions to End Child Poverty (*Continued*)**

Focus	Suggestion for Improvement	Reduction in Child Poverty	Cost
Child and dependent care tax credit (CDCTC): nonrefundable tax credit that reimburses families for a portion of child or dependent care expenses	Expand the credit to be fully refundable and increase the maximum percentage of costs from 35% to 50% for lower income families.	1% (lifting 146,500 children out of poverty)	$1.6 billion
Child support: (averaging 40% of income for poor custodial families) families who receive TANF have their child support collected by the state to reimburse the cost of assistance	Allow families to receive 100% of their child support, and have TANF and SNAP disregard child support income when determining eligibility for benefits.	Less than 1% (lifting 89,300 children out of poverty)	$1.1 billion
		Reducing child poverty by a total of 60% (lifting 6.6 million children above the poverty line)	$77 billion = 2% of the national budget

Source: Based on Children's Defense Fund. (2015). *Ending Child Poverty Now*. Washington, D.C. © Cynthia Crosson-Tower.

Summary of This Section

- The War on Poverty in the 1960s attempted to change the culture of poverty and a majority of the programs that exist today to help poor children and families can be traced back to the efforts of this time.
- Referrals to concrete services for poor families are often the first step in alleviating stress.
- The Wraparound Services model embodies an intensive and holistic approach to address complex needs of families struggling with multiple problems; this is done through individualized service planning and collaboration with multiple parties.
- The Self Sufficiency Standard has been adopted by the federal government and enables people who are struggling but technically above the poverty threshold to access job training programs and other services.
- The McKinney-Vento Act mandates that school districts have homeless liaisons to increase the retention rate of homeless children.
- Eight societal changes that have contributed to the high rates of poverty are (1) shift to low-wage jobs, (2) changes in family structure, (3) deteriorating public education, (4) mass incarceration, (5) rise of segregated neighborhoods, (6) increased deep poverty, (7) institutional racism, and (8) a worsening gap between the rich and the poor.
- Public policy, civic action, and volunteering are three solutions to fighting poverty.

The Children's Defense Fund (2015) suggests that expansion and improvement of programs that already exist, America could spend just 2 percent of its national budget to alleviate child poverty by 60 percent. The estimated $77.2 billion needed to implement the efforts mentioned below would only be about 15 percent of the current annual cost of $500 billion that is spend on the costs associated with children growing up poor due to the various negative outcomes they experience.

SUMMARY

- Twenty-two percent of children live below the poverty line, and 40 percent of them fall under 50 percent of the poverty threshold. Almost half (44%) of families with children are considered low income. There are several measures of poverty: Absolute poverty is a fixed measure of how much a family of a specific household size needs for basic goods and services; relative poverty refers more subjectively to a family's sense of deprivation in relation to its peers despite not meeting federal poverty standards; and the Self-Sufficiency Standard calculates the income necessary for a family to meet its needs without relying on entitlements. Children who live in the southern and western states and immigrants have higher rates of poverty than others; this is a factor in why children of color and ethnic minorities are disproportionately likely to live in poverty.
- Families and children find themselves facing economic disadvantages for many reasons. Although our nation has started to rebound from the Great Recession of 2008, changes in employment patterns and low wages have resulted in an increasing number of children and families in poverty. Those with fewer resources to begin with, such as those from marginalized groups, were significantly impacted by the recession and are still struggling to compete with the majority for resources such as employment. Homelessness, a predictor of child poverty, can be caused by a variety of circumstances such as lack of affordable housing, decreased governmental support, Intimate Partner Violence (IPV), and family conflict. Adolescents who run away from or are forced out of their homes, particularly youth who identify as LGBTQ, are at high risk for long-term homelessness. Other predictors of child poverty include the education and employment status of parents; immigration status; and having a family member with a disability.
- Children living in poverty often suffer from a number of risk factors associated with lower socioeconomic status, including substandard housing and education, inadequate food, and chronic health conditions. Lack of resources contributes to parental stress, which increases the risk of child maltreatment, substance abuse, mental health issues, and intimate partner violence. Consequently, children living in poverty have higher rates of mental health issues and are more likely to become teenage parents or join gangs as adolescents. Minority children are disproportionately among those struggling with poverty. Given all these stressors, it is helpful for the caseworker to be familiar with trauma-focused theory.

- Efforts to alleviate poverty began in the 1960s with President Johnson's declaration of the War on Poverty. Many of the programs that assist economically disadvantaged families today can trace their roots to programs that were initiated over 50 years ago. Providing referrals to concrete services, such as food pantries, homeless shelters, and childcare vouchers, provide immediate help for families in need. For longer-term assistance in lifting a family out of poverty, however, a Wraparound Services model should be used that includes various agencies and entitlements. At the micro and mezzo level, individuals and communities can help to fight child poverty by getting involved with public policy, civic action, and volunteering. At the macro level, state legislatures and the federal government can make changes in programs that already exist to alleviate America's child poverty rate significantly.



4

The Impact of Violence and Addiction on Children

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Describe the sources of violence within the community that impact children.
- Discuss how children might be exposed to violence at home or in their relationships with peers.
- Explain how children are impacted by their parents' substance abuse at various points in their development.
- Discuss substance abuse as it affects children and adolescents and how they might be treated.

Few would dispute the contention that we live in a violent society. Children are exposed to violence in a variety of ways each and every day. Newspaper headlines speak of shootings, murder, suicide, and the casualties of war. Gunfire in our streets takes its toll not only on children but also on those who remain alive. Domestic violence threatens the lives of the children who are witnesses. At the same time, those addicted to drugs often turn to violence as they strive to meet their needs.

This chapter will address the various ways in which the violence of our culture touches our children from violence in the streets, in relationships, and in their homes to the plight of military families. Throughout these various types of violence is woven the thread of substance abuse.

CHAPTER OUTLINE

CHILDREN AND VIOLENCE IN THE COMMUNITY 88

War in the Streets 88

School Violence and Bullying 92

VIOLENCE AT HOME AND IN INTIMATE RELATIONSHIPS 95

Violence in Families 95

Peer Violence in Relationships 97

CHILDREN AND THEIR PARENTS' SUBSTANCE ABUSE 98

Substance-Abusing Parents 98

CHILDREN AND ADOLESCENTS WHO ABUSE SUBSTANCES 104

Effects and Treatment of Adolescent Drug Abuse 106

SUMMARY 108

CHILDREN AND VIOLENCE IN THE COMMUNITY

It would seem that today, more than ever before, our children are exposed to violence on a daily basis. In an older but classic study, Kotlowitz (1992) observed the world of two brothers, Lafeyette and Pharaoh Rivers, as they fought to survive amid the turbulence of their home in Henry Horner, a crime-ridden Chicago housing project. Gunfire was an all-too-familiar sound that caused their concerned mother to count her children for fear one of them would be the victim. The young project-dwellers were often caught in the middle of the violence perpetrated by the rival gangs. Kotlowitz describes how Bird Leg, the 14-year-old friend of the Rivers brothers, was gunned down by a 24-year-old gang member who shot the boy at point blank range.

So common are deaths in Henry Horner that a protocol has already been established that when someone in the housing project was killed, mimeographed sheets went up in the buildings' hallways, giving details of the funeral.

Life has not changed for many American children in the 20+ years since Kotlowitz wrote his memorable book. In fact, the United States is one of the more violent societies among the Western powers. A recent study compared the experiences of youths witnessing violence across three cultures—Russia, Belgium, and the United States. In a sample of 3,309 14- to 17-year-olds, the researchers (Schwab-Stone et al., 2013) found that those in the United States had the highest incidence of exposure to violence. Fifty-five percent of American boys and 48.8 percent of girls had witnessed someone being beaten up or mugged compared to 32 percent and 28 percent respectively in Russia and 54 percent and 38 percent respectively in Belgium. More American teens had seen someone shot or shot at (45% for boys and 36% for girls) compared to 5.1 percent of Russian boys and 3.5 percent of Russian girls and 10.5 percent boys and 4.5 percent girls in Belgium. About 30.6 percent of American boys and 23.7 girls witnessed someone being stabbed with a knife compared to 7.4 percent boys and 5.4 percent girls in Russia and 22 percent boys and 15.6 girls in Belgium. And finally, 64.6 percent boys and 46.8 percent girls witnessed someone being chased by a gang compared to 20 percent boys and 9.5 percent girls in Russia and 35 percent boys and 19 percent girls in Belgium (520).

War in the Streets

The Children's Defense Fund (2014) reports that each day seven children are killed by firearms. There were 2,694 children killed by guns in the United States in 2010. Of these, 1,773 were victims of homicide and 749 were victims of suicide. In fact, children in the United States are 17 times more likely to die by a gun than the children of 25 other high-income countries combined (Children's Defense Fund, 2013, 5). In 2010, the majority of the deaths by guns (45%) were among African American children. On the other hand, Native American children have the highest incidence of suicide by guns.

One might assume that teens are the most vulnerable for firearm deaths. Yet in 2010 there were 55 children under 5 years old killed by guns, which was more than the number of law enforcement officers killed in the line of duty that year (Children's Defense Fund, 2013, 6).

The violence that children witness and are exposed to in today's communities has an impact on children's development and well-being. Studies indicate that exposure to such violence can produce physical symptoms and create mental health issues (Collins et al., 2013; Mohammad et al., 2015).

Influences on Youth Violence

In what context does violence in the streets occur? Certainly, as we become a more violent society, our children are increasingly aware of violence. There is not a single news broadcast aired on television (TV) or radio that does not have at least one account of violence perpetrated against an individual or group. Fiction mirrors reality as prime-time TV shows feature myriad crimes and acts of violence; even situation comedies depict people being victimized by others, as though there were humor in victimization. Some critics of modern TV and movie entertainment suggest that violence depicted in the media actually increases violence by desensitizing us to it (Regoli et al., 2010; Siegel and Welsh, 2014).

The concern over promoting violence through the media is not new. As early as 1954, congressionally authorized studies looked at the influence of TV violence on human behavior. In 1968, a group of mothers in the Boston area, concerned over their children viewing too much violence and being influenced by certain commercials, founded Action for Children's Television (ACT) to try to influence what their children watched. By 1982, the National Institute of Mental Health had concluded that excessive levels of TV violence could lead to aggressive and even violent behavior on the part of children (Kinnear, 1995). Today the typical American child between ages 8 and 18 watches 7 hours and 30 minutes of TV each day in addition to accessing other forms of media at the same time. In so doing, they manage to be exposed to 10 hours and 45 minutes of media, much of which contains violence, in that 7 hours and 30 minutes. Children now have more exposure to media than they have interaction with their parents. In addition, the time they spend with some type of media is greater than the time they are at school or even sleeping (Hutton, 2015). A University of Michigan study reported that 63 percent of households with children have the TV on during meals, and 51 percent have it on "most of the time." It was also reported that 68 percent of children (8–18 years old) have a TV in their bedroom and 54 percent have a DVD player/VCR in their bedroom. Most children also have access to other types of media (e.g., video games) that depicts violent acts (University of Michigan Health System, 2008). More recent estimates have increased these numbers. Thus, not only do these children view violence, but the undertone of violence in TV programming and on other types of media may permeate their subconscious (American Academy of Child and Adolescent Psychiatry, 2014; American Psychological Association, 2015).

Why does **media violence** promote violence in society? The most obvious answer is that when children see violent acts committed by heroes and villains alike, they tend to want to emulate them for the risk and the thrill. But critics tell us that the effects go beyond this simple explanation. Constant exposure to violence not only desensitizes individuals to its commission but also increases the indifference one feels as the acts take place. This, in turn, decreases the ability to empathize with the victims. Psychoanalyst Denise Shrine feels that there are three elements in the makeup of juvenile violent offenders: lack of respect, inability to understand or empathize with another person, and impatience (Hoffman, 1997; Bushman and Anderson, 2001; Regoli et al., 2010; Siegel and Welsh, 2014; American Psychological Association, 2015). The American Academy of Child and Adolescent Psychiatry (2014) contends that children will tend to imitate the violence that they see on TV and other types of media.

In addition to the media, some experts blame today's sports for the increase in violence among young people. Although sports are usually thought to be played for enjoyment and

Research-Informed Practice

Behavior: *Use and translate research evidence to inform and improve practice, policy, and service delivery.*

Critical Thinking Question: What research has been done on TV and other media violence? What do you feel might be a solution to reducing the effects of media violence on children? How might you work with families and children to reduce this impact? How might you become involved in policy change regarding media violence?

relaxation, an intense emphasis on winning can elevate competition to violent behavior. How many children observe hockey players club each other with sticks, football players use more force than necessary, and baseball players spit in the faces of umpires? Although there has always been some degree of highly charged emotions in sports events, the price tag placed on winning now creates an intense and even violent atmosphere (Hoffman, 1997; Bushman and Anderson, 2001; Jamieson and Orr, 2014).

It is not just males, **enculturated** by this society to be more aggressive, who fall under the spell of violence. Noted child advocate and researcher James Garbarino (2006) points to a marked increase in aggression among young girls of today.

Gangs on the Streets

Gangs have been the subject of sociological and psychological study for decades. The classic musical *West Side Story* romanticized the violence of gang warfare, but the reality is not as appealing. Today gangs are responsible for a great deal of the violence perpetrated against teens. They exist not only in urban areas but in suburban and rural areas as well. The National Youth Gang Center survey (2014) reports that in 2012, there were 850,000 gang members across the United States, representing an 8.6 percent increase over the previous year. Although the prevalence of gangs had leveled off overall between 2005 and 2009, there has been an increase in reports of gangs in suburban areas. The number of gang-related homicides increased by 28 percent between 2011 and 2012.

What constitutes a **gang**? A youth gang is a group of teens who band together for a variety of reasons, usually including a sense of belonging and protection. This group, usually between the ages of 12 and 24, identifies itself as a gang using a name and symbols or clothing to stand out. There is an element of permanence in that members band together over time—at least a year or several years and have some organization, some more formal than others. Gangs also claim certain geographic areas as their turf and are involved in some type of criminal activity (Sheldon et al., 2013; Delaney, 2014).

It is difficult to accurately encompass all gang activity in one definition. And there are numerous opinions about types of gangs. Sheldon et al. (2013) suggest that these can be summarized by characterizing gangs as follows: the **Hedonistic or social gangs** enjoy using drugs to get high but have little involvement in violent crime; **party gangs** use and also sell drugs but the only crime in which they engage is vandalism; **instrumental gangs** engage in property crimes but while they use drugs, they do not tend to be into selling them; **predatory gangs** are involved in serious crime and with addictive drugs. They engage in more selling of drugs than a party gang but this is not their main enterprise; **scavenger gangs** engage in petty crimes sometimes just for enjoyment. The members are motivated by a need to belong and enjoy preying on weaker people. They are loosely organized, have no real goals, and do poorly in school; **serious delinquent gangs** are heavily involved in all degrees of crime but in drug use to a much lesser degree that some other gangs; **territorial gangs** exist in a particular geographic area or turf and conflict with other gangs to maintain their ownership of their turf; **organizational or corporate gangs** are heavily involved in crime of all kinds including the sale of drugs. They are organized and strictly disciplined, and advancement in the gang is based on merit; and **drug gangs** are often smaller, more cohesive and their object is the business of selling and distributing of drugs (45). Gangs may also be organized along racial lines conflicting with other ethnic gangs often to defend a turf (Sheldon et al., 2013; Delaney, 2014; Howell and Griffiths, 2016).

Members of gangs may fall into different categories as well. There is the regular or hard-core member who has strong identification with a particular gang and will often remain part of the gang into adulthood; the peripheral or associate members who may have a strong attachment to the gang but are not as involved due to outside interests; the

temporary members have often joined the gang later (14 or 15 years) and are not as committed. They may also come and go; the situational members have limited involvement and may only participate when the gang needs them (e.g., a turf war); and finally the wannabes are youth of 11–13 years who aspire to be a part of the gang and the "could bes" are children under 10 years who have been raised in an environment where their eventual gang membership is probable (Sheldon et al., 2013; Delaney, 2014; Howell and Griffiths, 2016).

Gangs offer youths a great deal in a time of family breakdown and social anonymity. In addition to a sense of belonging, gangs can offer status and a feeling of importance. This is especially true for ethnic groups who band together to cope with the stigma and discrimination of being in the minority. Gangs offer social situations and opportunities to take risks in the company of others who are also taking these risks. Gangs that sell drugs also offer financial gains. With the element of combined power, gangs can exercise more power than individuals and have access to more resources (Garot, 2010; Delaney, 2013).

Case Example The Diablos

The Diablos were a Hispanic youth gang in an old, predominantly Italian neighborhood. Individually, the Mexican boys involved in the gang were not accepted by the old-time residents, but collectively they had made their mark. When the gang entered the local grocery store, the owner knew that it was easier to ignore their shoplifting of candy bars and soda than to repair the damage done when the gang members chose to retaliate because their shoplifting was prohibited. The store owner figured into his budget the loss of his merchandise, and the arrangement persisted for years.

There is some debate as to how much violence among gangs has increased over the years. It does seem clear, however, that the character of the violence has intensified. As this society becomes increasingly violent, the acts committed by gangs become more brutal and less comprehensible. More guns are involved and the rate of homicides has skyrocketed (Sheldon et al., 2013; Delaney, 2014; Siegel and Welsh, 2014; Howell and Griffiths, 2016). Many communities not previously affected by gang activity are finding that the gangs from nearby cities have moved into their area. **Gang migration** explains why many areas not previously plagued by gang activity now feel its impact. Gangs migrate because the drug markets are better or more open in new cities or because individual gang members relocate and form new gangs (Siegel and Welsh, 2014). Today gangs are becoming more prevalent in smaller cities and suburbs. According to a recent survey, 44.1 percent of gangs are in larger cities, 29.1 percent in smaller cities, 21.4 percent in suburban areas, and 5.4 percent in rural areas (National Youth Gang Center, 2010). Hispanic, African American, and white gangs are joined by Asian gangs. Some authors suggest that gangs of minority groups are based on their frustration with their inability to readily integrate into the dominant culture. Not only is English a major stumbling block for newly immigrated youths, but they often do not understand the cultural mores.

For example, traditionally in Asian cultures, problems are handled by the family. But as youths find themselves trying to fit into new-world traditions, they become increasingly at odds with the traditions of the family. Hence, they look for a sense of belonging elsewhere and often find it with their peers, who are experiencing similar conflicts. In addition to belonging, Asian youths find that gangs can bring in money. As they remember the poverty that many of them experienced in their families of origin and observe their parents' financial struggles, because they lack the skills recognized in this new culture and get caught up in the U.S. emphasis on financial success, it is not surprising that easy money has an appeal. Auto theft, drug selling, and armed robbery provide

quicker returns than hard work. Even the risks involved have an allure for teens. War is not foreign to them; many spent their early years absorbing the skills necessary to survive in a war-torn environment. Gang wars and the risks inherent in crime feel old and familiar (Lee and Zhou, 2004; McWhirter et al., 2006; Sheldon et. al., 2013; Delaney, 2014).

The role of girls in gangs has also evolved over the years. Usually studies of females and gangs have concentrated on their roles as auxiliary members of male gangs. Early accounts of female gang involvement were based on the girls' dependence on male gang members. They were largely portrayed as sexual objects who were cajoled, tricked, or forced into sexual relations for the enjoyment of male gang members. A girl's status within the group was largely dependent on her relationship with specific male members, although her allegiances and partners may have changed from time to time. In addition to sexual objects, girls may also have been used as lookouts, drinking partners, and weapon carriers (Chesney-Lind and Pasko, 2003; Miller and Brunson, 2004; Valdez, 2009).

Researchers now suggest that early descriptions of female gang members trivialized their role. New research indicates that females may have strong identities independent of male peers (Valdez, 2009; Sheldon et al., 2013; Delaney, 2014; Howell and Griffiths, 2016). They join gangs for reasons similar to those of their male counterparts (dysfunctional homes, poor economic conditions, and the need for a sense of belonging), and they too may be involved in violent or illegal acts. One difference between males and females in gangs is the length of their membership. Males are more likely to remain in gangs until and into early adulthood while girls are more likely to leave in later adolescence, while they tend to join the gang initially at younger ages (Sheldon et al., 2013; Delaney, 2014).

Contemporary female gang members appear to be organized in one of three ways: as units functioning independently of male gang members, as regular members of mixed-gender gangs, and as auxiliary members of male gang groups. Unlike the boys, the girls are usually not pressured into joining a gang but do so as a result of friendships or network connections. These girls are responsible for their own affairs. They are usually closely knit as a sisterhood and resent the efforts of male gang members to interfere. Girls exert peer influence over the sexual behaviors of their sisters. They are also as likely as male members to engage in fights, violence, and illegal acts (National Youth Gang Center, 2010; Sheldon et al., 2013; Delaney, 2014).

Autonomous girl gangs appear to be gaining prominence although they are nowhere near as numerous as male gangs. Membership in their own female-run gangs provides an even closer sisterhood and saves them from the exploitation they often experienced at the hands of male gang members, although some engage in prostitution for financial gain.

In 2005, Congress passed H. R. 1279, the Gang Deterrence and Community Protection Act, which authorizes increased federal spending to bolster efforts at the federal, state, and local levels to combat gang violence. This legislation also provides funds for education and gang-prevention efforts.



Assessment

Behavior: *Collect and organize data, and apply critical thinking to interpret information from clients and constituencies.*

Critical Thinking Question: What stands out for you from a social work perspective about the Sandy Hook school shooting? Research other school shootings. Are there similarities? Imagine yourself as a social worker given the task of working with the Sandy Hook parents. Where would you begin? Does knowledge of other school shootings aid you?

School Violence and Bullying

On December 14, 2012, 20-year-old Adam Lanza opened fire killing 20 children and 6 school staff members and wounding 2 others at the Sandy Hook Elementary School in Newtown, Connecticut, making this the second deadliest school shooting in U.S. history, surpassed only by the massacre of 32 at the 2007 shooting at Virginia Polytechnic Institute.

While the nation grappled with ways to understand this tragedy, experts searched for answers. Schools instituted more stringent security measures. Concerned parents wondered if it could happen again. This was not the first act of such violence. On April 20, 1999, in the worst incident to date, Eric Harris and Dylan Klebold, calling themselves the "Trenchcoat Mafia," went on a shooting spree that killed 12 students and 1 teacher and wounded 24 others at Columbine High School, Littleton, Colorado. The boys then committed suicide.

One gun safety group reported that since Sandy Hook, there have been 135 shooting in educational in schools and college, with 77 of those in schools of K-12 (see http://everytown.org/article/schoolshootings/ and Infoplease, 2012).

How did such horrendous events take place in our schools? The events of Columbine sparked speculation and research about such issues as gun control and an age-old phenomenon that is recently gaining the attention of school authorities and parents—bullying. **Bullying** is difficult to fully define. It is focused predominantly on playing up differences and using them as tools to hurt (Hamarus and Kaikkonen, 2008; Rivers et al., 2009; Potzner, 2010). The three elements of bullying are the intent to harm, that it is repetitive, and that there is a difference in either physical or social power between the victim and the bully (Jacobsen and Bauman, 2007; Olweus, 2011). Olweus (2011) identifies nine ways in which students complained of being bullied:

- Verbal bullying including insulting comments and negative names
- Through social exclusion and isolation
- Physical bullying such as being kicked, hit, shoved, or spit upon
- The spreading of false rumors or lies
- Having possessions damaged or stolen
- Being threatened or forced
- Racial slurs
- Unwanted sexual comments, attention, or pressure
- Being bullied on the Internet, often referred to as cyberbullying (see Juvonen and Gross, 2008).

Some students are bullied in a variety of ways.

> Georgette was a significantly overweight 10-year-old who walked the several blocks from her home to school and was often taunted en route by neighborhood children who called her names in response to her weight. Trevor, one of her classmates, would often wait for her and walk with her, which he told her was for her protection. But Trevor would then hit her, telling her how stupid she was to let people call her names. He frequently took her lunch saying "Fatty, you don't need this!" or rifled through her backpack taking anything that appealed to him. She longed to be part of the other girl's group at school but Amanda, the apparent leader, encouraged the other girls to ostracize Georgette and sometimes spread rumors about her. Georgette was afraid to tell her parents about any of this treatment, feeling that it was her fault that she was overweight.

Those who bully have been found to have a strong need for power, often because they secretly feel less powerful themselves. Some of these perpetrators find pleasure in the suffering of their victims. They may also be rewarded knowingly or unknowingly by the reactions of their peers or the adults around them (Hamarus and Kaikkonen, 2008; Rivers et al., 2009; Potzner, 2010; Olweus, 2011).

> Nobody messed with Jerry," admitted one student. "We were all afraid he'd turn his bullying on us. I think his dad liked Jerry to be a big guy at school and even encouraged it

when he picked on weaker students. To talk to Jerry, you'd think that it was all tied up in his "being a man." That sounds like something his Dad would have told him. I suspect that if Jerry didn't act like enough of a man in his Dad's eyes, he'd get his fist instead.

On the far end of the continuum of bullying is the bully whose anger intensifies until he is stealing, vandalizing, and even carrying weapons and threatening or shooting others. Ironically, as is suggested about the Columbine shooters, Harris and Klebold, some bullies were formerly victims of bullying themselves (Kellerman, 1999; Daniels and Bradley, 2011).

The effects on the victims of bullying are multifold. Victims often suffer from depression, low self-esteem, and anxiety, which often translates into psychosomatic problems and/or poor school performance and sometimes suicidal thoughts (Hamarus and Kaikkonen, 2008; Miller, 2008; Rivers et al., 2009; Potzner, 2010; Olweus, 2011; Jones and Augustine, 2015; Hartley et al., 2015). There are secondary victims of bullying in that those who observe it often feel fearful and powerless to act, and may then feel guilty about not acting. The psychology of identifying with an aggressor may also lead observers to choose to join in as bullies themselves (Olweus, 2011).

Bullying is often focused on those who appear different such a students identified with special needs. Currently, 95 percent of students with special needs are educated in the regular classrooms with other students. In one study of students in grades 5 through 12, researchers found that students with special needs are more likely to become targets of bullying than those in general education groups (Hartley et al., 2015).

Another population increasingly subjected to bullying are gay, lesbian, and transgender youth. One study of secondary school youth found that 81.9 percent were verbally harassed over the last year and 38.3 percent were physically harassed due to their sexual orientation. Disturbingly 56.9 percent of these students also reported hearing homophobic comments from their teachers or other school staff (Jones and Augustine, 2015).

Bullying does not just take place on the school grounds or neighborhoods. A 2008 study of 1,454 youths between ages 12 and 17 found that of the students studied, 72 percent of those responding reported at least one online experience of being bullied. And 85 percent of these students had also had an incident of being bullied at school. Two-thirds of those who were victimized by cyberbullying knew their perpetrators, and in half of these cases, they knew the bully from school (Juvonen and Gross, 2008).

Cyberbullying refers to harassment or inflicted harm through words and pictures via the Internet using e-mails, texts, chat rooms, blogs, instant messaging, or social networking sites like Facebook. The cyberbullying research center reports that 50 percent of all teens have been cyber bullied at some point and 20 percent are cyber bullied on a regular basis. Much of this bullying is done via cell phones as over 80 percent of students have these. Girls are twice as likely to be bullied in this manner than boys (Waggoner, 2015).

The increased recognition and seriousness of bullying has prompted schools and youth facilities to develop policies and programs to address this problem in an effort to promote safer schools and neighborhoods.

Summary of This Section

- Children in the United States are exposed to a variety of forms of violence including crime and violence in the community, exposure to gangs, and school violence including bullying.

- A significant percentage of children are killed by guns every year and the presence of constant threat can have a psychological impact.
- Not only are children and youth exposed to violence in the community but also the influence of violence comes into the home through the media. TV and other media sources allow youth to view violent acts and can desensitize them to the impact of such violence.
- Sports also models using violence to relate and respond to disagreements in inappropriate ways.
- Gangs have become increasingly prevalent on American streets—not just in large cities but also in suburban and rural areas. Gangs are both male and female and sometimes organized along ethnic lines.
- Bullying has become an increasing problem in American schools, often leading the targets of bullying to become violent themselves. Bullying includes verbal as well as aggressive acts that demean or threaten. The effects of bullying are multifold. More recently bullying has taken a cyber form, which has led to concern over cyberbullying and its impact.

VIOLENCE AT HOME AND IN INTIMATE RELATIONSHIPS

Violence in Families

Many of us think of home as a place of safety. However, it is estimated that 15.5 million children are exposed to violence in their homes (referred to as **domestic violence**) every year (National Network to End Domestic Violence, 2015). For these children, the home is far from a safe place. In addition, children are at significantly greater risk of being harmed either as a result of the abuser's wrath or accidentally.

Spouse abuse has been tolerated for many years. The implications of this type of violence for not only the spouse but the children as well are multifaceted. Shelters for battered wives also report that women leave and return to their husbands numerous times before they are able to break the bond between them, thus compounding the exposure children have to such violence. Although men can also be battered, males as batterers tend to do more harm. Studies show that nearly 11 percent of males who batter their wives end up murdering them (Zastrow, 2009; Buzawa et al., 2011).

Men batter their wives for a variety of reasons. Many share the stereotyped view of women as submissive individuals who should do their bidding. When the woman resists, the man cannot tolerate it. Most have poor self-images; having power over another enhances their self-esteem. The cycle of violence is well known. When a husband batters, he usually escalates from verbal assaults, such as finding fault and name-calling, to physical aggression. Following the beating episode, he is usually guilty and contrite, often apologizing and "trying to make it up" to the victim. It is this inconsistency that causes many women to assume things will be better and to remain in the relationship. In addition, battered women often come from backgrounds in which abuse was the norm. Violence in their marriages seems all too familiar to them. A seeming paradox, the familiarity gives comfort. Women may also be financially dependent on their husbands. And, trained by society to be the peacemakers, women often strive for harmony rather than confront the impossibility of their situations (Zastrow, 2009; Buzawa et al., 2011).

It is the effect not only on the victim but also on her children that concerns child welfare experts. From watching their mothers, battered children learn that this is an acceptable way to treat women (Bancroft, 2005; Buzawa et al., 2011). Some children **identify with the aggressor**, a less-threatening stance than becoming victims themselves. This may put them at risk for being an abuser when they later become involved in intimate relationships. This may also cause them to criticize the victim or even abuse her when they become older and stronger. Other children identify with the victim, feeling fearful, withdrawn, and depressed. Children from families fraught with domestic violence grow up to exhibit low self-esteem, depression, developmental delays, acute anxiety, rage, conduct disorders, chronic fear and rage, self-blame, and heightened suicide risk, and they are more prone to be violent toward others. These children learn poor boundaries and how to use deceptiveness, lying, and cheating as protection. These behaviors often spill over into their dealings with others, especially at school (Bancroft, 2005; Buzawa et al., 2011; Crosson-Tower, 2013).

Case Example The Cordovas

The Cordovas were typical of families in which violence is the norm. Will Cordova, trained as a military police officer, expected that his family would respect him. With a history of violence in his own parents' home, Cordova had had no other model. Tess Cordova, his wife, had also grown up in an abusive household, but when Will showered her with attention between his bouts of anger and abuse, she came to believe that she had married a good man who occasionally was "a bit demanding." The Cordova children, Matt, age 10, and Belle, age 7, cowered in the corner when their father began to shout and hit his wife. But soon Belle, always her father's pet, saw that siding with her father against her mother met with more approval from her powerful parent and earned her special attention. When Will was out of the house, Belle began to criticize Tess and eventually began to hit her as well. Matt, on the other hand, felt protective of his mother but was too fearful to oppose his father. It was not until he was 15 that Matt found the gun with which his father had threatened his mother and shot his father. Although Will was not seriously injured, the incident served to cause the family finally to seek help.

For a discussion of the abuse of children, see Chapter 8. Although obvious aggression toward children is easily labeled child abuse, Graziano (1994) suggests that there is a phenomenon he calls "subabuse," which cannot be as readily characterized as abusive but is nonetheless harmful. Subabuse includes acts of violence that do not reach the proportions that are categorized as abuse. These include various forms of corporal punishment such as spanking, whipping, and hitting. He suggests that these seemingly acceptable forms of child rearing may also convey to children that violence is condoned and cause them to replicate this behavior with their own children. Graziano urges researchers to continue to study the effects of subabusive behavior on children.

Parent abuse is also exemplified in the Cordova scenario. When children observe one parent being abused by the other, they often identify with the aggressor and adopt the battering behavior themselves. Elder abuse occurs when an adult child batters his or her elderly parent, grandparent, aunt, or other elder. For children, this can also have an impact. When the child sees a weaker person being subjected to abuse, that child may either identify and feel threatened or take on the aggressive behavior as well. Even if a child adopts neither of these stances, witnessing the abuse of an elder can have a significant effect on the child's relations with the family or view of interpersonal relationships.

The home should be the child's haven. When violence permeates the home environment, the effects on children cannot help but be significant.

Peer Violence in Relationships

The violence among teens in dating relationships has increased in the last decade (Sanders, 2004; Bowen and Walker, 2015). In a survey of over 4,000 high school students, Silverman et al. (2001) found that one in five girls reported being physically or sexually abused by their dating partners. Sexual assault, often termed **date rape**, appears to be related to specific attitudes and accepted behaviors among adolescents. The first attitude, still present despite the influence of the women's movement, is that girls should be submissive. Romance novels and popular TV shows perpetuate the image that females desire to be overpowered sexually. In addition, the popular assumption that males cannot control their sexual urges adds fuel to the fire. When a girl "leads a boy on" sexually, the myth is that he has the right to continue the sexual encounter (Sanders, 2004; Zastrow, 2009). Currently estimates are that as many as 40 percent of teens are involved in teen dating violence (Offenhauer and Buchalter, 2011).

The use of substances, especially alcohol, also influences aggression between adolescents. Not only does alcohol lower inhibition, which might otherwise prevent both sexual and aggressive behavior, but it can also be used as a rationalization for aggression.

In addition to sexual violence, teens are now more likely to engage in physical abuse by slapping, pushing, and grabbing in relationships. Contrary to popular opinion, studies have shown that females are more likely than men to aggress against their partners but less apt to cause severe harm when they do (Sanders, 2004). Females' aggression was viewed less negatively, however, than that of their male counterparts. Acting out aggressively was often based on jealousy or the inability to successfully negotiate disagreements.

Why is there more violence in peer relationships? Some feel that because dating is an opportunity to rehearse later marital roles, the increase in domestic violence has an impact on the current rate of dating violence (Offenhauer and Buchalter, 2011; Bowen and Walker, 2015). In addition, the predisposition in this culture to use violence instead of negotiation is mirrored in intimate and peer relationships. Peer mediation in schools is one technique that appears to be having some impact on the incidence of peer violence.

Summary of This Section

- Approximately 15.5 children witness domestic violence each year often perpetrated by their male parent. The victim will usually leave and return several times exposing the children to increased levels of violence.
- Men batter their wives for a variety of reason including to enhance their self-esteem and to feel powerful. The abuse often escalates from verbal assaults to physical aggression.
- Children witnessing violence at home learn that such behavior is acceptable and may identify with the batterer for their own safety. Witnessing such violence results in psychological symptoms including low self-esteem, depression, developmental delays, acute anxiety, rage, conduct disorders, chronic fear and rage, self-blame, and heightened suicide risk, and increased violence toward others.
- There is increased violence in teen dating relationships over the last decade. The use of substance may increase the likelihood of such abuse. Peer violence may take the form of verbal insults and escalate to physical aggression.

CHILDREN AND THEIR PARENTS' SUBSTANCE ABUSE

Why combine the topics of violence and **substance abuse** in one chapter? There is good reason to do so. Over and above the fact that abusing substances is a form of violence to the body, those who are involved in substance abuse, especially street drugs, are often no strangers to violence. Robberies are often perpetrated for the purpose of finding the money for drug. Those who abuse substances are often involved in crimes. Interwoven in the mosaic of violence are statistics about the increase of substance use and abuse among not only adults but children and adolescents as well. The dimension of substance use and abuse as it affects children can be seen at two levels: the effects on substance-abusing or addicted parents and on addicted children.

Substance-Abusing Parents

In the United States today, substance abuse has become an alarming reality. When parents abuse drugs or alcohol, the impact on their children is profound. Nearly 8.3 million of today's children under 18 live with at least one parent who is dependent upon illicit and addictive drugs or alcohol (Hedges, 2012). The use of drugs and alcohol can greatly diminish one's parenting ability. Substance-abusing parents can neglect, emotionally and physically abuse, sexually abuse, and even abandon their children, not to mention present a model of individuals who cannot control their own lives. The correlation between substance abuse and family violence is significant (Bancroft, 2005; Solus et al., 2012; Suchman et al., 2013; Ruiz et al., 2014). And, research on the children of alcoholics indicates that there is a biological risk for alcoholism passed from parents to children. Also, mothers addicted to drugs and/or alcohol may well pass the effects on to their newborns. Parents who abuse substances tend to be less responsive to their children's needs failing to express affection, encourage their children or interact with them in meaningful ways. This may lead to insecure attachment in children. In addition, children of substance-abusing parents are more likely to demonstrate poor academic performance, more likely to internalize their feelings creating anxiety, depression, and low self-esteem or to externalize their upset by developing conduct problems and aggression (Solus et al., 2012).



Assessment

Behavior: *Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary frameworks in the analysis of assessment data from clients and constituencies.*

Critical Thinking Question: How does substance abuse manifest itself across the life cycle? What factors contribute to such abuse in each age group? What problems might arise for each age group of children within their social context when they are dealing with substance-abusing parents?

Addicted parents come from all socioeconomic levels, but it is often the additional factor of poverty that brings them to the attention of child welfare agencies. Parents at higher income levels are often able to pay for outside childcare when their addiction prevents them from parenting adequately. How many prominent community figures have been stopped for driving under the influence but have not been referred to children's services for neglecting or endangering their children?

Fetal Alcohol Spectrum Disorders

Studies done on infants born to alcoholic mothers point to the possibility that alcohol abuse during pregnancy can leave the child with **fetal alcohol spectrum disorders (FASD)**, often referred to as **fetal alcohol syndrome (FAS)** or **fetal alcohol effects (FAE)**. FAS involves a variety of physical and psychological defects in children, including low intelligence or developmental delay, physical abnormalities (including characteristic facial features), hyperactivity,

impaired development, and failure to accurately distinguish cause and effect (Zastrow, 2009; Abel, 2013; Murawski et al., 2015). These symptoms result from the fact that when a pregnant woman drinks, alcohol crosses the placenta, creating in the fetus the blood-alcohol levels present in the mother. Such babies are also more likely to be born prematurely, have low birth weight and neurological defects, and become extremely irritable. The greater the amount of alcohol the pregnant woman drinks, the greater her chances of producing a baby with FASD. Studies indicate that five drinks or more at a given time produce a 10 percent chance that the baby will have FAS. Even an ounce a day can result in a 10 percent chance, whereas two ounces results in a 20 percent possibility, and so on (Golden, 2005; Zastrow, 2009; Murawski et al., 2015). The difficulty is not only in the effects on the infant; drinking alcohol may also affect the mother's ability to care for her child.

Case Example Ellen

Ellen drank heavily during her pregnancy. She and her live-in boyfriend, Greg, had been drinking partners before her pregnancy, and her fear was that she would lose him if she did not go out drinking with him. Their relationship had been a fairly satisfying one until she became pregnant, but now Greg's annoyance about her getting pregnant was putting pressure on their interactions. Barbie was born prematurely and weighed only 4 pounds. She had "a funny little face"; her eyes were far apart. Her first few weeks were spent in the neonatal intensive care unit with her anxious parents looking on. When they were not with her, however, they would drink to drown their fears and distress. Ellen had heard that she should not drink during pregnancy, and she blamed Barbie's sickly first weeks on herself. When the infant finally did come home, she was fussy and wanted to eat constantly. Ellen was exhausted, and Greg soon tired of the routine. Barbie's poor muscle tone and constant crying sent Ellen to the clinic in tears. When the clinic diagnosed a heart defect, Ellen could not be consoled. She cried constantly and drank continuously. Greg left them. A neighbor, hearing the baby's cries and finding Ellen drunk and asleep as she had many times before, called the protective services agency.

The reality of her drinking being manifested in Barbie's FAS greatly affected Ellen's ability to parent and made her want to drink more to escape her problems.

FAE entails less dramatic symptoms. The mother may have ingested less alcohol, or the child may have escaped alcohol's full effects for some other reason (Golden, 2005; Abel, 2013; Murawski et al., 2015).

Due to the high incidence of FASD, a federal law was passed in 1989 that required manufacturers to put warnings on the labels of alcohol products that they can adversely affect fetuses. Yet, it remains the mother's responsibility to protect her unborn infant. This may change in the future because some child welfare advocates and lawmakers feel that abusing substances—drugs or alcohol—during pregnancy should be considered a form of child abuse (Boyce, 2010).

Effects of Parental Drug/Alcohol Addiction on Infants

Drugs and alcohol not only affect children in utero; they also can have a significant effect on the newborn. Statistics tell us that there are still a significant number of mothers who have used crack and cocaine, marijuana, hallucinogens, stimulants, and sedatives during pregnancy, and an even greater number who still use alcohol during this important prenatal period. The result is that babies may be born addicted or suffer the effects of their mother's substance use. Nurses in neonatal facilities can describe the heart-wrenching experience of watching newborns go through withdrawal symptoms from the drugs or alcohol that were present in their first environment, the mother's body. The effects of such withdrawal are still being researched. There

is evidence that some types of drugs leave long-term effects, whereas others exit the system within hours or days (Zuckerman et al., 2000; Zastrow, 2009; Lewis et al., 2015). For example, babies born to mothers who are addicted to crack cocaine experience significant effects at birth. The drug has a physiological effect on the mother, causing her blood vessels to constrict, resulting in a decrease in the flow of oxygen and nutrients to the fetus. During the first months of life, deprivation of such important elements and of proper blood supply caused by the mother's use of cocaine negatively impacts the baby's cognitive development. Although the baby may appear normal at birth, he or she will later appear smaller, with a diminutive head circumference that is often associated with lower IQ (Zastrow, 2009; Lewis et al., 2015). So-called **crack babies** can have numerous deformities from which they never recover; they require extensive treatment and a variety of services to survive.

Children whose parents are addicted to other narcotics may go through withdrawal soon after birth. Withdrawal symptoms often include chills, severe cramping, sweating, nervousness, vomiting, dilated pupils, respiratory problems, and muscle aches. Hallucinogens can cause genetic damage in children. Since all the eggs for her lifetime are present in a female at the time of her birth, her use of such drugs may cause abnormalities for the next generation (Zuckerman et al., 2000; Zastrow, 2009).

In addition to the chemical aspects of parental substance abuse, parents who abuse drugs or alcohol are less able to care for their infants. Children whose parents are under the influence of drugs or alcohol may have difficulty bonding because the care they receive may be inconsistent. Their basic needs may not be met in infancy while their parents pursue their habit. As they grow older, they may become the caregivers for younger siblings and take on the role of parentified child (the child who meets adults' needs) (Bancroft, 2005).

Case Example Marcy

At seven years old, Marcy became her mother's caregiver. Early in the morning, she would awaken to find that her mother had already given herself a shot of heroin and was drifting in her own world of fantasy. Marcy would bathe her, try to get her to eat, and prepare for her own day. She got herself off to school and got herself dinner in the evening with food that a neighbor brought in. Only rarely was her mother not "strung out." If she tried to kick the habit, she would become very sick, and Marcy would take care of her. It was the only life that Marcy knew.

Marcy is not unlike many children of addicted parents. When Marcy's mother began to work as a prostitute to support her habit, the child was exposed to a variety of men and sexual acts. It was not surprising that, at age 9, she was sexually abused by one of her mother's johns.

Frustrations inherent in caring for babies can lead to further substance abuse, feeling overwhelmed, resenting the baby, abusing or neglecting the child, or withdrawing from the parenting experience altogether. Many young women are totally unprepared for motherhood. Especially if she comes from a substance-abusing family, the mother may have no healthy models of parenting to follow. Her hormone imbalance after childbirth may make her emotions volatile, and the chemical effects of her abuse during pregnancy may create a fussy baby who further challenges her.

Addicted Parents and Preschool Children

Toddlers need to explore their world but have a safe place to which to return. Substance-abusing parents may not be able to provide the consistency and nurturance that translates into a "safe harbor" for their toddlers. The child who is just about to enter school has already begun to engage in internal dialogues about his or her view of the environment and the ability to cope with it. Inconsistency and a parent who is out of control or constantly criticized

by the other parent for addictive behavior do not provide the safety or modeling that help the young child develop the internal controls to cope with the environment. The child who has two drug/alcohol-addicted parents has even fewer resources with which to work. The ability to put his or her experiences into perspective becomes affected, and his or her reality testing is impaired (Zuckerman et al., 2000; Ruiz and Strain, 2014; Lewis et al., 2015).

Addicted Parents and Older Children and Adolescents

A child whose reality testing is impaired will have difficulty accepting and abiding by rules and will not have the skills necessary for learning. His or her peer relations may also be impaired. Being a parentified child is not uncommon, and it is likely that such a child will be diagnosed in school as learning disabled, hyperactive, acting out, or even having a borderline personality. Because domestic violence and child abuse and neglect strongly correlate with substance abuse, the child may also carry the scars of these problems (see Chapter 8). Sleepiness in class may indicate that the child has had little sleep as he or she hears drunken parents fight or cringes in bed wondering when she or he will next be physically or sexually abused (Zuckerman et al., 2000; Crosson-Tower, 2013).

For adolescents, a major developmental task is the consolidation of identity, which involves planning for the future and separating from the family of origin. It is difficult to complete these tasks effectively when besieged by the family problems brought on by substance abuse. The adolescent may also have developed survival skills that are not necessarily functional in other parts of his or her life.

Case Example Callie

Callie was the eternal caregiver. She had learned early in the home of two drug-addicted parents that to stay out of the way, unless one or the other parent needed something, was the best course of action. As her parents began to deteriorate, she took on more and more responsibility. It was actually due to her ability to cover up their addiction that the school and the protective agency did not recognize the full extent of the problem. In school, she was described as "bossy." "Callie is a real manipulator," said one teacher, "and she often antagonizes others by her need to be in control all the time. In addition, when the other children do something they should not, she is always there to clean up after them. We used to think she just wanted so much to be helpful and liked, but it seems like more than that. She really doesn't seem to care if she's liked. It just seems like a compulsion to do everything for everybody."

Practicing Alcoholic/Addicted Parent (PAAP) Syndrome

The children of addicted parents are seen in many social agencies for a variety of reasons. The alcoholism/addiction of their parents creates in them a wide number of symptoms, some physiological, some emotional, and some perceptual. Some theorists see these issues as falling into several categories: the parents' ability to perceive information correctly (perceptual); their ability to learn and understand (cognitive): their variable and often unpredictable responses (affect); their mood, which may be anywhere from apathetic and complacent to compulsive and driven (motivation); their relationship skills (social); their activity level, which might be hyperactive and lack coordination (motor); their self-concept, which may be characterized by poor self-esteem, inability for self-care (self-regulation); and their ability to cope with stress meaning that they may be plagued by somatic complaints, sleep issues, inability to concentrate and a variety of other problems related to stress (Suchman et al., 2013).

Children of Addicted Parents and the AIDS Epidemic

In the year 2010, in the United States, approximately 217 children under the age of 13 years were diagnosed with the HIV infection. The major of these were infected perinatally through their mother's pregnancy, their birth, or through breast milk. Among these numbers, the highest percentage of prenatally infected children were African American (CDC, 2011). Since the beginning of the HIV/AIDS epidemic, 10,769 children under 14 years of age and 7,214 adolescents between ages 15 and 19, living in the 50 states and the District of Columbia, have been diagnosed with AIDS (CDC, 2011a).

There are two ways in which children of chemically dependent parents are affected by the HIV/AIDS epidemic: as bystanders watching their parents, who are victims of the disease, and through contracting the disease either in utero or at birth or from an infected parent. Parents may have contracted the disease themselves either through intravenous drug use (from the small amount of blood left in shared needles) or sexual contact with someone who was infected. There are also a small group of people who developed the disease as a result of a transfusion in the early years before the testing of blood was perfected.

AIDS was first brought to light in the early 1980s when it appeared to be affecting primarily homosexual men and intravenous drug users. Now the disease has become a household word and has affected millions of people. The epidemic has increased among ethnic minorities and women. Today AIDS is the leading cause of death among African American and Hispanic children (Forsyth, 1995; Geballe et al., 2011; CDC, 2012). The disease is spread through the sharing of blood or other bodily fluids from one person to another as well as through sexual contact. Although most parents do not have sexual contact with their children (except in the case of sexual abuse), they may come into contact with their children's blood, and vice versa. Breast milk is also thought to transmit the virus. HIV-positive mothers face not only living with their infection but the guilt of what they have inflicted on their children (Geballe et al., 2011). Unlike adults, for whom the onset of AIDS can take time, children tend to develop symptoms very quickly. Of children exposed at birth, 70 percent develop symptoms by about 1 year, and 17 percent of those die within the first year (Forsyth, 1995).

Contracting AIDS in utero means that the infection in the mother's system has crossed the placenta. The virus attacks the white blood cells in the baby's system and impedes the development of the baby's immune system. The immune system is activated by T cells, sometimes called "helper cells." These vital cells impede the reproduction of unhealthy cells that might harm the body. HIV attacks the T cells in order to reproduce. Once weakened, the T cells are incapable of doing their work, and the AIDS cells become stronger. When babies are born, they first have B cells, small cells that are present for only the first few days of life. When the AIDS virus attacks the B cells, the immune system is weakened. When, several days after birth, the T cells begin to develop, they may already be weakened and impeded in their growth. The baby may then be said to be HIV-positive when tests for AIDS come up positive. It is possible for some babies' immune systems to recover, however. A baby diagnosed positive at birth may later shake off the virus. For other babies, the damage has been done; they often die within the first year. Death is not actually from AIDS but from other infections that take hold as a result of an inefficient or inactive immune system. For example, *Pneumocystis carinii* pneumonia (PCP) is a frequent killer of individuals with AIDS (Roberts, 2002).

Contracting AIDS in childhood is less likely but certainly possible. An increasing number of children contract the virus because they were sexually abused by someone with AIDS.

Effects in Later Life of Having a Substance-Abusing Parent

Some children of addicted parents are not strangers to sexual and physical abuse, violence, and being used to carry or buy drugs or alcohol. Many of these develop a variety of survival strategies that protect them against a world that has not treated them kindly. They may hoard, lie, steal, and physically assault others as they imitate what they have seen. Seeing their parents' addicted behavior, they may decide to try drugs or alcohol themselves. Others react in the opposite way and become almost phobic about substance use. Many carry the scars of their parents' addictions into later life.

Adult children of substance-abusing parents battle with the need to control; denial of feelings; lack of trust, guilt, fears, or difficulty with intimacy, depression, or sadness; "black and white" thinking; an excessive need to please; and an exaggerated sense of responsibility. These traits may cause these individuals to have problems in their intimate relationships; in finding, keeping, or enjoying a job; and in regulating their lives in general. It is not uncommon for them to turn to chemical dependency as a way of escaping or coping with their feelings of inadequacy or lack of control. In addition, there is much research to suggest that the chemical predisposition adds to the emotional need to become drug dependent (Woititz, 2002; Zastrow, 2009; Solus et al., 2012).

Summary of This Section

- Children and youth are impacted by substance abuse in two ways: when their parents abuse substances and/or addicted or when the children or youths themselves are addicted.
- Parents who abuse substances are more likely to neglect their children; emotionally, physically, or sexually abuse their children; or be unable to meet their children's needs or demonstrate consistency in care taking, which may in turn lead to the children's insecure attachment. These parents may also abandon them. There may also be a biological and psychological risk that children of alcoholic parents may become alcoholic themselves.
- Pregnant women who abuse alcohol may give birth to children with fetal alcohol spectrum disorder (FASD), which is a continuum that describes the biological impact on their children. Fetal alcohol syndrome (FAS) may lead to physical and psychological abnormalities such as developmental delay or low intelligence, impaired development, hyperactivity, and a variety of learning issues. Fetal alcohol effects (FAE), although impacting children less severely can nonetheless affect their development.
- Children experience a variety of different effects from their parents' substance abuse depending on the children's level of development. Infants are not only affected physically but addicted parents may be unable to care properly for their babies. Infants may also go through withdrawal if their mothers have used street drugs during their pregnancies.
- Older children and adolescents of substance-abusing and or addicted parents may have difficulty in developing, learning, and achieving. Some children are also infected with HIV/AIDS from their parents. The effects of parental substance abuse can create long-term results for their offspring.

CHILDREN AND ADOLESCENTS WHO ABUSE SUBSTANCES

A recent survey reported that in 2014, 22.6 percent of adolescents in grades 8, 10, and 12 consumed alcohol, with 11.9 percent admitting to have been drunk. In addition, 14.4 percent have used marijuana or hashish and 5.4 percent have used an illicit drug other than marijuana including amphetamines (3.2%), tranquilizers (1.5%), inhalants (1.4%), hallucinogens (1.0%), heroine (0.3%), cocaine (0.7%), and crack (0.4%) (Johnston et al. 2015).

The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that in 2013, 8.8 percent youths between 12 and 17 were illicit drug users. At the same time, SAMSHA estimated that 2.1 percent of teens between 12 and 13 years, 9.5 percent of 14- and 15-year-olds, 22.7 percent of 16- and 17-year-olds, and 43.8 percent of 18- to 20-year-olds consumed alcohol. Those reporting binge drinking were 0.8 among 12- and 13-year olds, 4.5 percent for 14- or 15-year-olds, 13.1 percent for 16- or 17-year-olds, and 29.1 percent for persons aged 18–20 (p. 36).

The rate of males from 12 to 20 who drank alcohol (11.2%) was similar to their female (11.9%) counter parts, Racially, the rates of current alcohol use were 8.0 percent among Asians, 8.2 percent for Native Hawaiians or Other Pacific Islanders, 9.3 percent for American Indians or Alaska Natives, 9.7 percent for African Americans, 10.7 percent for Hispanics, and 12.9 percent for whites. The rates for Hispanic and white youths were lower than those reported in 2012 (12.8% and 14.6%, respectively) (SAMSHA, 2014, 38).

Case Example Dominic

Dominic began drinking alcohol at age 8. "My friend's old man used to buy us six-packs," he reports. "He thought it was a riot to see us get wasted [drunk]. We used to try and hold our liquor just to get at him. Then over the years we could drink a lot more." His drug habit began soon after. A neighbor offered him a bag of marijuana and later got him hooked on cocaine so he could "study better." By age 15, Dominic had a serious drug and alcohol problem.

Although adolescents are seen as the primary users of all types of substances, children are using all types of drugs at younger and younger ages. The drugs of choice tend to be marijuana and inhalants. A smaller number of youths also use cocaine, hallucinogens, sedatives, and stimulants. Some drugs are of more concern than others. For example, a variety of substances used in the home or also so-called **designer street drugs** plague emergency rooms and drug prevention agencies across the country. Designer drugs are those that are created in a laboratory or at-home settings by changing the properties of a drug that comes from a plant—such as cocaine, morphine, or marijuana—using the tools of chemistry.

One at-home substance, bath salts (also known by the names Vanilla Sky and Ivory Wave) have a similar chemical composition as cocaine and crystal methamphetamine and have been responsible for a numerous overdoses. When ingested, inhaled, or injected, bath salts cause disorientation, racing heart, and confusion along



Intervention

Behavior: *Critically choose and implement interventions to achieve practice goals and enhance capabilities of clients and constituencies.*

Critical Thinking Question: What do you feel are the solutions to adolescent alcoholism? Imagine yourself counseling a teen who is an alcoholic. Where would you begin? What type of program might you design to stem the tide of adolescent substance abuse?

with the euphoric effects. Over the long term, abuse of this drug caused skeletal muscle breakdown, kidney failure, and death. Spice, another newer concoction, sometimes called K2, moon rock, or fake marijuana, is a typical designer drug, similar to marijuana and also created from plant materials. Sold as incense, Spice is also smoked and can cause drowsiness, paranoia, nausea, appetite loss, hallucinations, and rapid breathing. Over time, it can be addictive (National Institute on Drug Abuse, 2015). Other drug variations continue to be developed.

There is some thought that there has been an upsurge in drug use since 1997, but most recent studies report that we may be entering another period of slight decrease (SAMHSA, 2011). Although these statistics apply to adolescents, the rates of drug and alcohol use among younger children have been only anecdotal. Yet, teens or adults who drink or use drugs often report beginning at a very early age, and more recent studies disclose that children in eighth grade and younger may still have illicit drug involvement (Woititz, 2002; Siegel and Welsh, 2011; National Institute on Drug Abuse, 2015).

What causes children and adolescents to become chemically dependent? Experts on substance abuse and children cite social isolation as a factor that can predispose them to addiction to substances. Poor self-concept may lead both young and older children to find compensation through drugs. Certainly, these factors also play a role in the substance abuse of adolescents, but there are other important factors as well (see Hunt et al., 2010; Siegel and Welsh, 2014).

A number of developmental issues and societal influences affect an adolescent's likelihood of becoming dependent on drugs or alcohol. Developmentally, teens go through many changes. The peer group becomes increasingly important as adolescents strive for independence from authority figures. Thus, they rebel against the attitudes of their elders, paradoxically mirroring the behavior they may have observed.

Case Example Jan

Jan's parents were alcoholics during her younger years. When she was 6 years old, her father was laid off and forced to attend an alcohol rehabilitation program before he could be reinstated. He began to attend Alcoholics Anonymous (AA) and pressured his wife to become sober. Finally, when Jan was 9, her mother too started recovery. During her early teens, Jan watched her parents conscientiously attend AA meetings and work hard at their sobriety. This effort was combined with their lectures to their daughter about the evils of alcohol and how she should never drink lest she become addicted. Jan promised that she would not drink, but she was constantly frustrated by the taunts of her peers. She convinced herself that a few smokes of pot would feel good and would not betray her promise to her parents. But the more they urged her not to drink, the more involved she became in drugs, first pot, and later cocaine. By age 17, the same age at which her mother had become alcohol-dependent, Jan was as addicted to drugs.

Even teens whose parents do not have a substance abuse problem may find themselves becoming involved with substances as a way of asserting their independence.

One thing that adds to teens' perceptions that using substances makes them more important is the influence of the media. The prominent message on TV and in the movies is that substances are fun and give one a cool or powerful appearance. Even the efforts made by drug prevention programs do not obliterate these strong subliminal messages (Hilarski, 2005; Flowers, 2008; Siegel and Welsh, 2014).

Adolescents are also influenced by their peers, many of whom use substances. Some studies conclude that teens actually select their peers depending on the amount of drug use they find comfortable. Preoccupation with acceptance by others is paramount in the teen years, and if peers choose to do drugs, other teens feel compelled to go along (Ross, 2002; Hilarski, 2005; Sheier, 2015). For some, their peer group is the gang that may be involved in taking or selling drugs (Glick and Moore, 1990; Flowers, 2008; Siegel and Welsh, 2014; Sheier, 2015).

Drugs and alcohol also become antidotes for the pain and stress of growing up. Minority children who face discrimination on a daily basis, the children of the poor, and children from dysfunctional homes soon learn that a high is more pleasurable than dealing with the realities of their lives. Besides major life crises, all manner of issues can be stressful for the vulnerable adolescent, such as failing a test in school, being shunned by a member of the opposite sex, moving to a new town or school, or having one's parents go back to work.

Finally, many adolescents are attracted to the thrill and risk of taking drugs. For those under the legal drinking age, alcohol is illegal. And illegal drugs, especially marijuana, cocaine, crack, and hallucinogens, are the substances most likely to be used by youths. With all these chemicals, there are risks to getting, possessing, and sharing them. There may also be a profit motive if the teen sells them to others.

Case Example Sean

At age 9, Sean started taking one beer at a time out of his father's supply and selling it to a teen down the street. He next experimented with taking two and drinking one himself. When a friend asked to share with him, Sean suggested that he would sell half the can for 25 cents. As he grew older, his friends were able to get alcohol themselves, and his trade lost its appeal. When a local drug dealer suggested to 13-year-old Sean that he sell bags of drugs, the boy agreed. By this time, it felt good to have his own money. He reasoned that the market for his product had dried up, so he needed another one.

Society's emphasis on chemicals is obvious: There are TV ads for every type of substance to heal or alleviate every type of condition. From this, teens learn that substances have a miraculous effect. This, combined with the culture's need for the quick fix and the emphasis on power and control, conveys the message that if substances help in these areas, they are well worth the risks.

Effects and Treatment of Adolescent Drug Abuse

Adolescents who are chemically dependent are usually experiencing problems in many aspects of their lives. Research indicates that these problems include attendance and discipline difficulties in school; withdrawal from and conflict with the family; fights with or withdrawal from the peer group; stealing; absenteeism; decreased participation in school- or work-related activities; and anxiety, injury, accidents, or suicidal ideation that affect health. As an adolescent's addiction progresses, a variety of factors influence the addiction pattern and therefore which type of treatment will be most effective. Influencing factors are environmental variables such as drug availability, drug cost, and the models (other teens or adults) who also use drugs/alcohol. In addition, the teen's family history, personal traits, and developmental issues will be important (Ross, 2002; Hilarski, 2005; McWhirter et al., 2006; Kaminar, 2010; Sheier, 2015).

Less attention has been paid to the definitions of types of treatment needed for adolescents than to assessing and documenting the problem of adolescent substance abuse. Part of this problem is related to the fact that there has been little differentiation between adolescents' and adults' treatment needs; adolescents are at a significantly different developmental level. Treating adolescent abuse also involves telling parents that their son or daughter has a problem—a fact that many parents prefer not to face (Hilarski, 2005; Kaminar, 2010; Sheier, 2015).

Experts suggest three types of treatments for adolescents: (1) drug-free treatment, (2) detoxification, and (3) maintenance. *Drug-free treatment* refers to counseling the teen without the use of medications. This is often used when the addiction is not so far advanced that the individual is unable to abstain. When the dependence has reached the point of chemical addiction, detoxification may be necessary. *Detoxification* is often undertaken in the same units that house adults. Increasingly, however, there is a recognition of the need for specialized services due to the inexperience of teen substance abusers. *Maintenance* refers to the use of some type of medication, such as methadone, and is usually employed only with long-term addicts (Ross, 2002; Hilarski, 2005; Kaminar, 2010; Sheier, 2015).

Due to recognition of the increased problem with adolescent substance addiction, treatment programs designed specifically for this population have increased in the last few years. Some are conducted on an outpatient basis; others require a stay in an inpatient setting. Self-help groups such as AA are expanding their programs to include adolescent services. Current research emphasizes the importance of "multisystematic treatment," which looks at the family and seeks to make changes there (Siegel and Welsh, 2014).

Because of concern with the magnitude of the problem of substance abuse among young people, programs have been developed across the country that seek to provide primary prevention. Such programs strive to enhance parent–child relationships that contribute to the later ability of youths to talk to their parents about things that bother them and resist the temptations of taking drugs as an escape or due to peer pressure. Schools, too, recognize the need for early intervention if the substance abuse problem among youth is to be addressed.

Whether the substance abuse problem is with the parent or with the child or adolescent, the issues are significant. Much additional research and attention will be needed in the years to come to combat the problems in this area.

Summary of This Section

- Recent studies have reported that 8.8 percent of youths from 12 to 17 are using alcohol with 22.6 percent in grades 8, 10, and 12 admitting to having a drink during 2014.
- The rate of males who drink is not significantly different from females. The rate is highest among whites, followed by Hispanics, African Americans, Native Americans, and Asians.
- Adolescents are also using street drugs at young and younger ages. Most use marijuana, but others use hallucinogens, amphetamines, cocaine, and crack cocaine. Of particular concern are drugs that are easily accessible as they can be created from everyday substances. Two of these are bath salts and a plant-based drug called spice or fake marijuana.
- Experts relate that children and youths may become drug dependent as a result of factors that predispose them to drug use including social isolation, low self-esteem, peer influence, an interest in thrill seeking, and the availability of drugs.

- The use of substances by youths can create school difficulties, alienation from family, aggression, crime, injury, suicidal ideation, and other health problems.
- There is a need for adolescent-specific drug treatment programs as well as programs for primary prevention.

SUMMARY

- Increasingly, children are exposed to violence on the streets and in their homes. Some people feel that the media and the violence in sports activities play a large role in desensitizing people and normalizing violent behavior. One manifestation of violence—gangs—has become a significant problem. Gangs offer youths a sense of belonging, a feeling of purpose, and often the thrill of risk taking.
- Relationships, too, have become violent for many teens. These abusive relationships often carry over into the home environment, creating men who sexually or otherwise physically abuse wives. Battering, in turn, has an effect on the children by making them fearful and guilty as well as causing them to repeat the cycle of abuse.
- Children are affected by substance abuse when they watch their parents abuse substances and when they themselves become substance abusers. Children whose parents abuse alcohol or drugs may suffer physiological symptoms, such as FASD, or may suffer from withdrawal at birth from some kind of drug. These chemicals can leave children with permanent impairments. In addition, children whose parents are chemically dependent are affected psychologically and may end up becoming caregivers of both their addicted parents and younger siblings and having psychological scars. Some children also contract HIV from substance-abusing parents.
- Many chemically dependent children are attempting to cope with lives that are less than satisfying. Others become addicted as a result of peer influences. The notion, often perpetuated by the media, that a quick fix is a thrill is another allure of taking drugs. For chemically dependent youths, there are often limited treatment resources, although the number of such services appears to be increasing.



5

Children Against the Backdrop of War: Addressing the Needs of Military Families

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Describe the military culture that some children are raised in today.
- Explain what effect living in a military culture might have on a family.
- Discuss the types of military families that exist today.
- Describe the issues that children and families raised in a military culture face.
- Explain what is meant by a strength-based approach to working with military families.

There has always been a need for services for military families, but numerous factors have brought this need to the attention of the civilian child welfare and counseling world.

TODAY'S MILITARY: ANOTHER CULTURE

Since September 11, 2001, more than 2 million U.S. troops have been deployed in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) in Afghanistan (Institute of Medicine [IOM],

CHAPTER OUTLINE

TODAY'S MILITARY: ANOTHER CULTURE 109

THE MILITARY CULTURE AS IT IMPACTS THE MILITARY FAMILY 112

Reasons for Enlistment 112

Belonging to the Warrior Society 113

TYPES OF MILITARY FAMILIES 115

Military Men 115

Military Women 115

Dual Military Couples 116

Families of the National Guard and Reserves 116

ISSUES FACING THE CHILDREN OF MILITARY FAMILIES 117

Living with Change 117

Effects of Deployment and Return 118

Educational Issues 120

Spillover of Violence 121

Financial Concerns 123

A STRENGTH–BASED APPROACH TO WORKING WITH MILITARY FAMILIES 124

SUMMARY 126

2010; Baiocchi, 2013), the largest number of deployments, and often multiple deployments, since World War II (Hall, 2008; Lincoln et al., 2008; Mmari et al., 2009; Savitsky et al., 2009; Sheppard et al., 2010). Since 2008, the cumulative time that any soldier has spent on deployment has increased by 28 percent. By 2011, nearly 73 percent of active duty soldiers had deployed to Iraq and/or Afghanistan, a 67 percent increase from 2008. Many of those deployed were on their second, third, and even fourth deployment. Approximately, 54 percent have been Army, 17 percent Navy, 15 percent Air Force, and 14 percent Marines (Baiocchi, 2013)[1].

As we discuss the background for service members and their families, it is important to understand the campaigns in which they served. **Operation Enduring Freedom (OEF)** began in October of 2001 and was primarily fought in Afghanistan. It officially ended in December of 2014. In January of 2015, **Operation Freedom's Sentinel (OFS)** began with the purpose of supporting and assisting Afghan security forces. **Operation Iraqi Freedom (OIF)** started in March of 2003 and was ended by President Obama in August of 2010. Transitional Forces under the name **Operation New Dawn (OND)** remained in Iraq through December 2011when that campaign officially closed. In October of 2014, military operations were instituted in both Iraq and Syria against the Islamic state of Iraq and titled **Operation Inherent Resolve (OIR)** (Fischer, 2015). It is these campaigns that impact the military families of today.

There are several differences in the nature of these conflicts compared to other more recent military campaigns (e.g., Desert Storm, Viet Nam), meaning that more attention must be given to these military families. First, the *voluntary nature of today's armed forces*, with strong reliance on the National Guard and the Reserves, coupled with the fact that both men and women serve. This suggests that dual-career families are often the norm, leaving children impacted by the deployment of both of their parents (Park, 2011; Blaisure et al., 2016). According to the Department of Defense, at least half of the service members are married and many have children. Of these, 41 percent of these children are under 5 years of age, while the children of deployed reservists tend to be in the 6- to 14-year-old range (as cited in Makin-Byrd et al., 2011). Estimates are that 470,000 young children have been affected by their parents' deployments (Barker and Berry, 2009). Such numbers suggest that the problems associated with repeated separations and reunifications between children and their military parents require special attention. And, unlike the previous military conflicts, there have been longer and more frequent deployments for military members of OIF/OEF, with over 40 percent having been deployed more than once (IOM, 2010; Makin-Byrd et al., 2011).



Assessment

Behavior: *Develop mutually agreed-on intervention goals and objectives based on the critical assessment of strengths, needs, and challenges within clients and constituencies.*

Critical Thinking Question: A primary tenet of social work is to begin where the client is. What might be some of your personal challenges in working with those in the military? How might you overcome them in assessing the needs of your clients and developing treatment goals with them?

The voluntary nature of enlistment also means that *service members may have become involved at younger ages*, often marrying and becoming parents earlier (Collins and Kennedy, 2008; Blaisure et al., 2016). The normal stressors of early parenting combined with the impact of war and their duties in the service, may create a greater need for help.

Another difference relates to the *type of warfare* that characterizes OIF/OEF/OND (Operation New Dawn), which greatly influences personnel health. Over 75 percent of the injuries sustained by service men and women have resulted from explosions, most often from **improvised explosive devices (IEDs)**, car bombs, or suicide bombs. In addition, the unpredictable nature of these explosions has greatly increased the likelihood of

[1]Percentages represent the total number of deployment troop years

psychological consequences as well (Collins and Kennedy, 2008; Hall, 2008; Sammons and Batten, 2008; Makin-Byrd et al., 2011; Blaisure et al., 2016). Estimates are that over 320,000 service members have been diagnosed with **traumatic brain injury (TBI)** and over 300,000 with **post-traumatic stress disorder (PTSD)**. The impact, not only of multiple deployments, but of physical and psychological injuries, cannot help but affect military families.

Savitsky et al. (2009) point out that many of these military families may seek out or be referred for service with civilian counselors for several reasons. First, many of the mental health professionals who are in the military themselves have also been sent overseas to meet the needs of service members serving there, leaving a shortage of such professionals stateside. Working under combat conditions also causes earlier burnout (Hall, 2008). In addition, there remains a perceived stigma among military families that seeking mental health service will reflect badly on the service member, who is expected to have everything under control—including all aspects of his family life. And the culture of the military dictates that one does not talk about emotions but rather should "suck it up and go on." In the field, most service members would rather turn to a chaplain for emotional needs than to admit that they need a mental health counselor. When it becomes painfully obvious that the service member or the family cannot handle problems, seeking help unobtrusively is what most service members prefer. **Civilian counselors** may be easier to see without the requisite paperwork and attention that seeking treatment through the military would entail (Hall, 2008).

Military families may come to the attention of the child welfare system through domestic violence as well. Training for combat cannot always be neatly turned off when a service member returns home. Until recently, the debriefing after deployment was either lacking or minimal, leaving some returning service members ill prepared to meet the challenges of being home without reverting to the violence that had been a part of their military training.

For all of these reasons, civilian child welfare workers, whether in close proximity to a military base or not, must be prepared to treat military families and children.

Summary of This Section

- Since September 11, 2001, more than 2 million U.S. troops have been deployed to Iraq and Afghanistan. These conflicts have been characterized by multiple deployments of individual military personnel, in all branches, although more Army soldiers.
- There have been several campaigns including Operation Enduring Freedom (OEF) in Afghanistan (2001–2014), Operation Iraqi Freedom (OIF) in Iraq (2003–2010), Operation Freedom's Sentinel (OFS) to support the Afghan security forces (2015–), and Operation New Dawn (OND) as troops remained in Iraq (2010–2011). Operation Inherent Resolve (OIR) was instituted in Iraq and Syria.
- The voluntary nature of today's armed forces involves fewer numbers requiring greater numbers of reservists and National Guard members to be deployed. Their families are also impacted by their deployments.
- At least half of all service members are married and many of these have children. Forty-one percent of the children of active duty service members are under 5 years of age. The children of reservists and National Guard are more likely to be between 6 and 14.
- Service members are likely to have become involved with the military at younger ages than in earlier conflicts.

- The type of warfare, which often involves explosives that are unpredictable by nature, greatly influences the personal health of military personnel. A significant percentage of service members have been diagnosed with traumatic brain injury (TBI), post-traumatic stress disorder (PTSD) as well as physical injuries. These injuries in turn impact family members especially when the service member returns home.
- Many families must seek help to deal with the issues created.

THE MILITARY CULTURE AS IT IMPACTS THE MILITARY FAMILY

Training in child welfare emphasizes the need for practitioners to develop cultural competence as they work with specific clients. Unless you have been exposed to the military, you may not recognize that it represents a culture just as unique as any ethnic group and understanding that culture is essential.

The first prerequisite to working with military families is to become familiar with the vernacular and makeup of military service. Just determining how to reference military personnel can be a challenge. Hall (2008) points out the need to recognize that those in the Army are known as soldiers, the Air Force as airmen, the Navy as seamen or sailors, the Marine Corps as marines, and the Coast Guard are usually called members of the Coast Guard. To refer to a marine, for example, as a soldier immediately betrays one's lack of familiarity with the military. It may also suggest to a potential client that his or her counselor cannot possibly understand his or her situation—a feeling that the service member may already be attempting to overcome when choosing to see a civilian practitioner. In addition, it is vital for a civilian to recognize that enlisted personnel and officers live in two distinctly different subcultures that have rules governing their interactions. **Noncommissioned officers** are those who have risen to the rank of enlisted officers but are still considered to be in the enlisted subculture (Hall, 2008; Savitsky et al., 2009; Blaisure et al., 2016).



Engagement

Behavior: *Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks to engage with clients and constituencies.*

Critical Thinking Question: The military represents a different culture from that of civilian life. In addition, each member of the military will be influenced by other aspects of his or her individual culture including (but not limited to) race, gender, sexual preference, and religion. How would this influence the work that you do with your clients?

There is a clear and respected hierarchy in the military world and this fact influences communication and interactions within this culture. **Rank** describes the service member's status and authority in comparison to others, although ranks may be called by different names in different service branches. In the Coast Guard, the term **rate** is used rather than rank. **Grade** is a term that is used for pay functions; while ranks have different names depending upon the service, members receive the same pay for comparable grades (Hall, 2008).

Reasons for Enlistment

Individuals join the service for a variety of reasons and these may affect the way they see their military lives and how their families see them as well. Some join as part of *family tradition.* It is not unusual for sons and daughters to follow in the footsteps of parents and grandparents who have served their country. Those who grow up as children of active service members may find comfort in that familiarity of that way of life. Families may express great pride in the fact that their son or daughter has chosen to serve. Other men

and women see *benefits in the financial support, training, education,* or *future education* that are available through the military. Young people from lower socioeconomic levels that might not have the means to get training beyond high school find that they can do so through serving in the military. And the military has been called the "great equalizer" socioeconomically (Hall, 2008; Blaisure et al., 2016).

For some young people, joining the military becomes an *escape* from the world they know. Difficult childhoods, failed endeavors, or problematic relationships may be at the root of this desire for something new. At the same time, almost paradoxically perhaps, there is comfort for some in the structure that also satisfies their need for dependence on others. The camaraderie of military life provides the "family" when this need had not been adequately met (Hall, 2008).

Belonging to the Warrior Society

To further understand the culture of the military itself, one must have knowledge of what is sometimes referred to as the **warrior society**, which can be characterized by its authoritarian structure, the isolation felt by its members, a distinct class system, a sense of mission, and the preparation for disaster or death (Hall, 2008; Savitsky et al., 2009; Makin-Byrd et al., 2011; Blaisure et al., 2016).

Hall (2008) points out the irony of the fact that while engaged in the fight for democracy in Iraq, the military itself is not a democracy. There is a rigid *authoritarian structure* within the military that allows it to function. This clear hierarchy with its rules and intolerance for breaking or questioning those rules may also become a model of family life. As one sergeant's wife explained:

> It is hard for Frank to come home after giving orders to the men and women under his command all day and to take off that hat at the door. He expects that the kids mind him without question and I try to keep some order so that he can relax. It feels like the least I can do to make his life better when he gets home.

The fact that the wider civilian culture places increasing emphasis on individual autonomy within families, sometimes makes these military families feel at odds with society (to be discussed). This, along with the fact that the ideals of the military sometimes clash with those who favor peaceful solutions at all costs, can make military families feel on the "outside" in comparison to their more liberal neighbors. At the same time, frequent moves promote *isolation and alienation* for those services members' wives and children who have not yet learned to build relationships quickly after each move (Hall, 2008; Savitsky et al., 2009; Makin-Byrd et al., 2011; Blaisure et al., 2016).

Military families have often left their extended families and roots, and are expected to thrive—often without the deployed service member—in a foreign environment. Those who live on **bases** and **posts** may find a sense of community but for those who live in civilian neighborhoods, the sense of differentness can be difficult.

> The kids and I lived with Jeremy's folks while he was deployed. His Dad is a chiropractor and his mom works in his office, so I was alone during the day while the kids were in school. I knew that most of the neighbors were not in happy when Jeremy joined up. They talk a lot about how the US shouldn't be over there and how we should worry about our own country. I was proud of my husband and his sense of duty and I felt angry at their lack of ability to see our sense of mission. And when one of my daughters came home from school crying and about how she got teased about being a "military brat," I had really had it. I grew up in Florida and the biting winter cold and snow where Jer's folks lived was getting to all of us too. The whole world felt cold to me.

The *distinct class system* was already mentioned in reference to officers and the enlisted. At one time, military wives joined together in clubs—officers' wives in one and enlisted wives in another—but, given the fact that many now work outside the home, this is not always the case in today's military. Even when children go to the same school as other military children, students may not feel comfortable associating with each other based on their parents' designations (Hall, 2008; Savitsky et al., 2009; Blaisure et al., 2016).

Military members carry with them a *sense of mission*. Not only is it impressed upon them during basic training, but many have learned this value from childhood, especially when they have been raised in military families. Most are proud of serving and eager to do so even if it takes them into dangerous situations. The sense of teamwork along with the value that being a part of the military is about something greater than the individual, often infuses the home and family as well. Studies have shown that when a service member has a solid family who shares his or her values, it enhances his or her job performance. At the same time, the family is expected to take the position that this mission requires: loyalty, dedication, and a dependency on the military that comes first in the service member's life. The long hours and dependence upon the team in times of stress can also create tension and spouse insecurity for some (Hall, 2008, 2011; Blaisure et al., 2016).

Finally, families must learn to recognize and accept that the military trains for combat and that fatalities are always a possibility. They must be *prepared for the disaster and death* that might be a part of their lives. As one father of a soldier and an officer himself put it:

> When my son joined the Army, we were not at war. He wanted an education and saw this as a way to get one. No one ever anticipated that he would go to combat, let alone be permanently disabled over there. Now the young soldiers that I command join up recognizing that they will be deployed and will face a variety of life threatening situations. Their families need to adjust to it as well—something that is not always easy for them to do.

Summary of This Section

- Work with military families necessitates familiarity with the vernacular and the structure with which they live. The terms, ranks, and pay grades may differ from branch to branch but having knowledge of these is vital to gain trust in clients that they are understood. No matter the service branch, there is a clear hierarchy to which service members must adhere.
- Service members enlist for a variety of reasons including family tradition, financial support, training or education, search for a meaningful future, or even an escape from a difficult childhood.
- The military is sometimes referred to as a "warrior society." Within this society is a distinct class system, dedication to a sense of mission, and a recognition that one must be prepared for danger, disaster, and even death.
    - Along with the service member, the family is expected to demonstrate loyalty, dedication and the recognition that the military must come first in the service member's life.

TYPES OF MILITARY FAMILIES

Any discussion of military families must take into consideration that there are different types of families and different experiences. For the most part, this chapter discusses the full-time service member's family but even here there are variations based on who is serving.

Military Men

When the man of the family is serving in the military, his wife usually expects that she will be his emotional support, but many military wives do not initially envision the other responsibilities that become hers. She must be prepared to follow her husband as he is transferred or—if the family decides that she and the children will stay in one place (e.g., with relatives)—she must expect long separations. Even if she follows her husband, his **deployment** will mean that she struggles with the loneliness and the fear that accompanies knowing that a loved one is in combat, plus the family responsibilities such as handling finances, the challenges of running a household, and the care and raising of children. The balance of power shifts when her husband is deployed and suddenly she is in the position of making crucial decisions. When her husband returns, the power may shift again as he seeks to regain his role in the family, and this too can be an adjustment (Hall, 2008; Esposito-Smythers et al., 2011; Park, 2011; Blaisure et al., 2016).

It is not uncommon for a military spouse to feel the need to enter the workforce whether it is for financial reasons or just a desire for fulfillment or something to enhance her life. Having a work schedule may increase her stress and necessitate childcare or after-school care for the children. Her employment may also offer her the emotional support that she needs. Nonworking wives in the military often seek out others in their position for just such support. However, for the working wife whose husband returns home and is later transferred, she faces leaving a job she may have enjoyed.

Despite her own fears, loneliness, and stress, she must also help the children deal with having their father away (see later for issues facing children). As mentioned earlier, military wives are often young and the challenges that they face may require experience that they do not yet have.

Military Women

When the wife is the one who serves, her husband will be faced with many of the same issues that are challenges for his female counterpart. Bill paying, running the house, and childcare will all be up to him when she is deployed. Statistically, civilian husbands of military women tend to have more education, have prior military experience themselves, and be employed full time. Emotional support is not always easy for these men. They do not feel that they can become close with the female spouses of those deployed for fear of looking suspect. And many men already report concerns about their wives cheating while on deployment (Hall, 2008; Blaisure et al., 2016). And their male colleagues who are not married to women who serve, may not understand. As one man explained:

> All the guys at work used to ask me how I could let Gina stay in the military and be deployed. Some of the older ones really felt that she should be home with the kids. Having her stay in the army was a decision that we had made when my enlistment was up. I thought I agreed with it, but the razing my colleagues gave me really got to me.

Male spouses often find their support through online chat groups where they can connect with others in similar position.

Dual Military Couples

When both parents in a family serve in the military, life can become even more complicated. Partners may be deployed at different times or their deployments may overlap, requiring that they have a care plan for the children. All branches of the service require parents, whether only one or both serve, to file a **Family Care Plan** that indicates who will care for children while parents are deployed. Some military branches prohibit women with children under 4 months of age from being deployed, and some require that dual military spouses not serve in the same unit to prevent them from being deployed at the same time.

Dual military families must work out issues such as switching roles depending upon who is deployed, honoring each other's career goals and requirements, having outlets for emotional support so that undue stress does not fall on the other spouse, being proactive in finding joint assignments that allow for the family to be together, taking advantage of professional support services, and making realistic plans for the care of the children, while still giving their best to their chosen roles (Hall, 2008; Blaisure et al., 2016).

Families of the National Guard and Reserves

In years past, those who joined the National Guard or the Reserves did not expect to go into combat; and yet this is no longer the case.

The National Guard was originally organized (in 1636) as militias that protected the homeland from attack. The Guard also provides services such as restoration after major disasters. The Reserves can be from any branch of the service—Army, Marine Corps, Navy, or Air Force—and serve as a fully trained force in the wings, ready to be mobilized when the need arises. While at one time, the Reserves was predominantly comprised of older men who had served on active duty and now were serving their time in the Reserves, now more younger men choose to train 1 weekend a month with 2 weeks a year of continuous training while they join the regular civilian workforce. Currently more than half of the Reserves and National Guard are under 30 years old (Hall, 2008).

The fact that most who joined the traditionally home-based military had not initially anticipated being deployed into combat, impacts the families of these individuals. Families have accommodated the 1 weekend a month and 2 weeks training duty, but when one or both parents suddenly face deployment, things change. National Guard members and Reservists may not be as well prepared to face the challenges of deployment. These individuals now face time away from jobs and professions, which was unexpected. While technically, employers are expected to rehire those who have been deployed, businesses change and often this does not work out. Guards and Reservists who are self-employed may be faced with the loss of a career. The significant difference in military pay versus salaries in the private sector may mean that families now anticipate financial difficulties.

Emotionally, families are often not prepared for the sudden deployment of a parent. While full-time military families learn about the challenges of separation, the families of "part-time warriors" do not.

When Phil and I married and had our kids, it was fine that he was in the Reserves. He went off for one weekend a month and two weeks a year and that just became a part of our lives. We both had teaching jobs and Phil had a consulting business on the side that had really seen us through the early years with raising our kids, one of whom has special needs. And suddenly Phil's unit was being called up to go to Iraq. I couldn't believe it! We all felt panic. What would we do without him? He'd lose his teaching job and obviously couldn't keep the consulting business. Our income would be slashed in less than half. Our whole way of life would have to change. And then there were our fears. What if Phil was killed—something we didn't even voice to one another? It was a really rough time for all of us and it took some serious talks for us to pull it all together.

Summary of This Section

- Today, men are the most likely to serve in the military. The wife of the military man is expected not only to provide emotional support but also to assume the duties of both parents when her husband is deployed. It is also common for a military wife to be required to work outside the home for financial reasons.
- The woman who serves in the military will require the same support from her husband, including emotional support, the running of the house during her deployment, and childcare. Statistically, the husbands of military women tend to have more education, have had military experience themselves, and be employed full time.
- Both husband and wife may be in the military, called a dual military couple. There is an effort on the part of the military to ensure that military parents are deployed at different times and there may be restrictions on deployment depending on the age of the children. Dual military couples may be challenged by the assignment of roles within the home, and how acres will be managed.
- Families of Reservists and members of the National Guard may face additional challenges. Although Reservists were older men retired from the military at one time, the average Reservist is now under 30 and may be either male or female. The voluntary nature of the military means that more Reservists and National Guard have been deployed as backups to active-duty service members. Families are often ill-prepared for the realities of deployment.

ISSUES FACING THE CHILDREN OF MILITARY FAMILIES

Living with Change

The one thing I knew that I could count on when I was growing up was change. My father was in the military and every few years he would be transferred. It got to be a joke in our family: Get out the boxes! we'd say. We kept all our packing boxes because we knew that we would need to pack up once again. When the moves were further afield, like Germany or Japan, we couldn't take as much stuff. Mom had packing down to a science. But it was hard, always making new friends, never knowing where you'd be in a couple of years. I went to thirteen schools before I graduated. If someone asked me where home was, I am not sure I could answer them. Home was wherever we all were—and who knows where that would be.

Frequent moves can be difficult for children especially when they must constantly leave friends and make new ones. The average military child moves between six and nine times between kindergarten and graduation from high school (Blaisure et al., 2016). In some children, it develops resiliency, but in others, feelings of isolation.

It is not only the fact that military personnel are often transferred routinely that creates this cycle of mobility, but also today's military environment. The 2005 Base Realignment and Closure initiative, for example, anticipated that over 100,000 family members stationed overseas would be brought back to U.S. military bases by 2010. At the same time, families already in the United States would be relocated to other bases, approximately 33 percent of military families each year (Bradshaw et al., 2010; Park, 2011). This does not account for service members who are deployed, creating another change for their children. And when one parent is deployed, some families move in with relatives, meaning one more move.

When a family moves frequently, the atmosphere within that family becomes especially important. Families that have developed healthy interpersonal relationships can buffer the effects of change on children. Park (2011) suggests that, in peacetime, military children often fare better than their civilian counterparts in rates of child psychopathology. Hall (2008) also points out that military children have greater respect for authority, are more tolerant, adaptable, responsible, and welcoming of challenges. When families adopt positive attitudes toward relocation, their children can actually benefit (Park, 2011). The military values that emphasize honor, sacrifice, community, loyalty, and a sense of purpose can also work toward building resilience in children (Park, 2011).

When there is dysfunction in families or the parental figures are not able to adjust to relocation, the children may suffer. The transient nature of the life style exposes children to greater influence of these negative factors and presents fewer opportunities for support outside the family.

> Everyone knew that Mom drank, but no one talked about it. Dad coped by working at the base or going off on tours of duty. We moved so often that by the time people in our immediate neighborhood would guess what was going on, we'd be gone. But it took a toll on my sisters and me. We isolated ourselves and never wanted to make friends, so embarrassed were we about our mother's drunken rages. We spent our time trying to make excuses for her while at the same time trying to keep out of her way. And we didn't want anyone in the Navy to know because we were afraid that it would impact Dad's career.

Effects of Deployment and Return

Deployment—the time when a service member is away from his or her home base in support of some type of military operation—can be divided into four phases of a cycle: predeployment (the time from notification to deployment), deployment (time during which the parent is gone), **reunion** (the period of preparation just prior to the return), and **postdeployment** (period following return) (Savitsky et al., 2009; Esposito-Smythers et al., 2011). Over 900,000 children in the United States have had at least one parent deployed since 2001 (Park, 2011). Long and multiple deployments have created in children more psychosocial problems than ever before. The Department of Defense reports that mental health services, both on an inpatient and outpatient basis, for children of military personnel have increased significantly in the last few years (Park, 2011). Adolescents as well as children have been found to suffer from significantly higher levels of stress, with accompanying higher systolic blood pressure and heart rates (Barnes et al., 2007).

Each phase of the deployment cycle can be associated with specific stressors. During *predeployment*, the family is often in shock that the parent will be deployed and suffers from anxiety about what this will mean. During *deployment*, children feel loneliness for the parent and fear what will become of him or her. The remaining parent's own stress about her or his spouse's absence can be felt by the children whose affect or behavior may change in response. Some children will test the limits imposed by this remaining parent who is now the sole caretaker. Routines have changed and everyone may find the adjustment challenging (Hall, 2008; Park, 2011; Esposito-Smythers et al., 2011; Lemmon and Stafford, 2014; Blaisure et al., 2016).

The anticipated *reunion* with the deployed parent may take on idealistic fantasies and may initially be looked forward to as a time of joy. But on some level, the child realizes that things will change and may have some trepidation about this fact. The boy wonders if he will have as much one-to-one time with Mom when Dad comes home. The children may remember Dad as the stronger disciplinarian and begin to mourn their loss of freedom.

The reintegration of the deployed parent (*postdeployment*) into the family brings with it a myriad of challenges. Roles and boundaries within the family will need to be renegotiated. Childcare responsibilities may change; there may be conflict over household management and house rules. There may be conflicts about new relationships that developed during the service member's deployment (Hall, 2008; Park, 2011; Esposito-Smythers et al., 2011; Lester et al., 2011; Blaisure et al., 2016). For example, Gabrielle, a young military wife had befriended an older man during her husband's deployment. Herbie had initially offered to cut the lawn and had soon become a regular guest, handyman, and an important figure in the children's lives. When Tom returned home, he resented the presence of family's helper and friend, insisting that he could now do the chores. Being cut off from their friend created resentment in Gabrielle and her children.

Policy Practice

Behavior: *Identify social policy at the local, state, and federal level that impacts well-being, service delivery, and access to social services.*

Critical Thinking Question: Policies to aid soldiers who have returned from combat, and their families, are newly emerging. Can you identify the policies at the local, state, and federal level that impact veterans and their families? What needs outlined in this chapter suggest that additional policies are necessary? How could these be instituted?

Many families experience residual feelings of resentment over the abandonment they felt after the deployment. Old issues previously unresolved may also reassert themselves. At the same time, children and youth may experience ambivalence toward the returning parent, often acting out their confusion. If the parent is different (e.g., suffering from PTSD, TBI, or a physical injury), children may need help in figuring out how to relate to this new personality. And finally, all family members may worry about future deployments. In fact, the longer and more frequent the deployments, the more difficulty with reintegration there may be (Hall, 2008; Sheppard et al., 2010; Park, 2011; Esposito-Smythers et al., 2011; Chandra et al., 2011; Gewirtz et al., 2011; Lincoln and Sweeten, 2011; Lester et al., 2011; Blaisure et al., 2016).

Recent studies have looked at the effects of deployment on military children. Gorman et al. (2010) found that in children ages 3 through 8, behavioral and stress disorders increased by 18–19 percent when a parent was deployed. Flake et al. (2009) discovered that children between ages 5 and 12 internalized symptoms (39%), externalized symptoms (29%), had sleep problems (56%), or had school-related issues (14%). Teens (between ages 12 and 18) often withdrew; socially isolated; had eating or sleeping difficulties; or reported sadness, crying, and fears over their parent's deployment (Huebner and Mancini, 2005; Lieberman and Van Horn, 2013; Russa and Fallon, 2015). Nguyen et al. (2014) found that in their population of 95 preschool children with parents who had been deployed at some time, there was some delay in the children's normal development. These

authors also noted that the anxiety and depression over the deployment and possibly the return might also be a factor.

Chandra and colleagues (2011) conducted phone interviews with 1,507 military families with a deployed parent of children between 11 and 17 years of age. They found that these children were exhibiting higher emotional problems than the national average of youth in the same age group. The longer the deployment and the more frequent the number of deployments coupled with the poorer mental health and adjustment of the caregiver meant that children had more difficulties emotionally during deployment and reintegration of their military parent. A similar study conducted by Chartrand et al. (2008) some years earlier found that, of the 169 families living on Marine bases, the 3- to 5-year-olds with a deployed parent demonstrated significantly poorer adjustment than those whose parents were not deployed. This study also figured in the caregiver's stress or depressive symptoms as a factor contributing to the children's distress.

It is clear from the research that the deployment of a parent, with the resulting pressure placed upon the remaining parent can be upsetting to children in military families. This difficulty in children's lives is seen not only in the home but also in their educational settings.

Educational Issues

> I don't think Sammy feels as if he has any control over his life, one mother confided. Doug [his father] has been deployed three times in the last couple of years and we have moved twice. Sammy [a third grader] told me the other day that he doesn't think there is any point in learning in school. He said that he knows he will have another teacher soon and that teacher will teach totally differently. Rather than being confused, I think he is just shutting down. I try to help him, but what can I say? Do any of us have control of what is happening in our lives? Not when you're in the Army and at war! So I try to help him realize that I am his safety net. But then he has nightmares about what would become of him if anything happened to me.

Emotional upset, insecurity, and anxiety cannot help but impede learning. Harrison and Vannest (2008) found that it is the children of the increasing number of Reservists and National Guard being deployed that feel the most profound effects. These authors explain that:

> Whereas children of active duty soldiers are accustomed to a military lifestyle, which may include frequent separation from one or both parents for training exercises, deployments, unaccompanied tours, and other temporary duty exercises, reservists' children are not. Often reservists' children lose their sense of security without daily parental involvement, support, nurturing, and guidance from their reservist parent. (19)

One teacher pointed out after teaching a class where there were four children of Reservists who were currently deployed:

> My colleagues and I were unprepared for this new challenge. We knew that some children would have deployed parents but no one told us what that might mean. When one of my students demonstrated a great deal of anxiety and anger—something his previous teachers told me was new—I did my own research on the effects of deployment on children. Just imaging the fears, sadness, and sense of isolation that these children must be feeling as we asked them to learn, was a real eye opener. Now I have convinced my school to offer an in-service training to help all of us address the needs of children with deployed parents.

Most theorists would argue that, although children of full-time military families become better adapted to their way of life and actually develop resilience as a result, the number and frequency of deployments has impacted all military children to some degree.

Children affected by frequent moves and deployments may exhibit increased anxiety, anger, fears, sleep difficulties, irritability, depression, eating problems, and frequent crying. Some cope with their feelings by isolating themselves, withdrawing, demonstrating short attention spans, and having difficulty concentrating in school (Cozza et al., 2010). Learning requires psychic energy and when this energy is sapped by anxiety, fear, and depression, children cannot learn. Other children will act out their emotional difficulties through becoming aggressive or difficult. Some become preoccupied with war and violence, drawing graphic pictures that express the concerns that they have for their parent's safety. Toddlers, seen in preschool settings, may regress in their development or develop separation anxiety from their caretaker. Some teachers report that children of deployed parents ask for more attention than the others in their classes. They may need to control more or conversely will totally abdicate any control (Lincoln et al., 2008; Harrison and Vannest, 2008; Barker and Berry, 2009; Mmari et al., 2009; Aranda et al., 2011; Lincoln and Sweeten, 2011).

Bradshaw et al. (2010) studied the adjustment of adolescents to the frequent moves that forced them to change schools. Some of their subjects' parents were also deployed. Using 11 focus groups from eight military bases, with students between 12 and 18 years of age, these researchers found that the adolescents saw several types of stressors as affecting their school performance. First, stressors at home associated with moves were noted. Some teens reported anger at their family for uprooting them again and a common theme was the young person would say that he or she refused to move. This tension would then spill over into the school environment, causing the teen to have school difficulties and sometimes acting out.

Second, was the teens' concern over ending friendships and having to make new ones. They may also feel that they are seen as different because of their frequent moves and this may alienate them from their peer group. Adolescents often found it difficult to adapt to new environments, again feeling as if they stood out and were not accepted (Mmari et al., 2009; Bradshaw et al., 2010).

Adolescents commented that it was often challenging to go from one school system to another. The differences in policies, resources, and teaching methods combined with different teaching schedules can be confusing to students. One college-bound student facing college board exams, complained that he had never had a course in geometry because one school taught it in junior year while the school he transferred to expected students to have taken it in their sophomore year. He was never able to fit it into his schedule given the requirements of the new school.

And finally, teens complained that interacting with new teachers and administrators all the time was stressful. Teachers may also not know how to respond to a student whose parent is deployed. Does the student need to talk about it or should the subject be left alone? As previously mentioned, it is important for teachers to be prepared to cope with both children and adolescents of deployed parents (Mmari et al., 2009; Bradshaw et al., 2010).

Spillover of Violence

It is not always easy for those who have been trained in combat, and who have spent months and even years doing this job, to turn off the inclination to use violence to solve problems. In addition, *family violence* may occur due to the high stress level associated with the military lifestyle (Hall, 2008). Separations, deployments, and the lack of control

over one's future may add to the stressors already inherent in family life. The rates of family violence among military families—two to five times greater than civilian families—may also be dependent upon several other variables: (1) The military tends to be made up statistically of more men between the ages of 18 and 25 than the general population; (2) families are often separated geographically from their extended families thus cutting them off from natural support systems; (3) often victims are afraid to get help lest the fact of the domestic assault affect their spouse's career; (4) military wives are often more financially dependent upon their husbands and thus less able to leave; and (5) military couples are often married very young and not emotionally mature (Hall, 2008, 182).

The effects on children who witness violence are discussed in Chapter 4. For the military family, there are additional implications. The isolation felt by some families experiencing domestic violence may be intensified when all members worry about what disclosure will do to the service member's career. The stoicism, denial, and secrecy of living in the military "fortress" not only contributes to the violence but also adds impact to the feelings of not wanting to report what is happening (Hall, 2008). Already surrounded by a mindset of violence, children can become even more fearful or conversely more apt to strike out.

Another casualty of living in an environment of combat is the *misuse of substances*. Alcohol has various uses in the military. Service members report that they use it for recreation, socializing, relieving stress, and coping with their lives or with combat (Poehlman et al., 2011: Blaisure et al., 2016). During deployment, military personnel may use alcohol as a way of getting through the experience, although reportedly some alcohol use is off-limits altogether when in countries where it is not tolerated due to religious or cultural mores. And a slightly higher incidence of alcohol abuse is now reported among service members returning with combat-related injuries, PTSD, and TBI (McDevitt-Murphy et al., 2010; Heltemes et al., 2011).

Drug addiction has also been noted in returning veterans, possibly due to the ease of access to drugs during deployment. Street drugs are also used by some of the 10–20 percent of military personnel returning with PTSD and TBI to cope with their conditions (Hutchinson et al., 2008).

Any type of substance abuse alters an individual's behavior and can impact the lives of their children. The effects of substance-addicted parents on their children is discussed in some detail in Chapter 4.

Domestic violence and the abuse of substances are not the only residual effects of war that affect military families. The stresses of combat leave indelible scars on those who are exposed and these scars will impact the way in which the victims related to their families.

> Nate was a great dad before he was deployed. He was very much involved in the care of our three children when they were infants. His more flexible hours gave him a lot of time with them and we all appreciated that. His deployment to Iraq took a toll on all of us. The girls, then 6, 5 and 3 could not understand why he had gone away. His subsequent injuries from being too close to an explosive device that went off near his convoy, gave him a severe concussion and injured his right leg. The leg was repaired and healed and after long months in the Army hospital he finally came home to us. The girls, now all a year older, were so excited to see him. But none of us were prepared for the man who returned to us with severe PTSD.
>
> Nate took little interest in our children. He preferred to be alone and would sit for long hours in the darkened bedroom. He was irritable with them and startled so easily that any little sound would send him into a fit of shaking. The VA doctors saw him regularly, medicated him, talked with him and we hoped that things would

> change. Things have gotten a bit better. Nate tries to interact with the girls and as long as they do not make any loud noises, it goes pretty well. But his nightmares and sleeplessness leave him exhausted and he still has difficulty going out of the house. Even if he does leave the house, being in crowds is out of the question for him. It causes him too much anxiety to be around groups of people. The girls miss him at their ball games and recitals. It has been quite an adjustment and I know that the children have found it difficult.

It often rests upon the nonmilitary parent to help children cope with the changes in their father or mother as a result of combat-related disabilities. These disabilities may be emotional—like PTSD or TBI—or physical with the resulting emotional impact of such injuries. Children are often faced with watching a parent learn to cope with being wheel chair–dependent or walking with prosthetics. Children must be helped to realize that the impact of combat and the difficulty a service member may have with coping is not the children's fault or responsibility. Often this requires bolstering the nonmilitary parent so that she or he can cope and then help the children to understand.

Financial Concerns

A frequently overlooked concern that affects military couples and therefore their children is the issue of finances. Businesses are more than willing to give credit to service members knowing that they can be found and their pay attached if they ever default on a loan. But the youth of many service members often means that they may not have gained the maturity to handle finances. The demands of a family make them believe that they must have money—often borrowing to get it—without considering how that money will be paid back (Hall, 2008).

There is a preconception among many service members that the military will care for them. After all, their housing is provided, medical care is free, and uniforms limit the number of clothing items needed. But provision of these necessities does not promise that military families will know how to spend wisely and may find themselves in debt or taking out loans. Such financial stressors affect the whole family.

Service members returning with combat-related PTSD or TBI also find that they must be screened by the military before they can be put on full disability. Appeals for disability compensation are not always approved no matter what the apparent need, and families face financial hardship as they strive to make ends meet.

The stressors on the military family can be multiple and meeting these challenges requires not only fortitude but often professional intervention as well.

Summary of This Section

- Children of military parents must cope with a variety of stressors. One of the most challenging is the frequent moves as their parents are transferred from one duty station to another. The average military child moves between six and nine times. How a child copes with these moves is often dependent upon the emotional atmosphere within the family.
- There are phases identified in the deployment process: **predeployment** (the time from notification to deployment), **deployment** (time during which the parent is gone), reunion (the period of preparation just prior to the return), and postdeployment (period following return). Each phase is associated with specific stressors.

- Predeployment is marked by anxiety, uncertainty, fear, and shock over the fact that the service member will be deployed. Deployment is a lonely time for the remaining parent and children and a time when this parent must assume all the household duties herself or himself with a variety of possible responses from the children. Reunion may be fraught with unrealistic fantasies about what it will be like when the service member returns as well as some fears over what changes will occur. Postdeployment presents a myriad of challenges including re-entry issues for the service member and conflicts over changes and redefined roles within the family.
- Recent studies suggest that children of deployed parents may demonstrate behavioral and stress disorders, developmental problems, externalized symptoms, sleep issues, and emotional upset.
- While on one hand children of military parents may develop resilience in the face of the uncertainty that they face, some also have difficulty in school and learning.
- Studies of adolescents required by their parent's military career to move, losing friends and needing to make new ones, found the life particularly difficult.
- Family violence is not uncommon in military families. This may result from the age group and maturity level of service members combined with the interruption of family systems, military training that the service member has undergone, and the fact that military spouses are often dependent upon their service member. Children are impacted emotionally by domestic violence.
- The abuse of substances is also common among service members and their families. Service members who are impacted by combat may use substances to self-sooth perhaps not realizing the impact on children.
- Having the regular paycheck from the military does not immune veterans and their families from financial concerns. While during active duty, everything was provided for them, service members and their families must now learn to be self-sufficient, which is not always easy, especially when many service members were enlisted at a young age when they had not had a chance to be self-supporting themselves.

A STRENGTH–BASED APPROACH TO WORKING WITH MILITARY FAMILIES

Against the backdrop of living in a warrior society with clear rules and expectations, there are elements of predictability that help at least the full-time military families to develop strengths. They lead a relatively predictable lifestyle, knowing that they will be provided for in most things by the military. There is support built in to their relocations in that they are often on bases, posts, or in contact with other military families. Children, due to their familiarity with change, can accept others coming and going at school and in their environment. There is a predictability in the knowledge that the family will be required to relocate at some time. The family unit, due to frequent moves, has the opportunity to pull together in a common experience.

As one Army wife explained:

> As tough as it can be to relocate, we also know that it will happen. We know when the orders are coming and we are ready to pick up and start again. I tried to impress upon my children that we, as a family, had an opportunity for a new life, meeting new people and having new experiences.

Families learn to be resourceful and self-reliant. Although their reliance upon the military may seem paradoxically to foster dependence, military families can be creative in exploring their options, sometimes more so than nonmilitary families. And their exposure to foreign cultures often develops in them a more acute awareness of diversity in people and of other world communities (Hall, 2008; Blaisure et al., 2016).

There has been increased discussion in the helping community about how to foster resilience. Military families often demonstrate resilience in the way that they handle a multiple number of stressors.

Recognizing these strengths and building upon them becomes the role of the social worker seeking to meet the needs of military families. Civilian social workers may be called upon to serve these families in a variety of settings, either by serving the whole family or the family as the support to work with one or more members:



Assessment

Behavior: *Select appropriate intervention strategies based on the assessment, research knowledge, and values, and preference of clients and constituencies.*

Critical Thinking Question: Military personnel, veterans, and their families represent a growing population in need of services. How might you acquaint yourself with the services to meet these needs? How might you ensure that these services are strength-based? How would you join with clients to meet their needs?

- child guidance centers addressing the symptoms of children
- family service agencies
- child protection agencies addressing family violence and child abuse
- battered women's shelters
- school social work helping children with barriers to learning
- veterans hospitals
- agencies specializing in PTSD and TBI
- prison settings
- rehabilitation for addictions
- agencies dealing with homelessness
- agencies helping with financial concerns.

In whatever setting the family is seen, it is important for the civilian social worker to prepare herself or himself in the following ways:

1. *Become familiar with the military culture and jargon.* The ability for you to speak "militarese" will augment the comfort level of your clients (the extra time necessary to explain some of the military buzz words or phrases, if you do not know them, may serve to frustrate and alienate your clients).
2. *Assess and understand the origin of your own attitudes and prejudices* about the military and those who serve.
3. *Consider how you feel about such issues* as what honor means to you and what you believe is "working for the higher good" and having a sense of mission.
4. *Consider your concept of death and what it means to you.* What will be your reaction to working with clients for whom death is very real? Those in the military have seen people die, may have killed, and accept that they might die in combat. Family members too know that death is possible for their loved one (Hall, 2008).
5. *Become aware with some of the issues that affect military families* and how these relate to or are influenced by the military culture. For example, because of the value of the military to "suck it up and move on," many service members and their families will find it very difficult to seek help.
6. *Actively develop and practice sensitive strategies* designed to address this population (Hall, 2008). For example, visual imaging as a technique might only increase

the anxiety of someone who has been traumatized in combat, until you are able to help that client visualize a "safe place" that he or she can return to mentally.

7. *Consider how you can create a safe environment* in which the service member or the family can do the work that they need to do.

Above all, work with the military family necessitates a strength-based approach. Although these families face a myriad of challenges, they also develop an adaptability and resiliency that can teach us much in working with all clients.

Summary of This Section

- Using a strength-based approach might begin with the recognition that there is predictability in the lives of military families. There are expectations of families and service members that are accepted as part of their lives. Families and children know that they will relocate at some point, and they learn to become resourceful, self-reliant, and can acclimate to new situations and cultures.
- Civilian social workers may be called upon to work with military families in a variety of settings including child guidance, child protection, battered women's resources, hospitals, prisons, addiction counseling, as well as agencies helping with financial issues and homelessness.
    - There are variety of ways to prepare for working with military families, such as becoming familiar with the military as a culture, assessing one's own attitudes, especially about death, developing sensitivity to the struggles these families face, and learning how to create a safe environment for them.

SUMMARY

- Since September 11, 2001, more than 2 million troops have been deployed to Iraq, Afghanistan, and Syria. Today's military culture is characterized as voluntary in nature meaning that the service members tend to be younger and often have young families. The warfare is characterized by the use of explosive devices, which have increased the number of psychical and mental health injuries.
- Living in a military culture—what is frequently referred to as a "warrior society"—means living within a hierarchy where ranks designate the interaction between individuals and families. Service members and their families abide by specific rules and traditions. People enlist for a variety of reasons, including family tradition, financial support, training or education, search for a meaningful future, or even an escape from a difficult childhood. Families as well as service members are expected to demonstrate loyalty, dedication, and the recognition that the military must come first in the service member's life.
- Families may be made up of either a male or female service member or be a dual military family, meaning that both parents are in the military. Reservists and National Guard, while originally designed to cover the home front, may now be deployed due to a decrease in active duty service members. Many service members are faced with multiple deployments.

- A variety of issues face families and children with military members. Relocation is the norm and families learn that there is a predictability in the fact that their lives will change. Some children adjust well to these moves, while others—especially adolescents—find it more difficult. There are different challenges depending upon whether the service member is preparing for deployment, is deployed, or has returned from deployment. Some military children adjust well, while others experience greater anxiety, issues around development, and problems in school. The violent nature of combat sometimes leads service members to return home and have problems with domestic violence and child abuse.
- Military families also have a good many strengths and research has found that using a strength-based approach in serving them is the most effective. To successfully service military families, a counselor must become familiar with the military culture. In addition, it is important to examine one's own prejudices and attitude, especially those toward death, war, and what military families face.

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6

Trauma-Sensitive Educational Settings

By Laura M. Garofoli

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Explain how trauma impacts a child's ability to succeed academically and socially.
- Describe the practices employed across a variety of trauma-sensitive educational settings.
- Discuss the special role of social workers in educational settings.
- Explain the educational rights of traumatized children.

Educating America's children is a weighty task. Teachers are faced with preparing students to meet the challenges of an increasingly global and technologically demanding world. According to ChallengeSuccess.org, standards-based education and the push for accountability have placed mounting pressures on educators, children, and families to the point where all parties often feel overwhelmed with the demands of achieving and maintaining impressive grades and test scores. Such emphasis on performance can be even more worrisome for students facing risk factors for academic failure. Low-income, minority, and disabled students are frequently recognized as at-risk populations, but a growing number of educators and advocates are calling for attention to another at-risk population of children in educational settings—those who have experienced trauma.

CHAPTER OUTLINE

AT-RISK: TRAUMA AND ACADEMIC FAILURE 130

CREATING TRAUMA-SENSITIVE EDUCATIONAL SETTINGS 133

Childcare 133

K–12 Schools 134

SOCIAL WORKERS IN EDUCATIONAL SETTINGS 138

EDUCATIONAL RIGHTS OF TRAUMATIZED CHILDREN 140

SUMMARY 145

An **educational setting** is a place where learning is a primary goal of a child's participation. This includes **childcares** and **K–12 schools**, as well as colleges and universities. **Trauma-sensitive educational settings** are those that recognize trauma as a risk factor for academic and social failure and use this knowledge to propel changes within the setting to limit the negative effects of trauma on all students. For the purposes of this chapter, we will focus on childcare and K–12 schools, and the ways in which trauma sensitivity can be integrated into these settings.

AT-RISK: TRAUMA AND ACADEMIC FAILURE

Why should we care about academic success in at-risk populations? While there are many compelling reasons, a very important one is that education is the passageway to a brighter future, including better employment opportunities and earnings, which often translates into better access to health care as well. College graduates earn 66 percent more over their working lifetimes than high school graduates, and 200 percent more than high school dropouts (College Board, 2015). While dropout rates have steadily declined since 1970, low-income, minority, and special education students continue to experience higher dropout rates than their higher income, white, and nondisabled peers (Children's Defense Fund [CDF], 2014; Stark and Noel, 2015). In 2012, nearly half of America's 49 million school children qualified for free or reduced lunch (National Center for Education Statistics [NCES], 2013a, Table 204.10), with ethnic minorities greatly overrepresented in this group. In addition, while special education students account for only 13 percent of our public schools' total student population, 46 percent of these students are nonwhite (NCES, 2013b, Table 204.50).

Researchers have noted that differences in cognitive ability can emerge between low-income children and their higher income peers during infancy, and that by age 3, significant gaps in vocabulary development place these children at increased risk for reading problems and academic failure before they even begin formal schooling (Biemiller and Slonim, 2001; CDF, 2014). In addition to the risks for academic failure associated with poor reading and mathematics achievement, low-income and disabled students are at increased risk for experiencing traumatic events in childhood such as physical, sexual, or emotional abuse, neglect, and exposure to violence both within the home and in the surrounding community (Ford, 2012; Centers for Disease Control and Prevention [CDC], 2015). Traumatic exposures, in turn, increase the risks of academic failure (Cole et al., 2005), a particularly disheartening finding given that educational attainment can serve as a protective factor that is associated with better coping and recovery after traumatic experiences (Ford, 2012).

Of course, childhood trauma does not discriminate, and children from all walks of life have the potential to experience traumatic events. The American Psychological Association estimates that over 65 percent of American children will experience some form of trauma prior to the age of 16 years (La Greca et al., 2008). In addition to abuse, neglect, and violence, these traumas may take the form of medical traumatization, accidents and injuries, acts of war and terrorism, loss of loved ones, natural disasters, and other occurrences perceived as traumatic by the victim.

Like the academic risks associated with low income or disability, children experiencing the adverse effects of trauma exhibit a variety of cognitive, behavioral, and socioemotional changes that can have a negative impact on their ability to succeed in school. La Greca et al. (2008) note that almost all traumatized children exhibit some form of observable effects, such as irritability, anger, sadness, anxiety, difficulty concentrating, nightmares, the development of new fears, and withdrawal from schoolwork or other activities

of interest. For most children, these adverse effects are typically short term in nature, particularly when the traumatic event was an **acute stressor** or single occurrence. This finding is consistent with recent research demonstrating that structural changes do not occur in the brains of patients with acute stress reactions to trauma (Szabo et al., 2015).

However, children facing longer-term traumatic experiences, including those diagnosed with **trauma- and stressor-related disorders**, are at increased risk for prolonged or chronic interruptions in daily adaptive functioning. Children who have been traumatized by maltreatment exhibit lower levels of academic engagement, social competence, and resiliency (Shonk and Cicchetti, 2001). They can have a harder time connecting or getting along with others, and they may demonstrate difficulties engaging in creative or cooperative play (Buss et al., 2015). Traumatized children tend to be hypervigilant, often overreacting to situations that may not be perceived as stressful or threatening by others, and they may exhibit poor decision-making and reasoning skills (Rossen and Cowan, 2013). Children of trauma may also have underdeveloped language and attention skills that make it challenging for them to engage in social or learning activities (Cole et al., 2005). In school, traumatized children may have difficulty remembering, engaging in academic tasks, making important learning connections, and monitoring their own learning efforts (Cole et al., 2005).

Case Example Michael

Twelve-year-old Michael is the son of two military parents. In his short career as a student, Michael has attended four different schools, one of which was in Germany, and he has struggled to make friends every time he has moved. Last year, Michael's father was killed in combat. He now lives in fear that his mom will be deployed for active duty and that she will die in combat too, but he is afraid to tell anyone how he is feeling. He has vivid recurring nightmares and has had a hard time concentrating in school. His grades have plummeted and he has no desire to improve them. No matter how hard he tries, his days seem to be filled with negative interactions with peers and adults, and Michael always leaves school convinced that he is a bad kid. Michael had once dreamed of attending West Point and becoming an officer, but now he wonders if he will even graduate from high school.

Experts believe that these behaviors are the result of changes in the brain caused by **toxic stress**, the repeated and prolonged exposure of the brain and body to cortisol, adrenaline, and other stress hormones (Bremner, 2006; Hornor, 2015). Using brain imaging technologies, scientists have been able to provide physiological explanations for the outward behaviors that traumatized children exhibit. While there are many structures and processes involved, the **limbic system** is often implicated. Three structural areas of the limbic system that have been investigated extensively with respect to the effects of trauma on the brain are the amygdala, the hippocampus, and the anterior cingulate cortex.

The **amygdala** is implicated in emotional functioning. A recent **meta-analysis** found reduced volume in both the left and right amygdala in individuals with trauma backgrounds, including those diagnosed with **post-traumatic stress disorder**, or PTSD (O'Doherty et al., 2015). The researchers suggest that this finding correlates with increased hypervigilance and the development of **conditioned fear responses** in traumatized individuals. This finding may also account for some of the social and behavioral difficulties these children face.

The **hippocampus**, which is involved in memory functioning, has been measured at reduced volumes in cases of adult trauma (Bremner, 2006). In children, hippocampal volume appears to remain in-tact, but hippocampal function is disrupted, particularly for

explicit memory recall (Kitayama et al., 2005). **Explicit memory** is important for academic learning tasks, including the processes of information encoding, storage, and retrieval that are so essential to classroom learning and academic success. While memory for explicit information may be degraded in traumatized children, it appears that the hippocampus displays enhanced activation when encoding or retrieving negative stimuli, like that experienced during trauma or during events that are perceived as threatening (Brohawn et al., 2010). Thus, it appears that, in school, traumatized children might struggle with memory for academic tasks while encoding with greater success the negative experiences of their days.

The **anterior cingulate cortex**, or ACC, is a frontal region of the brain that is involved in both cognitive and emotional functioning. The ACC has many connections to other regions of the brain, including the amygdala and other limbic areas. It is implicated in **conditioned emotional learning**, information processing, decision making, problem-solving, error detection and correction, and cognitive effort (Bush et al., 2000). O'Doherty et al. (2015) noted significantly reduced volumes in the ACCs of patients with PTSD, suggesting a physiological explanation for the observable difficulties that traumatized children exhibit with attention and other cognitive tasks important for navigating both the academic and social demands of a school day.

The research on disruptions in the functional and anatomical development of the brain as a result of trauma might make the problem seem insurmountable, but there is hope. **Neuroplasticity** is the process by which the brain can continue to change over time and with new experiences, potentially compensating for impoverished or disrupted developmental opportunities. It is widely acknowledged that the earlier an intervention begins, the greater the chance that the brain will be able to recover the lost or damaged function. Perry (2009) notes that this is precisely the case with traumatized children. Early interventions are critical to the recovery of adaptive social, learning, and behavioral functions in traumatized children, making identification in childcare settings crucial to more positive outcomes for traumatized children. There is hope for school-aged children and adolescents too, with researchers and practitioners working to identify evidence-based treatment options to maximize the best possible outcomes for children of all ages, including cognitive-behavioral therapies and interventions that target a child's neurological responses to stimuli (Perry, 2009; Jaffee and Christian, 2014). The challenge is in creating an integrated model of services within and in conjunction with educational settings to better reach traumatized children and their families.



Research-Informed Practice

Behavior: *Use and translate research evidence to inform and improve practice, policy, and service delivery.*

Critical Thinking Question: What resources can you think of to help you identify sound, research-based practices that would be successful in working with traumatized children to improve their academic engagement and social skills?

Summary of This Section

- Education is positively correlated with better outcomes in adulthood.
- Traumatized children are at increased risk for academic failure. They exhibit cognitive, behavioral, and socioemotional changes that impede their ability to succeed academically and socially in school.
- Acute or short-term traumatic responses do not appear to have lasting impacts on school performance.
- Prolonged exposure to traumatic stressors can alter brain development.

- Reduced volume in the amygdala may underlie the hypervigilant and emotionally reactive behaviors exhibited by traumatized children.
- While the hippocampus remains intact structurally, hippocampal functions are disrupted, leading to difficulties with the explicit memory skills necessary for encoding, storing, and retrieving information.
- Reduced volume in the anterior cingulate cortex may underlie traumatized children's difficulties with attention, information processing, decision making, and cognitive effort in school.
- Interventions for traumatized children are best delivered early and may reduce or improve the adverse effects of trauma on brain development and function.

CREATING TRAUMA-SENSITIVE EDUCATIONAL SETTINGS

Creating trauma-sensitive educational settings is important from the moment that a child enters an educational system, from childcare through high school.

Childcare

Approximately 11 million children under the age of 5 years require some form of childcare due to parental employment (Child Care Aware of America, 2014). Depending upon the age of the child, childcare services can cost families over $16,000 per year per child, a figure that rivals the costs associated with many public colleges and universities in America. Finding affordable, high-quality childcare is a significant challenge for American families, particularly for those with infants and toddlers and those living in poverty (Polakow, 2007). With nearly a quarter of America's youngest children living below the poverty level, it is concerning that only one in six income-eligible children receives **childcare assistance** (Child Care Aware of America, 2014).

Parental employment is not the only reason that children enter childcare. Some stay-at-home parents seek childcare as a tool for socializing their children or as a respite for themselves to recharge their physical and emotional batteries. Still, there are other parents whose children are placed for respite care as part of a protective factors approach to reduce instances of abuse and neglect in at-risk families (Center for the Study of Social Policy, 2007). Critical to the success of such arrangements is the inclusion of education, support programming, and resilience building for parents.

Many at-risk children, particularly those living in poverty, benefit from childcare placements as a source of enrichment across the domains of development. Programs like **Head Start** ensure that children receive healthy meals, are engaged in a variety of cognitively and socially stimulating activities, and are nurtured in a safe environment. Founded in the 1960s as part of President Johnson's War on Poverty, Head Start's mission has always been to provide comprehensive, publicly funded, high-quality enrichment services to support the healthy physical, cognitive, and socioemotional development of America's poorest children. Head Start programs serve our nation's infants, toddlers, and preschoolers as the only federally funded early childhood programs in America. Because of the disproportionate numbers of racial and ethnic minorities living in poverty (CDF, 2014), Head Start primarily serves a segregated subset of America's children.

Head Start programs provide vital outreach to families through home visits, parent education and job training, and connecting families with **community resources** (Polakow, 2007). Unfortunately, in 2012, the government funded only 41 percent of the 2 million children eligible for Head Start (CDF, 2014). While Head Start serves children from ages 3 to 5 years, **Early Head Start** was established for children ages from birth to 3; less than 4 percent of the nearly 3 million children eligible for Early Head Start were funded in 2012.

What's more, most childcare providers are ill equipped to educate and care for children with special needs, including traumatized children. To begin to address this problem, Head Start partnered with the Crittendon Children's Center in Kansas City, Missouri to develop early childhood programming called Head Start Trauma Smart (Holmes et al., 2015).

Head Start Trauma Smart (HSTS) works within the **a**ttachment, self-**r**egulation, and developmental **c**ompetencies (ARC) framework to develop learning and intervention services for preschool children, families, and communities struggling with early childhood traumatization (Blaustein and Kinniburgh, 2010). Staff members are trained in the ARC framework to help them re-conceptualize and redirect children's behaviors. Children receive cognitive-behavioral therapy services, classrooms receive ongoing therapeutic consultations, and families receive support through peer mentoring and therapeutic interventions. Initial data from the program are promising, with demonstrated improvements in the cognitive and behavioral profiles of participating traumatized children as well as improvements in the skill levels of families and childcare providers who live and work with these children (Holmes et al., 2015).

While HSTS is a promising new endeavor, America has reached a critical need to develop and fund stronger, more consistent educational services for young children, particularly those at greatest risk for victimization and later academic failure (Holmes et al., 2015). And with so many forms of childcare available, it will be very challenging to implement wide sweeping changes that address the needs of traumatized children in a systematic way. Table 6.1 provides an overview of the many types of childcare available. Please be aware that, as quality of the facilities and care increases, so does the expense, making high-quality childcare increasingly less affordable. High-quality childcare consists of a number of critical components, including licensing and accreditation, low child-to-staff ratios, group sizes, staff training and qualifications, curriculum and pedagogy, health and safety measures, nutrition and movement programs, family communication and involvement, and the physical environments available to children both indoors and outdoors (Polakow, 2007). As you examine Table 6.1, try to think of the complexities associated with attempting to integrate psychological and social work services into each setting, and how quality, affordability, and funding might factor into these endeavors.

K–12 Schools

All children in the United States are required to attend school from at least the ages of 6 through 16 years (depending on the state). While all children in America are entitled to a free public education, families have the right to make choices about where and how their children are educated (U.S. Department of Education [U.S. DOE], n.d.). Of the 62 million school-aged children in America, 49 million of them attend a public school.

Table 6.1 **Characteristics of Different Childcare Settings**

Childcare Type	Characteristics
Childcare Centers	• Typically, more expensive but also subject to greater oversight • May be run by corporations, schools, churches, colleges/universities, or other groups • Can be public or private, nonprofit or for profit • Requires both site and individual teacher licensure in most states • Operate under a variety of philosophies • May or may not include services for children with special needs • Best positioned to integrated trauma-sensitive practices into their existing operations
Childcare Homes	• Offered in a childcare provider's home • Typically more affordable than center-based care but subject to less oversight • Licensure requirements are more variable, with some states requiring no licensing at all • Provider illnesses and vacations can prove challenging for working families to find alternate care • May or may not be equipped to adequately care for children with special needs
At-Home Care	• Children are cared for in their own home by a hired provider or relative • Not licensable in any state • Lack of oversight is a concern • Provider illnesses and vacations can prove challenging for working families to find alternate care • May or may not be equipped to adequately care for children with special needs
Before/After School Programs	• Offered at a variety of sites, including schools, churches, recreation centers, childcare centers, and organizations (e.g., Boys and Girls Clubs of America) • Serve primarily to cover gaps between school schedules and parent working hours • Can reduce truancy, delinquency, and stress
Vacation/Summer Camps	• Can be run as day or overnight programs • Some offer summer enrichment to maintain gains made during the academic year • Some offer specialized programming for children with a variety of learning, health, and social needs • Some experiential camps available that are dedicated to traumatized children • Public schools are required to offer and/or fund summer school programming for students with extended year services in their individualized education programs (IEPs)

Sources: Based on CDF (2014), Holmes et al. (2015), Child Care Aware of America (2014), Polakow (2007), and U.S. OPM (n.d.).
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Most children attend a neighborhood public school, either as determined by their district or as enrolled by their parents through **school choice** (U.S. DOE, n.d.). Neighborhood schools tend to be conveniently located within the communities they serve, and their teachers, staff, and administrators typically understand the social, economic, and political landscapes from which their students hail.

Charter schools are special public schools that are allowed to deviate from state and local edicts by employing innovative teaching and learning strategies, but they are also required to meet more stringent accountability standards than their neighborhood counterparts (U.S. DOE, n.d.). Charter schools are typically proposed and developed by parents, community or business leaders, or other citizens who are concerned with offering students creative opportunities for challenge and achievement that are not found in the neighborhood public schools.

Magnet schools are also special public schools. Each tends to emphasize a specific subject, like math and science or the arts, while attempting to attract students from racially, ethnically, and economically diverse backgrounds (U.S. DOE, n.d.). Magnet schools are heralded for their ability to reach and support at-risk populations of students while providing challenging and engaging curricula.

Sometimes, students with special emotional and behavioral needs require placement out of district, either at a **residential school** or in a **substantially separate day school** program, to ensure that their needs are accommodated in a manner that allows them to succeed in school. These students are usually supported by an **individualized education program (IEP)**, and a placement decision has to have been made and agreed to by both the school personnel and the parents or guardians. Such placements are typically very expensive, as many of these schools are private institutions that specialize in treating children with these types of disorders. In many states, departments of social service will share the cost of a residential placement with the sending public school district, while day placements are typically paid for by the public school district alone. Because the majority of the students who attend these schools are covered by public funds, residential and day treatment programs may be required to operate under the state's prescribed curriculum standards, participate in statewide accountability assessments, and maintain accreditation and licensing.

Parents may also choose to educate their children at home. While each state has its own guidelines and requirements for homeschooling, all states have compulsory attendance laws, which require some form of documentation of the learning and mastery that occurs in cases of homeschooling (U.S. DOE, n.d.). The efficacy of homeschooling depends upon a great deal of planning and structure. Effective homeschooling draws from a variety of sources to develop the homeschool plans, including distance/virtual learning, curricula published by homeschool organizations, the public library, museum exhibits and programs, and state curriculum standards (DiStefano et al., 2005). **Virtual schools**, through which students can take courses or even complete their diploma requirements online, are relatively new and offer a creative option for homeschooled students, students who wish to take coursework not offered within their schools, or students who require an alternative to the physical neighborhood school setting.

Unlike public schools, **private schools** charge tuition and fees, require entrance applications (some requiring intelligence or achievement test scores as a part of this process), and are most often affiliated with a church or religious denomination (U.S. DOE, n.d.). Some states offer **school vouchers** as a part of their school choice options, which allow parents to send their child to a private institution through the use

of public taxpayer funds. School vouchers are controversial and are often criticized by proponents of the public schools as weakening the public education system's financial health, public reputation, and social importance. In addition, these schools are not governed by state curriculum standards or accountability measures, which could also exempt them from any statewide efforts to establish trauma-sensitive practices in schools.

Regardless of the type of K–12 educational setting, each can be enhanced by the integration of trauma-sensitive practices. Rather than asking educators to add additional responsibilities to their already full plates, trauma sensitivity advocates argue that whole-school professional development around issues of trauma and recovery serve to strengthen and augment existing skill sets, smoothing the path for working more effectively with traumatized children (Cole et al., 2005, 2013).

Schools employ a variety of professionals who collaborate to ensure that students are able to gain the most from their educational experiences. In addition to teachers and administrators, the umbrella of school personnel includes nurses, guidance counselors, social workers, school adjustment counselors, school psychologists, school safety officers, occupational therapists, speech-language pathologists, English language learner services, special education teachers, gifted educators, paraprofessionals, teacher aides, librarians, bus drivers, secretaries, and custodians. While each serves a different role within the school setting, the personnel who work in trauma-sensitive schools all strive to meet the same goal: working together within a common framework to help all students succeed in a safe and supportive environment.

Transforming educational settings into trauma-sensitive schools requires systemic change and unified personnel investment (Cole et al., 2005, 2013). Administrators must buy into the philosophy that an environment that supports traumatized children will be a safe and supportive environment for all children. Trauma-sensitive schools recognize that non-traumatized students can be adversely impacted by the challenging behaviors of their traumatized peers and thus strive to ensure an optimal and compassionate learning environment for all students (Ristuccia, 2013).

Developing a trauma-sensitive approach in schools requires a **multitiered system of supports (MTSS)** that includes staff-wide training and skill-set development (Rossen and Cowan, 2013). This first tier transforms the school environment to optimize learning, self-confidence, and trust-based relationships for all members of the school community. These skills include learning how to recognize and better understand the behaviors that traumatized children exhibit, as well as the development of skills for addressing and redirecting these behaviors using methods that are caring, fair, and supportive (Cole et al., 2005). Educators must also learn about the effects of trauma on the brain and cognition, so that they can better understand why traumatized children might struggle with learning tasks. In addition, educators in trauma-sensitive schools receive training in a variety of teaching techniques that help them to better engage these struggling students. Other first-tier changes include bullying prevention programs, school-wide social skills development, and adjustments to school discipline policies that allow for children to make mistakes and learn from them. Trauma-sensitive schools must also be responsive to the needs of their staff, as they themselves may have trauma histories or may experience **vicarious traumatization** via their work with traumatized children (Parker and Henfield, 2012).

For some traumatized children, first-tier adjustments to the school environment are not enough to address the complexity of their learning, behavioral, and social needs



Diversity and Difference in Practice

Behavior: *Apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies.*

Critical Thinking Question: How might a social worker's ability to monitor their own personal biases and values assist them in helping other school personnel to do the same when working to create a trauma-sensitive school environment?

(Rossen and Cowan, 2013). Second- and third-tier interventions within an MTSS tend to more directly target individual students by providing more intensive services. Tier-two services can be delivered to individual students or within small groups, and often involve family-based intervention services as well. This second tier of services is typically delivered within the school setting by school personnel. Third-tier interventions are the most intensive and may be delivered by professionals employed outside of the school who specialize in the specific needs that the child and family have. In both second- and third-tier interventions, connecting children and families to additional supports both within the school and the community is a powerful way to help traumatized children gain access to a continuity of services to help them thrive both inside and outside of school (Averill and Rinaldi, 2011).

Summary of This Section

- Childcares are considered educational settings and vary greatly in quality, affordability, and oversight. Childcare centers are better positioned than other childcare settings for integrating trauma-sensitive services into their programming.
- Head Start and Early Head Start are federally funded early education and care programs that seek to improve developmental outcomes for children living in poverty.
- Head Start Trauma Smart is a new program that targets traumatized children living in poverty by integrating trauma-sensitive trainings for staff with therapeutic interventions for children and families. All Head Start programs work to ensure that families are connected with available community resources.
- K–12 educational settings include a wide variety of publicly funded and private school options.
- Trauma-sensitive schools promote system-wide change by involving and training all school personnel to enhance their existing roles and skill sets to create safe and supportive settings for all students.
- Trauma-sensitive schools rely on MTSS to ensure service delivery at appropriate levels of intervention and intensity for traumatized students. First-tier interventions include training educators in new teaching techniques and modifying school discipline policies. Second- and third-tier interventions are more intensive, more individualized, and often involve family services. Interventions at this level might require helping students and families to access professionals and resources in the community.

SOCIAL WORKERS IN EDUCATIONAL SETTINGS

School social work is a specialty area within the broader discipline of social work. According to the School Social Work Association of America (sswaa.org), **school social workers**, also called school adjustment counselors, are master's-level mental health professionals with targeted expertise in serving children and families who are experiencing difficulties within and around the school setting. Their primary goal is to ensure

that barriers to student academic and social success are mitigated. They may provide direct services to children and their families, consultation services to school personnel, or advisory services to school districts. School social workers also serve as a vital liaison between community-based service providers and the children, families, and schools that need them.

Within the school setting, school social workers may be called upon to provide one-on-one or small group counseling with students experiencing trauma, stress, social difficulties, behavioral problems, substance use, or myriad other factors that can have an adverse effect on a student's academic success. Within a trauma-sensitive school, social workers may be integral in developing and implementing training programs and school-wide changes to create a safe and supportive environment (Cole et al., 2013). As such, the school social worker will likely function within all three tiers of the MTSS established within a trauma-sensitive school, often providing invaluable context when engaged in discussions of student progress in the educational setting.

Mental health professionals working within school settings often have similar goals, but each specialist's training helps them to address those goals in different ways. For example, **school psychologists** are trained to be experts in assessment, learning, behavior, disabilities, and education law. Because they are trained psychologists, their expertise in data collection, analysis, and interpretation is often called upon to help schools make informed, evidence-based decisions about individual students or school programs. School social workers, though working toward the same student-centered goals as the school psychologist, might approach problems from a systemic or community perspective. Their disciplinary focus on understanding issues of diversity, poverty, and social justice helps them to approach student problems with a broader perspective that often provides much-needed context in the development of solutions for students and schools (Cowan et al., 2013). Working together, mental health professionals can capitalize on their respective strengths while collaborating effectively to ensure the best outcomes possible for at-risk students in schools.

Unfortunately, schools rarely have optimal numbers of mental health professionals on staff, and many schools have no school social worker or school psychologist in the building (Cowan et al., 2013). When school districts do employ mental health professionals, they are often forced to divide their time between multiple school buildings within that district, creating caseloads that are unreasonably high. High caseloads are not uncommon in school settings, but when school social workers, psychologists, guidance counselors, nurses, and special education staff members have unmanageable caseloads, they are unable to provide a full continuum of services to the students who need them. In addition, advocates caution that relying too heavily on community partners to cover these gaps in service delivery may result in an unmanageable burden on community agencies who are often overburdened themselves (Cowan et al., 2013).

When community supports are needed, school social workers are essential in the process of identifying appropriate community partnerships for students in need. Often, the school social worker is the critical contact for students, families, and community partners, ensuring that students and families follow through with and maintain open access to the community-based services they need to help the student navigate the issues interfering with their academic success.



Policy Practice

Behavior: *Identify social policy at the local, state, and federal level that impacts well-being, service delivery, and access to social services.*

Critical Thinking Question: How might a social worker be able to help school districts advocate for greater numbers of mental health professionals in their school buildings?

Summary of This Section

- School social workers, often called school adjustment counselors, are master's-level mental health professionals who are specially trained to work with students, families, and schools.
- School social workers may provide direct or indirect services to children, families, school personnel, and school districts.
- School social workers often collaborate with other school-based mental health professionals to ensure the best outcomes for students.
    - There is a shortage of funding for school-based mental health professionals. Many school buildings function without a full-time mental professional in the building.
    - School social workers are uniquely positioned to serve as a point of contact between community-based partners and at-risk students and families.

EDUCATIONAL RIGHTS OF TRAUMATIZED CHILDREN

Most traumatized children can be accommodated within the general education setting when a safe and supportive environment is established using a trauma-informed MTSS (Cole at al., 2005). But for some children, their traumatic experiences push them toward the development of trauma- and stressor-related disorders, including PTSD, **reactive attachment disorder** (RAD), and **adjustment disorder** (DSM-5, 2013). Even for children who are not properly diagnosed with a trauma- or stressor-related disorder, severely traumatized students will likely present with characteristics associated with this class of disorders (Cole et al., 2005; DSM-5, 2013). Such behaviors include **hyperarousal** and **hypervigilance**, where the child is continuously attuned to potential threats within the environment, even when their surroundings present no perceivable threats to their safety. These children are also at great risk for depression, anxiety, aggression, and avoidance behaviors, which are often triggered by the memory or re-experiencing of traumatizing stimuli or circumstances. All of these presenting behaviors, regardless of the diagnosis of a trauma- or stressor-related disorder, place the traumatized child at even greater risk for academic and social failure in school settings. Unfortunately, it is often very challenging to make a trauma- and stressor-related disorder diagnosis, as childhood presentations of symptoms may be misdiagnosed as other disorders such as Attention Deficit Disorder with Hyperactivity (ADHD) (Cole et al., 2005; DSM-5, 2013).

While a child's needs should be identified and treated based upon patterns of symptoms and behaviors rather than a specific diagnosis, obtaining an official diagnosis can be helpful in securing special educational services under the law for children who need them (Wright & Wright, 2007). Most traumatized children will not qualify for special education services, but for those who do, there are two laws that protect their rights as students in our public schools.

Case Example Amaya

Amaya is an 8-year-old foster child who was recently placed with a new family and enrolled in a new school. Amaya was born with medical complications and has undergone several surgeries in her young life. Amaya was also severely neglected by her birth

mother, whose drug addiction ultimately resulted in Amaya's removal from the home. Amaya's foster parents are working with the school social worker to help Amaya adjust to her new life. Amaya was quiet and reserved when she first entered the school, but her behaviors have deteriorated as the weeks have passed. Amaya lashes out verbally and physically at her peers and teachers, often requiring separation from the group. She has wild tantrums where she will scream and threaten everyone who tries to help her. Sometimes, Amaya appears to be in her own terrifying world, unable to respond to the people around her because she is paralyzed in a state of fear. Amaya is not making progress in school, and her teacher is concerned that Amaya may be lacking the basic academic skills necessary for her to participate in the school's third-grade curriculum. Amaya's foster parents believe that she might be suffering from post-traumatic stress disorder. The school social worker has put them in touch with a local clinical psychologist and has suggested that they request a meeting with the school to begin a special education evaluation for emotional disturbance.

In 1973, **Section 504** of the Vocational Rehabilitation Act provided antidiscrimination protection for students with disabilities, requiring that all public school students, regardless of disability status, have access to educational opportunities that is equal to that of their nondisabled peers. In 2008, President Bush signed into law the **Americans with Disabilities Act Amendments Act (ADAAA)**, which expanded the definitions of disability and effectively expanded coverage for more students under Section 504. If a student has a disability that substantially limits one or more major life functions (e.g., breathing, eating, walking, learning), requiring **accommodations** within the setting to ensure equal access to all school-based services, that child is covered under Section 504.

Schools must consider only the disability itself in its raw state in the development of appropriate accommodations for disabled students, disallowing the existence of mitigating factors (such as medications or other interventions) that may compensate for the effects of the disability. As such, schools are not allowed to use mitigating measures as a means for disqualifying students for coverage under Section 504. For example, children with life-threatening allergies are considered to have a disability that can substantially limit one or more major life functions (in this case, anaphylaxis can disrupt breathing and cause death). This disability, in turn, has the potential to adversely impact the child's equal access to all services offered within the school setting (e.g., potential allergen exposure in the cafeteria, lessons that involve the use of food for instruction, or transportation to and from school). The fact that a child with life-threatening allergies has access to epinephrine, which might save their life during an anaphylactic reaction, cannot be considered a factor in making decisions about the child's disability or the provision of accommodations for that disability.

The same is true for traumatized students who have been deemed to have an emotional or behavioral disturbance, such as PTSD or RAD. If the traumatized child is not able to participate equally in all aspects of their school day (including but not limited to learning activities, cafeteria access, transportation to and from school, and school-sponsored extracurricular activities), even within a trauma-sensitive setting, that child will likely qualify for protection and special accommodations under Section 504.

A small subset of traumatized children may require more than accommodations to make effective progress in school. In cases where children require specially designed or modified instruction, **PL 94-142** is invoked. Signed into law in 1975, PL 94-142, the Education for All Handicapped Children Act, remains one of the most substantial legislative changes in the history of education. At its core, two mandates are central: every child is entitled to a **free and appropriate public education (FAPE)** and every child must be educated in the **least restrictive environment (LRE)** possible. LRE is defined as the

instructional setting most similar to the regular education classroom, if not the classroom itself, as permitted by the child's abilities.

PL 94-142 established criteria for the identification of children who require special education services, the assessment and diagnosis of disabilities that impede academic progress, and the structured planning of IEPs. It also outlined the requirements for parental involvement and the child's right to due process. In 1990, the Individuals with Disabilities Education Act (IDEA) reauthorized PL 94-142 and expanded the list of disability categories to include traumatic brain injury and autism. In 1997, IDEA was reauthorized once again, this time to include protections for children with mental health and behavioral disorders. This iteration of the law also mandated improved communication between schools and parents of children receiving special education services.

In 2004, the **Individuals with Disabilities Education Improvement Act** (IDEIA, or IDEA 2004) was signed into law and remains in effect today. This law differs from previous iterations of IDEA in its emphasis on accountability and student outcomes, teacher qualifications, early intervention services, and positive behavioral interventions (Wright and Wright, 2007). One of the most substantial areas of revision in IDEA 2004 is the role of assessment, as schools are now authorized to use what is called **response to intervention (RTI)** in determining special education eligibility. Instead of waiting for a child to fail in the educational setting, students who struggle to make progress receive intervention services immediately at one of three increasingly intensive levels. Thus, intervention starts earlier and is included as a part of the assessment process.

RTI hails from the same model of MTSS that has been used to develop trauma-sensitive schools (Center on Response to Intervention, n.d.). As such, even within a trauma-sensitive school, if a child is not making effective academic progress despite all interventions provided within the three tiers of trauma-sensitive support provided by the school, that traumatized child might qualify for an IEP. The challenge is in the process of determining eligibility.

To qualify for an IEP, three criteria must be met (Wright and Wright, 2007). First, the child must be determined to have a disability (in this case, an emotional or behavioral disturbance). Second, there must be evidence that the child is unable to make effective progress in the curriculum as a direct result of the disability despite reasonable accommodations. Lastly, there must be a determination that the child requires **specially designed instruction** to make effective progress. Without this last piece, the child could be covered by a 504 plan instead of an IEP. If the child does in fact require **modifications** to content, instructional strategies, or assessment techniques, an IEP will be developed.

K–12 students, who are covered under Part B of IDEA 2004, are not the only children covered under special education law. Preschool children are also covered under Part B, requiring public schools to provide services to eligible children from the age of 3 years. Part C of IDEA 2004 is devoted to early intervention for disabled or developmentally delayed infants and toddlers (children from birth to 2 years). Families, caregivers, and medical personnel tend to be in the best positions to identify a struggling infant or toddler. Because caregivers are included in this list, childcare teachers are now on the front lines of identifying developmental difficulties, including childhood trauma (Holmes et al., 2015).

Children can be referred for special education evaluation by parents, teachers, or other school personnel. Such evaluations must be conducted by qualified professionals and may include the assessment of academic skills, cognitive functioning, socioemotional competencies, behavioral functioning, adaptive skills, or physical capabilities. School psychologists tend to administer intelligence and personality tests, while special

education teachers tend to evaluate academic skills and classroom behavior. School nurses conduct health-related assessments, occupational therapists evaluate sensory integration and motor skills, and speech-language pathologists investigate a child's linguistic capabilities. Independent evaluations by outside professionals, such as clinical psychologists or neuropsychologists, may be included as well, and are required at the school's expense when the disability in question cannot be assessed by school district personnel as is often the case with emotional or behavioral disturbances (Wright and Wright, 2007).

The IEP prescribes which school personnel are responsible for service delivery to the child and defines the capacities in which those personnel should function for the child. Classroom teachers, special education teachers, occupational therapists, speech-language pathologists, reading specialists, school social workers, or school psychologists may be identified in the IEP as providing direct service to the disabled child. They may also provide consultative services to the child's teachers and parents. The IEP provides information about whether services should be delivered inside or outside of the regular classroom, including any placements outside of the school district in residential or day treatment programs. The IEP also indicates whether services should be delivered in small groups or individually, and how often each of those services should be provided. An IEP can be used to provide for a longer or shorter school day, as well as a longer or shorter school year. Finally, the IEP outlines clearly the goals toward which the child will work and how progress data will be collected and reported.

Transition planning is a required element of any IEP that covers a student 16 years of age or older (Wright and Wright, 2007). The goal is to connect these students with community services and agencies that can assist in their transition to either independent or supported work, vocational programs, colleges, adult programming, or independent living services to support their success as adults in the community once they leave high school. For students in a trauma-sensitive educational setting, connections with community supports might already be established, but an examination of transition goals reveals that students with emotional disturbance are lacking in explicit transition planning goals on their IEPs (Powers et al., 2005). In fact, only half of students with emotional disturbance have employment or college education goals written into their education plans. The establishment of effective transition plans should be a priority if we wish to see traumatized children become healthy and self-sufficient adults. With the high incidence of trauma histories and mental illness within our incarcerated population (Northrup and Berkowitz, 2015), effective transition planning could serve as an important protective factor for students at risk of becoming criminal offenders.



Advance Human Rights and Justice

Behavior: *Apply their understanding of social, economic, and environmental justice to advocate for human rights at the individual and system levels.*

Critical Thinking Question: If a school social worker becomes aware that accommodations or modifications set forth within 504 plans and IEPs are not being provided, how might the social worker go about advocating for the rights of those students?

Section 504 plans provide for accommodations within the educational setting, while IEPs provide for modifications to curriculum, instruction, or assessment. IEPs are subject to greater oversight than 504 plans are, as progress toward stated educational goals is reported four times per year for IEPs. Both 504 plans and IEPs are reviewed annually (more frequently if needed), and new evaluations for IEP eligibility are conducted every 3 years. In both cases, families and guardians are often placed in the position of having to advocate fervently for the child's needs. Both 504 plans and IEPs are legal documents, and failure to comply with either is against the law. Families or guardians who are concerned that a 504 plan has been violated can file a complaint with the **Office for**

Civil Rights (OCR); complaints against a school for violation of an IEP are filed with the designated **State Education Agency (SEA)**. Teachers and families of children with 504 plans or IEPs should make sure that they are well-educated about **procedural safeguards**. Wrightslaw.com is an indispensable online resource for any party involved with special education, and is often a family's lifeline for advocacy issues, particularly when they cannot afford to hire an educational advocate for their child.

Wrightslaw.com is also a valuable resource for teachers, school social workers, school nurses, or other school personnel seeking to become more knowledgeable about their roles in special education. It is also a good place to start for those who are concerned that their schools are in violation of 504 plans or IEPs. These educators are encouraged to seek professional advice on how best to protect themselves when making school violations known, as they may face retaliation. Laws protecting teachers vary by state, but case law is rife with examples of school personnel who have won lawsuits against schools that have retaliated against whistleblowers.

Summary of This Section

- Not all traumatized students will qualify for special education services. Children with severe traumatization may be diagnosed with an emotional disturbance, a category of disability that is covered under special education laws.
- Children with emotional disturbance may be eligible for special accommodations under Section 504 of the ADAAA to prevent discriminatory practices that could exclude them from participation in all aspects of the school day.
- Some children with emotional disturbance may require modifications to curricular content, instructional methods, or assessment techniques to make effective progress in school as a result of their disability. These children are eligible for an IEP under IDEA 2004.
- Preschool and K–12 students are covered under Part B of IDEA 2004, while children ages birth to 2 years are covered under Part C.
- Students referred for special education evaluation must be assessed in all areas of concern related to the suspected or diagnosed disability, and only qualified professionals are allowed to conduct assessments for IEP evaluations.
- Schools must provide for assessments conducted by outside specialists if they do not employ the qualified professionals necessary to conduct any part of the evaluation within the school district.
- Trauma-sensitive schools may use a student's lack of response to established multitiered systems of support to substantiate their special education eligibility.
    - IEPs detail every aspect of a child's education, from learning and behavior goals to the personnel responsible for ensuring that those goals are met. IEPs must also include transition plans for students over the age of 16 years.
    - 504 plans and IEPs are both legal documents. Failure to comply with either is legally actionable by disabled students and their families.

SUMMARY

- Childhood trauma can produce cognitive, behavioral, and socioemotional changes that impede a child's ability to succeed academically and socially in school. Acute or short-term traumatic responses do not appear to have lasting impacts on school performance, but prolonged exposure to traumatic stressors can alter brain development. Differences in structure and function of the amygdala, hippocampus, and anterior cingulate cortex in traumatized children may underlie their emotionally reactive behaviors, difficulties with memory skills, and problems with attention, information processing, and decision making. Interventions for traumatized children are best delivered early and may reduce the adverse effects of trauma on brain development.
- Both childcares and schools are considered educational settings. Childcares vary greatly in quality, affordability, and oversight, making childcare centers the best candidates for integrating trauma-sensitive services into their programming. Head Start Trauma Smart is a new initiative that targets traumatized preschool children living in poverty by integrating trauma-sensitive practices into Head Start's existing framework. K–12 educational settings include a wide variety of publicly funded and private school options. Relying on multitiered systems of support (MTSS) to ensure service delivery at appropriate levels of intervention and intensity for traumatized students, trauma-sensitive educational settings promote system-wide change by involving and training all school personnel to enhance their existing roles and skill sets to create safe and supportive settings for all students.
- School social workers are master's-level mental health professionals who are specially trained to work with at-risk students and families in educational settings. They may provide direct or indirect services to children, families, school personnel, and school districts. School social workers often collaborate with other school-based mental health professionals to ensure the best outcomes for students, but they also serve as a point of contact between community-based partners and at-risk students and families. Many school buildings function without a full-time mental health professional in the building, decreasing the likelihood that traumatized children will receive the help they need if they do not attend a trauma-sensitive school.
- Some traumatized children may be eligible for special educational accommodations or modifications under the law, particularly those with severe traumatization or who are diagnosed with an emotional disturbance, a category of disability covering a range of mental health presentations including trauma- and stressor-related disorders. Students with emotional disturbance may be eligible for special accommodations under Section 504 of the Rehabilitation Act of 1973 to prevent discriminatory practices that could exclude them from participation in all aspects of the school

day. Some children with emotional disturbance may require modifications to curricular content, instructional methods, or assessment techniques to make effective progress in school as a result of their disability, making them eligible for an IEP under IDEA 2004. Only qualified professionals are allowed to conduct assessments for IEP evaluations. Once placed on an IEP, every aspect of a child's education, from learning and behavior goals to the personnel responsible for ensuring that those goals are met, is detailed in their education plan. 504 plans and IEPs are both legal documents. Failure to comply with either is legally actionable by students and their families.



7

Child Abuse and Neglect: Protecting Children When Families Cannot

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Discuss how children have been treated throughout history and how there has been evidence of maltreatment.
- Describe the various types of maltreatment and who might neglect or abuse children in this manner.
- Outline the process of reporting child maltreatment to the appropriate agencies.
- Discuss the types of court that might address child maltreatment.
- Describe the role of the social worker in protective services.
- Discuss the future of protective services for children.

CHAPTER OUTLINE

HISTORICAL VIEW OF CHILDREN AND THEIR WELFARE 147

Child Neglect Throughout History 148
Child Labor and Maltreatment 149
Sexual Mores and Abuses 149
Efforts to Control Child Abuse 150

MALTREATMENT DEFINED 152

Physical Abuse 152
Neglect 158
Sexual Abuse 162
Emotional or Psychological Abuse 170

REPORTING CHILD MALTREATMENT 172

Intake 173
Assessment 174
Case Management and Treatment 176

COURT INTERVENTION IN PROTECTIVE CASES 177

Juvenile or Civil Court 177
Criminal Court 178
The Effect of Court Involvement on Children 179

HISTORICAL VIEW OF CHILDREN AND THEIR WELFARE

The historical overview in Chapter 1 acquainted us with the fact that the concept of childhood is recent and that children were previously considered the property of parents and were dependent on those adults. Parents were free to kill children, sell them into slavery, maim them,

THE ROLE OF THE PROTECTIVE SERVICES WORKER 179
FUTURE OF PROTECTIVE SERVICES 182
Customized Response and the Necessity of Training 182
Community–Based Child Protection 183
Encouraging Informal and Natural Helpers 184
SUMMARY 184

or abandon them. Children might even be used in sacrifices as in the biblical account of Abraham's intent to sacrifice his son Isaac. DeMause (1995–1996) reports that archeological findings of an abundance of skeletons of infants and toddlers suggest that child murder and sacrifice were all too common. The much-quoted biblical passage that charges parents to "withhold not correction from the child for if thou beatest him with the rod he shall not die; thou shalt beat him with the rod and deliver his soul from Hell" (Proverbs 23:13–14) is often still paraphrased as "spare the rod and spoil the child" in support of corporal punishment of children.

The circumstances of the parents dictated the circumstances of their children. Poor parents, subject to **almshouses**, went there with their children, who often suffered **neglect** and even death. In the United States, children who arrived as immigrants worked alongside their parents and did much to shape this country. African American children came originally as slaves who were at the mercy of not only their parents but also their owners. It was not unusual for them to be beaten or separated from their families according to the needs of their owners. Asian and Pacific Islander children may have fared somewhat better. Their parents' cultural values ensured that these children were absorbed into and protected by the family, when the family was able to do this. Hispanic and Native American children, too, had the benefit of the family or the greater community. The fact that families also were not well treated impacted the children (Crosson-Tower, 2013).

By the late 1800s, some children from poor families found placement in so-called **orphan asylums**. This is a misnomer because many of these children still had at least one living parent. Conditions in these institutions varied, but incidences of physical and sexual abuse are well documented (Smith, 1995). Even if these orphanages had not been settings in which maltreatment could be hidden from the public, children suffered from being institutionalized.

As we consider the history of the welfare of children, it is important—for the purposes of this chapter—to see these in the light of possible maltreatment.

Child Neglect Throughout History

Neglect is a concept alluded to rather than fully discussed in historical contexts. Early images of neglect conjure up street waifs, cold, hungry, and destitute. To sustain themselves, these children resorted to theft, begging, and loitering, to the annoyance of the upper-class passersby. In fact, such scenes were a contributing factor to the child-saving movement. In reality, such children reflected the social conditions of their time when poverty was largely unaddressed. Swift (1995) contends that mothers were blamed for the neglect of these children; rarely was the father's role considered. These mothers were felt to be "morally wanting"; often it was assumed that they were under the influence of alcohol or guilty of "loose living." Early case records describe these mothers as "mentally limited" and immature. Rarely were circumstances other than their own ineptitude given weight.

Only recently have such societal issues as poverty and housing been considered. Yet, even today individual characteristics of mothers are seen as the primary reason why their children are neglected (Swift, 1995), despite assertions by some experts that neglect results from a complex matrix of societal, personal, and systemwide inadequacies (Garbarino and Collins, 1999; Taylor and Daniel, 2005; Horwath, 2013).

Child Labor and Maltreatment

Childhood as we know is a relatively new concept. Children of previous centuries were expected to be as useful as their parents. Many parents sought to ensure their children's future through **indenture**, apprenticing children to tradesmen or masters to learn a trade. Indenture began when the child was quite young and lasted into adolescence or early adulthood. Although it was seemingly a good way to learn a future vocation, reports tell us that masters were not always benevolent and that some children suffered from a variety of abuses.

As the industrial revolution dawned, children began to find employment in factories. They were expected to work long and hard, often beyond their endurance. Child advocates became concerned about the abuses to children in the workforce and urged reform. One such critic was **Jane Addams** of Chicago's Hull House. Hull House, a settlement house established in the Chicago slums on the model of New York's Toynbee Hall, strove to help immigrants integrate into their new society. Economic need found immigrant children working in factories along with their parents, but without the strength or endurance of their elders. Often the conditions under which they worked were also dangerous. Addams recounts her special concerns, in her memoirs, *Twenty Years at Hull House* (1910). She observed young children injured and even killed when machinery was not properly maintained and was horrified when the factory owners did nothing at all about the malfunction. She then learned of the documents that parents had been forced to sign exonerating the owners from any damages resulting from the children's "carelessness."

Although the staff of Hull House fought valiantly for the rights of children, it would be some years before the laws protecting children from unfair labor practices would be passed. Some families were actually dependent for their survival on the income brought in by their children. Thus, poverty must be viewed as an important contributor to early child labor.

Sexual Mores and Abuses

Children have been sexually exploited throughout history, although the definition of sexual exploitation has changed. In ancient times, female children, especially, were seen as the property of the father, who could do with them as he chose. A daughter was something that could be used for barter to gain lands, money, and prestige. Such practices are still evident in some parts of the world. Betrothal might also be sealed through intercourse if the father and tradition should dictate. Daughters given in betrothal or marriage might be as young as 12. Other girls entered the convent as young as 9, sometimes to later be used sexually by the monks associated with the convent (Rush, 1992).

DeMause (1991, 1995–1996) reports that mothers often masturbated their sons to increase penis size or handed them over to men to be indoctrinated into sexuality. For example, the ancient Greeks are known to have practiced **pederasty**, the use of young boys by men. Families of these boys might seek out a wealthy benefactor to whom they would offer their son for sexual training and pleasure. The rationale was that such practices turned boys into better warriors and prepared them more effectively for adult life (Rush, 1992; deMause, 1995; Hilarski, 2008). But the sexual use of children, largely sanctioned by society, has continued into modern times.

One often thinks of the Victorian era as staid and proper. On the surface, Western society frowned on sexuality; masturbation was considered a precursor to insanity, promiscuity, and even death; and women saw sexual behavior in the marital bed as an odious duty they

had to perform. Yet, the sexual abuse of children flourished. Child pornography and prostitution were the alternatives sought by men who felt they could not prevail on their wives. Slave owners in the southern United States took sexual pleasure in "breaking in" their slave girls at ages 13 and younger (Jackson, 2000; Hilarski, 2008; Crosson-Tower, 2014).

The Victorian era also was the setting of a debate over sexual abuse that would be written about until the end of the twentieth century. Sigmund Freud, the father of modern psychoanalysis, found that many of his female patients reported that they had been sexually molested by fathers, uncles, and brothers. Fleetingly, he considered the magnitude of the incidence of incest that the reports must represent. Yet, soon after disclosure the women would flee **treatment** or recant their allegations. (Modern therapists now see this practice as typical of survivors of incest.) For this reason and because he found little sympathy or precedent for this thinking in the medical community of his day, Freud eventually dismissed the women's reports as hysterical symptoms that originated in fantasy rather than actual occurrences (1966). Critics would later criticize him for not having developed his early theories, which might have helped incest survivors. It was not until the late twentieth century that women who reported incest tended to be believed (Crosson-Tower, 2014; see also Robertson, 2005).

Although in Western culture sexuality seems like an adult activity and one in which we should not involve children, deMause (1995–1996) believes that the practice of sexually using children continues today in many other parts of the world.

Efforts to Control Child Abuse

Sagatun and Edwards (1995) suggest that two reform movements, the **Refuge Movement** and the **Child Saver Movement**, influenced children's exposure to abuse in the nineteenth and twentieth centuries. The Refuge Movement began in the early 1800s by seeking to remove children from almshouses and placing them in institutions designed for their care. Unfortunately, the conditions in these refuge houses often rivaled those of the almshouses, and children rarely fared better than they might have if left with their parents. Abuse and neglect were rampant at the hands of overworked staff and other residents. In 1838, a Pennsylvania court also set a precedent by removing children from their parents' custody, thus establishing a practice that continues today (deMause, 1995–1996; Sagatun and Edwards, 1995). There is some question as to whether the early practices of the Refuge Movement were designed to protect children or keep them away from the rest of society. However, in 1874 a case in New York City changed the history of helping children.

Mary Ellen Wilson lived with Francis and Mary Connelly and was the daughter of Mary Connelly's first husband. It was not uncommon for neighbors to see the poorly clad 8-year-old shivering, locked out in the December cold. But it was her cries as she was beaten with a leather strap that made one neighbor alert a neighborhood church worker, Etta Wheeler. After getting no help from the police, Wheeler finally turned to the American Society for the Prevention of Cruelty to Animals (ASPCA) and its director, Henry Burgh, arguing that animals had more protection than little Mary Ellen. Whether Burgh acted on behalf of the ASPCA or as a private citizen is unclear, but history does record that the case was prosecuted by Burgh's good friend, attorney Elbridge Gerry. From this trial and the controversy surrounding it came the **Society for the Prevention of Cruelty to Children (SPCC)** in early 1875. From New York City, the SPCC spread to other major cities as the first agency designed to intervene on behalf of abused and neglected children (Shelman and Lazoritz, 2003; Crosson-Tower, 2013). By 1881, the SPCC was given authorization to make investigations and place magistrates in courts to protect the rights of children. At that time, the purpose of the society was not only to protect children but also to prosecute their abusive

parents (Sagatun and Edwards, 1995; Shelman and Lazoritz, 2003; Crosson-Tower, 2013). Today, as we understand more about the psychology of those who become abusive, the trend is toward the protection of children and the rehabilitation of their parents.

The Child Saver Movement was founded chiefly by middle- and upper-class women whose aim was to protect children from abuse, at the same time influencing child labor practices and legal practices affecting children. These efforts gave rise to the founding of the juvenile court system through the **Juvenile Court Act of 1899** (Sagatun and Edwards, 1995; Siegel and Welsh, 2014). The juvenile court system is the primary legal entity that deals with child abuse and neglect. The use of this system will be discussed later in this chapter.

Another milestone in the protection of children from maltreatment was the work of **C. Henry Kempe** and his colleagues. In the late 1940s, Columbia University radiologist **John Caffey** led his colleagues in the recognition that multiple unexplained and often improperly healed fractures in children could indicate abuse by their caregivers. As Caffey made his theory better known through medical conferences and writings, Kempe, then chairman of the Department of Pediatrics at the University of Colorado Medical School, began his own study of the phenomenon. In a subsequent article providing an early definition of child abuse, Kempe coined the term "battered-child syndrome," which he and his colleagues defined as a "clinical condition in young children who have been severely physically abused, usually by a parent or foster parent" (Kempe et al., 1962; Kempe, 2007). Clearer definition of this phenomenon brought it to the attention of a variety of professionals who sought to intervene through their own disciplines.

By 1972, the **National Center for the Prevention of Child Abuse and Neglect** was established, through financial aid from the University of Colorado Medical Center, for the purpose of research and the sponsorship of training programs in the area of child abuse and neglect. In 1974, 100 years after Mary Ellen Wilson endured the beating of her caregivers, the **Child Abuse Prevention and Treatment Act (PL 93-247)** was passed. This act established the National Center on Child Abuse and Neglect, which would administer funding for a variety of programs and research to help abused and neglected children. Since that time, great strides have been made in the interest of maltreated children. In 1980, Congress passed the **Adoption Assistance and Child Welfare Act (PL 96-272)**, designed to discourage long placements in foster care and encourage permanency planning for all dependent children, including those who were abused and neglected in their own homes. And in 1986 the **Child Abuse Victims' Rights Act** was passed to improve investigation, court intervention training, victim protection, and treatment for maltreated children. Finally, improvements in record-keeping and more stringent penalties for offenders were mandated by the **Child Protection and Penalties Enhancement Act of 1990**.

Over the years, child protection has been the focus of much controversy and the subject of extensive research. Although some say that the upsurge of societal violence and the higher incidence of drug abuse have caused abuse figures to escalate, the reality is that, with heightened awareness on the part of professionals and the general public alike, there is a much higher percentage of recognition and reporting. This trend, one hopes, can only serve to aid families in getting the help they need. It is up to future professionals to ensure that help meets the children's best interests.

Summary of This Section

- Our concept of childhood is relatively recent. Throughout history, children were seen as the property of their parents who determined their fates. Children from poor families often ended up following their parents to almshouse, institutions where the poor worked for their keep. Conditions were often deplorable.

- In the 1800s, poor children or those whose families could not care for them were relegated to orphan asylums where physical and sexual abuses were well documented.
- Children neglected by their parents often turned to begging or even theft to sustain themselves. Mother's were blamed for neglecting children and called "morally wanting." There was no consideration that their poverty might be one cause.
- Children were expected to work alongside adults. Some children were indentured—working for a master tradesman in exchange for room and board for a prescribed period of years. The settlement house in the later 1800s, especially Hull House funded by Jane Addams, took on the cause of child labor and were able to make significant changes including the act to aid the establishment of the juvenile courts in 1899.
- Children were subjected to a variety of forms of sexual abuse from ancient times. Young girls in convents were made available sexually to monks, well-meaning mothers masturbated sons to increase penis size, and men in early Greece practiced pederasty or the sexual indoctrination of young boys. The seemingly proper Victorian era actually saw young girls in prostitution.
- The Refuge Movement and the Child Saver Movement were two initiatives to promote better treatment of children and provide for them when their parents could not care for them. But it was the case of Mary Ellen Wilson that would change history when a neighborhood worker intervened when a child was being abused and neglected attracting the attention of the director of the Society for the Prevention of Cruelty to Animals. Their efforts would lead to the establishment of the Society for the Prevention of Cruelty to Children in 1875 and efforts to protect other maltreated children.

There was another breakthrough for intervention in child abuse when radiologist John Caffey postulated that unexplained fractures in young children might be indicative of abuse. A noted pediatrician C. Henry Kempe coined the term "battered-child syndrome," which increased attention to the treatment of abused children influencing the enactment of the Child Abuse Prevention and Treatment Act of 1974, the first significant piece of legislation to protect abused and neglected children.

MALTREATMENT DEFINED

Any type of maltreatment has the potential for creating trauma in children. It is important to understand the trauma and how it affects children when discussing the forms of maltreatment.

Child abuse and neglect fall into specific categories with different symptoms and often different etiologies. The four categories most often used are physical abuse, **physical neglect**, sexual abuse, and emotional or psychological abuse. Some authors break down neglect into physical neglect, emotional neglect, educational neglect, and medical neglect.

Physical Abuse

The **physical abuse of children** can be defined as a non-accidental injury inflicted on a child. The abuse is usually at the hands of a caregiver but can be perpetrated by another adult or, in some cases, an older child. Some protection agencies add the provision that the

abuse needs to have caused disfigurement, impairment of physical health, loss or impairment of a bodily organ, or substantial risk of death.

Two dilemmas arise in the consideration of what constitutes physical abuse. The first is related to cultural context. Some cultures have customs or practices that child protection would consider abusive. For example, some Vietnamese families, in a ritual called *cao gio*, rub their children with a coin heated to a point at which it leaves burn marks. It is an intentional act but designed, in that culture, to cure a variety of ills. Do the parents' good intentions exempt this practice from being considered abusive? Similarly, the use of corporal punishment is sanctioned in many Hispanic cultures but is seen as abusive in this culture when it becomes excessive. Some child protection advocates adopt the "when in Rome, do as the Romans do" attitude that minorities must abide by the laws of the culture in which they now reside. One Puerto Rican social worker, working in a predominantly Hispanic section of New York City, vehemently disagreed: "Yes, there are laws, but those laws were made by Anglos. Is it fair to deprive new immigrants of everything, including their customs? Maybe the laws should be changed!" The reality is that if a child is reported as being harmed for whatever reason, a child protection agency will usually investigate. If the reason is one of culture, this will be considered. Fontes (2008), in speaking of Hispanic families using harsh discipline, suggests that understanding the cultural values and approaching the family in a nonblaming way will go a long way toward gaining cooperation.



Research-Informed Practice

Behavior: *Use practice experience and theory to inform scientific inquiry and research*

Critical Thinking Question: Imagine yourself in the late 1800s confronting the case of Mary Ellen Wilson, a classic in child maltreatment history. What might you have done with the absence of any services for children? How do social workers become trailblazers in the interest of their clients?

Another dilemma for society is "What constitutes discipline, and how is that differentiated from abuse?" The physical punishment of children as a form of discipline has been practiced extensively throughout U.S. history. Although more recently many parents have started seeking alternatives to physical punishment in the raising of their children, a significant number of parents still hit as a way to discipline. Some argue that what separates this type of discipline from abuse is a matter of degree. If bruises are left on the child and those bruises last for a prolonged period, the act is considered abusive.

Symptoms

Children who have been physically abused display a variety of symptoms. Bruises are frequently what come to mind when one thinks of abuse, and indeed these constitute the most frequent symptoms. Children may acquire bruises over time, and one can often discern bruises at different stages of healing. On lighter skins, bruises usually are initially red but turn blue in about 6 to 12 hours. The site will become dark purple during the next 12 to 24 hours, take on a greenish tint in 6 days, and be a pale green or yellow by 5 to 10 days. Thus, a child who is observed to have bruises in various stages of healing may have been abused on different occasions (Hobbs and Wynne, 2001; Crosson-Tower, 2013; Child Welfare Information Gateway, 2013b).

Bruises may also be in the shape of objects such as ropes, cords, belt buckles, or coat hangers, indicating that the child has been hit with force using one of these instruments. Bruises inflicted on body areas that are less likely to sustain accidental injuries are also suspect (e.g., the face and head, upper arms, back, upper legs, and genitalia). Certainly it is possible for a child to be bruised by accident, but if there is an unusual quality to the bruise, poor supervision and abuse should be considered.

Another classic abuse symptom is the burn. Infants and small children may be especially vulnerable to being burned when a parent is angry. Burns may be inflicted by

cigarettes, pokers, irons, scalding liquids, heating grates, or radiators. Abuse burns often appear on such unusual places as the palms of the hands, soles of the feet, abdomen, or genitals (Hobbs and Wynne, 2001; Child Welfare Information Gateway, 2013b).

Fractures are one recognizable sign of abuse to the medical community. From Caffey's early work (mentioned earlier) to the present, physicians have been especially vigilant regarding certain types of fractures. For example, a spiral break is particularly indicative of abuse. A parent who grabs a child in anger and twists the child's leg or arm may cause this type of break. Previously untreated fractures, detected when X-rays reveal calcium deposits around improperly healed breaks, suggest a situation in which the parent was hesitant to seek medical treatment. When healthy children receive a fracture, there is swelling and pain, which usually prompts the parent to seek medical advice. But a parent who has inflicted the trauma may feel hesitant to do so. Head injuries or skull fractures are especially dangerous. In addition, blood can collect around the surface of the brain, causing a condition known as a subdural hematoma. Children experiencing this injury may vomit, have seizures, lose consciousness, or even die.

Physical indicators are not the only clues to abuse. Children will often act out their cries for help in their behaviors. As infants, children cry as a way to communicate with the world. Different cries mean different things. But a baby who has learned through being abused that the world is a threatening place may develop a shrill, undifferentiated cry. As abused children become older, their development may not progress as it should. They may be slow to reach milestones in social and physical development. The school years may find them unable to concentrate or doing poorly, without the necessary energy to learn. On the other hand, some abused children throw themselves into school as a way of coping with an unhappy home life. Such a child is the chronic overachiever, the child to whom a grade of B seems like the end of the world.

Some abused children shrink from contact and withdraw into themselves. Some wet the bed or soil themselves in their anxiety. Still others fight their world by becoming pugnacious or acting out in other ways. The source of the behaviors of many delinquent children is a background of abuse. Children who have experienced abuse may also be physically hurtful toward others, especially younger children or animals. Some run away in a desperate attempt to escape their pain (see Table 7.1). There are as many ways for children to cry out for help as there are individual children, and every symptom here may not spell abuse by itself. It is the cluster of symptoms that gives one cause for suspicion.

Profile of the Abuser

Who physically abuses children? Hurting a child seems so foreign to many of us that we question how any parent could be capable of such harm. Yet everyone has the potential, under certain circumstances, to harm another, especially a child. Parents who abuse may feel overwhelmed and depressed or angry with their own lives. Most people discover that it is possible to feel out of control. When one is out of control, anything can happen. It depends on how hard one is pushed.

In general, the causal factors of child abuse fall into several, sometimes overlapping categories: the parent's own childhood experiences, substance abuse, emotional stress, social stressors, or the individual child's personality.

Many abusive parents have not had their own needs met in childhoods, often coming from dysfunctional families. When adults have not been parented by stable, caring individuals who knew how to model good parenting, they may assume that that is how one raises children. They may be bitter about the alcoholism that racked their

Table 7.1 **Physical and Behavioral Indicators of Child Abuse and Neglect: Clues to Look for in Detection**

Type of Child Abuse/Neglect	Physical Indicators	Behavioral Indicators
Physical Abuse	Unexplained bruises and welts • on face, lips, mouth • on torso, back, buttocks, thighs • in various stages of healing • clustered, forming regular patterns • reflecting shape of article used to inflict (electric cord, belt buckle) • on several different surface areas • regularly appear after absence, weekend, or vacation • human bite marks • bald spots Unexplained burns • cigar or cigarette burns, especially on soles, palms, back, or buttocks • immersion burns (sock-like, glove-like, doughnut-shaped on buttocks or genitalia) • patterned-like electric burner, iron, etc. • rope burns on arms, legs, neck, or torso Unexplained fractures • to skull, nose, facial structure • in various stages of healing • multiple or spiral fractures Unexplained lacerations or abrasions • to mouth, lips, gums, eyes • to external genitalia	Wary of adult contacts Apprehensive when other children cry Behavioral extremes • aggressiveness • withdrawal • overly compliant Afraid to go home Reports injury by parents Exhibits anxiety about normal activities (e.g., napping) Complains of soreness and moves awkwardly Destructive to self and others Arrives at school early, or stays late as if afraid to go home Accident-prone Wears clothing that covers body when not appropriate Chronic runaway (especially adolescents) Cannot tolerate physical contact or touch
Physical Neglect	Consistent hunger, poor hygiene, inappropriate dress Consistent lack of supervision, especially in dangerous activities or for long periods Unattended physical problems or medical needs Abandonment Lice Distended stomach, emaciated	Begging, stealing food Constant fatigue, listlessness, or falling asleep States there is no caretaker at home Frequent school absence or tardiness Destructive, pugnacious School dropout (adolescents) Early emancipation from family (adolescents)

(*Continued*)

Table 7.1 **Physical and Behavioral Indicators of Child Abuse and Neglect: Clues to Look for in Detection (*Continued*)**

Type of Child Abuse/Neglect	Physical Indicators	Behavioral Indicators
Sexual Abuse	Difficulty in walking or sitting Torn, stained, or bloody underclothing Pain or itching in genital area Bruises or bleeding in external genitalia, vaginal, or anal areas Venereal disease Frequent urinary or yeast infections Frequent unexplained sore throats	Unwilling to participate in certain physical activities Sudden drop in school performance Withdrawal, fantasy, or unusually infantile behavior Crying with no provocation Bizarre, sophisticated, or unusual sexual behavior or knowledge Anorexia (especially adolescents) Sexually provocative Poor peer relationships Reports sexual assault by caretaker Fear of or seductiveness toward males Suicide attempts (especially adolescents) Chronic runaway Early pregnancies
Emotional Maltreatment	Speech disorders Lags in physical development Failure to thrive (especially in infants) Asthma, severe allergies, or ulcers Substance abuse	Habit disorders (sucking, biting, rocking, etc.) Conduct disorders (antisocial, destructive, etc.) Neurotic traits (sleep disorders, inhibition of play) Behavioral extremes • compliant, passive • aggressive, demanding Overly adaptive behavior • inappropriately adult • inappropriately infantile Developmental lags (mental, emotional) Delinquent behavior (especially adolescents)

Source: © Cynthia Crosson-Tower.

childhoods or the inconsistency that moved them from place to place. Most abusive parents do not intend to hurt their children. Granted, there are some who have been so damaged by their life experiences that they strike out to hurt others, but they are in the minority. Due to their own upbringings, these parents may be unprepared for parenthood and ways to handle issues that arise in raising children. Often in an effort to escape an unhappy environment, young people become parents too early sometimes believing that this will solve their problems. "I figured I could do a better job than my mother," explained one teen who had just had her child removed for severe abuse. Since abuse (or neglect) is all that some people know, the pattern often becomes intergenerational.

Another escape that some people fall into is the *abuse of drugs and alcohol*, which can impair their parenting abilities. Abuse of substances may be something they observed in their own childhoods. There are a variety of *other emotional stressors* that also inhibit parenting, such as mental illness, anger issues, and low stress tolerance.

Social stressors may combine with these to create problems. Social stress may have its roots in environmental factors but impacts the individual family personally. For example, an increase of violence in the culture not only desensitizes people to the use of violence but also leads to fear-based anxiety. One woman described her childhood in this way:

Case Example Dorita

When we lived in the projects, our mother used to lock us in the house all day. There were so many shootings and she was petrified that one of us would get killed. But with Ma it was an obsession. My brother left the house one time and she stormed out and found him. She dragged him back and beat the heck out of him all the time telling him what a dumb little **** he was and how he'd get us all killed. I wondered if she'd kill him instead! Then she got religion and she'd pray over us. But this was not just religion, she became obsessed that if the shooter didn't get us the devil would. My oldest brother said she was probably losing it because the stress of living there was just too much. And if we did something she didn't like, she'd make us kneel in the corner on the cold cement for hours, telling us we should pray and ask Jesus to take the devil out of us. My sister passed out once and Ma put water on her and made her go back to the corner and pray to be stronger because she was a sinner.

A strong conservative and idiosyncratic interpretation of religion might lead a parent to use discipline that is inappropriately severe.

There are other social factors that may impact parenting by creating undue stress. For example, poverty, social isolation, rejection by the community, inadequate and unsafe housing, disability, or being a single parent are some stressors that can combine with others and result in abusive parenting. It should be noted, however, that many families deal with emotional and social stress and are able to parent at least adequately if not effectively. Why a parent abuses may be difficult to pinpoint and has to do more with the manner in which the parent is ill-equipped to deal with the normal pressures of life.

Some parents abuse a child because of the *impact that a particular child has on the parent*. The self-esteem of these abusive parents may depend on their children's behavior. If their children "look good," they feel like good parents. A cranky, fussy baby may not be tolerated by the parent who already feels insecure about her or his abilities to parent. When their children misbehave, these parents often see themselves as failures. Some parents see their children as people who can nurture them when their own parents did not. And there are parents who were raised with corporal punishment and are only repeating with their children the patterns that they learned in their own childhood homes.

Although the above was placed in the section describing physically abusive parents, these characteristics may describe both neglectful and sexually abusive parents.

Fortunately, only relatively few parents, caught up in their rage over their own unmet needs, abuse their children sadistically. These parents may get high on the power they feel from hurting others, sometimes even to the point of killing them. Obviously, the prognosis for this type of abuser is poor.

Another type of abuse, once known as **Munchausen-by-proxy**, but more recently termed Factitious or Fabricated Disorder by Proxy (FDP) has gained more attention in the last few years. FDP is a variation of Munchausen syndrome, which affects adults. An adult with Munchausen syndrome so desperately needs attention that she or he induces some

form of medical condition so as to necessitate a hospital stay. The patient then basks in the attention of hospital staff while proving a very demanding patient. The psychological community has concluded that this syndrome is based on the internalized rage felt by the patient toward parents by whom he or she feels emotionally abandoned (Eminson et al., 2000; Lasher and Sheridan, 2004; Day and Moseley, 2010; Greenbaum and Myers, 2010).

FDP is manifested predominantly by mothers, although rare cases of fathers suffering from the condition have been recorded. These mothers, who may have been Munchausen patients, appear to be caring and concerned about their hospitalized children, almost to a fault. The children come to the attention of the medical community for a variety of reasons, and the etiology of their condition is often not discovered until well into their hospital stay. The mothers provide a picture of a concerned parent who is always involved in the resolution of the child's health problem. At the same time, this mother may have induced severe vomiting by giving the child large doses of ipecac, produced diarrhea by administering phenolphthalein, interfered with the blood-sugar level or contaminated the blood by injecting insulin or fecal matter, or even smothered the child to simulate sudden infant death syndrome or respiratory problems (Eminson et al., 2000; Lasher and Sheridan, 2004; Day and Moseley, 2010; Frye and Feldman, 2012).

It is difficult to understand this type of pathology, but experts now say that it is based on the mother's need to establish a close and collegial, albeit dependent, relationship with the physician. Her extreme need for this relationship with someone she sees as powerful distorts her perception of the harm she is doing to her child. Recognition of this syndrome as a form of child abuse is too new to have the benefit of any longitudinal studies of the residual effects on victims who survive.

Neglect

The concept of neglect differs from culture to culture. In general, it is the role of parents to meet the physical and emotional needs of their offspring. These needs usually encompass shelter, food, clothing, medical care, education, protection, supervision, and moral guidance. The manner in which they are met may differ, but failure to meet these basic human needs in some acceptable manner constitutes neglect.

DePanfilis (2006) breaks neglect into various types: physical neglect; medical neglect; inadequate supervision; and environmental, emotional and educational neglect. Also considered in the category of neglect are newborns addicted to drugs at birth.

Physical neglect includes **abandonment**, when a child is left for extended period without care or supervision; *expulsion*, the refusal to care for an underage child by expulsing him or her from the home without adequate arrangement for other care; *shuttling*, when a child is passed from one substitute caretaker to another due to the parent's unwillingness to care for the child; *nutritional neglect*, when a child is left repeatedly hungry for long periods or is undernourished evidenced by poor growth; *clothing neglect*, when a child is deprived of appropriate clothing like shoes or a coat in winter and; other types of neglect that may include other ways of disregarding a child's welfare or safety (e.g., driving while intoxicated, leaving a child in an car unattended).

Medical neglect refers to denying a child adequate health care or delaying obtaining health care in serious medical situation. *Inadequate supervision* encompasses the lack of supervision in terms of children being left unsupervised when it is deemed that they are not yet able to care for themselves. The determination of the child's ability to care for himself or herself is subject to a number of variables. The **assessment** of the maturity of children differs among cultures. In addition, the length of time the child is alone, the

neighborhood in which this occurs, the child's age, and the developmental level also come into play. Another aspect of inadequate supervision has to do with *exposure to hazards* such as safety hazards, including poisons, electrical wires, stairs, drug paraphernalia; exposure to secondhand smoke; availability of guns or other weapons; unsanitary household conditions such as rotten food, animal excrement, infestation by insects, lack of clean water; or lack of appropriate caregivers. Allowing a child to be exposed to any form of risking or illegal behavior (e.g., smoking or using drugs) may be considered to be neglect. *Environmental neglect* also refers to some of the above but is basically when a child is not protected from harm from the environment.

Emotional neglect becomes much more difficult to assess despite having more long-term and significant impact than physical neglect. In general, it refers to inadequate nurturing of affection, exposure to extreme spousal abuse, allowing a child to use drugs or alcohol or encouraging other maladaptive or harmful behaviors. *Educational neglect* encompasses failing to enroll a child in school, permitting chronic truancy, and failing to attend to the special education needs of a child.

Finally, as of 2005, states are now required to report the addiction of infants at birth to child protection agencies. Women who use drugs or significant amounts of alcohol during pregnancy may be exposed their infants to a variety of conditions in addition to immediate problems at birth. In addition, substance abuse on the part of a pregnant woman may also lead to her inability to care for the child later if her pattern continues (DePanfilis, 2006).

Various cultures define neglect differently (Horwath, 2007; Fontes, 2008). For example, protection and supervision in Native American culture is a communal rather than individual responsibility. A parent in such a culture would feel comfortable letting even a fairly young child out of his or her sight because of the knowledge that the neighbors will not let harm come to the child. In other cultures, it is the role of the extended family to assume supervision. In their study of how different cultures define neglect, Dubowitz and Klockner (1998) found that the definition differed only slightly between white and African American caregivers. These authors commented that there was a need for a clear definition of neglect if only to guide research and clinical intervention.

Symptoms

Although it may be difficult to be clear in all situations, protective services must have some guidelines to determine what symptoms to look for in children. Practice and research have developed a list of symptoms that can be found in children who are deemed neglected.

Neglected children may demonstrate consistent hunger and even malnutrition. Very young infants who have been neglected may withdraw from their environment and waste away, demonstrating a syndrome known as **Nonorganic Failure to Thrive**. Older children may also become listless and have little energy. They may not be appropriately clothed to protect them during cold weather. They may be dirty, with body odor and lice, although lice are highly contagious and do not always suggest neglect. Neglected children often demonstrate unattended physical or medical problems (Horwath, 2007; Bundy-Fazioli et al., 2010; Child Welfare Information Gateway, 2013a).

Case Example Zack and Tag

Zack's teeth were badly decayed. He and his 3-year-old brother, Tag, were often left alone and subsisted on the snacks that 8-year-old Zack could beg or steal from the package store near their apartment. Their mother, a heroin addict, had tried numerous times to "kick her habit" but to no avail. An "aunt" watched Zack and Tag while their mother

attended rehabilitation programs, but when the mother came home, they were once again left to her inconsistent care. Tag had developed a cough, possibly due to the fact that his light clothes offered little protection against the weather. It was not until Zack's sporadic school attendance was noticed that the family came to the attention of protective services.

Like Zack, children who are victims of neglect may steal either to get food or because they have learned not to trust that their next meal will be there when they need it. Neglected children are often tired and listless. Developmentally, they are usually significantly delayed, lacking the stimulation, consistency, and encouragement that have benefited other children. Some neglected children fail to bond with their inattentive caregivers and may demonstrate attachment disorder.

Many neglectful parents do not value education for their children. Or if they do feel that school is important, they lack the ability to get them there consistently. For this reason, school attendance may be sporadic. In later years the adolescent drops out of school because school seems to have little to do with life's struggles (Taylor and Daniel, 2005).

Neglectful Parents

Parents who neglect were often neglected themselves as children. For them, it is a learned way of life. Their childhoods have produced in them anger and indifference. Their adult lives are dedicated to meeting the needs that were not met for them as they were growing up.

Case Example Eulalia

Eulalia is a large African American woman with a quiet, indifferent manner. She seems oblivious to the bits of food on the cluttered table, the flies coming in through the broken windows, the stench of urine, and the children fighting and screaming in the background. She puffs absentmindedly on a cigarette, hardly seeming to hear as the social worker explains about the complaint CPS has received about her children's vandalism of a local school. Eulalia has learned to tune it all out. She has heard it before.

Pregnant at age 13, Eulalia followed her itinerant boyfriend to the city where she now resides. There was nothing for her at home. The middle child of 10 children, Eulalia had tired of taking care of the younger ones and being beaten up by the older ones while her parents were away working as field hands. There had been little to eat and less to do at home, and she longed to be on her own. But after dumping her with friends, her boyfriend left her, pregnant. She drifted from relationship to relationship, each promising her some stability. Now Eulalia, 21 years old and with five children, has an apartment in a rundown housing project. She is too involved in the goings-on of the neighborhood to find time for the children. She finds emotional safety in the predominantly black project. Even if this mother had time for her children, she would not know how to mother them adequately. Don't children just raise themselves? That is what happened in her family.

For Eulalia, life held little meaning. For her children, life would not be much different without intervention.

Throughout the years, it has been mothers who are described when neglectful parents are discussed. Polansky and colleagues (1991) have created the best-known profile of neglectful mothers. They have defended their one-gender profile by pointing out that fathers were usually unavailable in neglectful households. Swift (1995) suggests that abandonment on the part of these fathers is the ultimate neglect. Taylor and Daniel (2005) comment that Western cultures not only equate nurturing with the feminine but also idealize

mothering. This results in our pointing to the mothers as neglectful and often exacerbating their already-low self-assessments.

In one of the earliest attempts to characterize the neglectful parent, Polansky and colleagues (1991) studied neglectful mothers in both urban and rural settings and categorized them into five types:

1. The *apathetic futile mother* demonstrates little or no affect to the point of seeming numb. Burdened by her own unmet needs, she has little energy and finds that nothing is worth doing. Why put diapers on the baby when he will only get them wet? Why do dishes when they will only be dirty again? It is difficult to reach her because her thinking is very concrete and she communicates on only the most basic level, referred to by Polansky and colleagues (1991) as verbal inaccessibility. Her seeming depression is infectious, and social workers describe this mother as a very difficult client with whom to work.

2. The *impulse-ridden mother* is impulsive and inconsistent. She may have the energy to meet life's expectations but it is instead directed toward defiance, restlessness, and manipulation. She cannot tolerate stress and frustration. This is the mother who has never learned inner controls and who is therefore incapable of performing the tasks required by consistent mothering.

3. The *mother experiencing reactive depression* responds to life circumstances by giving up rather than fighting. She is intensely depressed or overwhelmed by grief.

4. A *mentally retarded mother* (currently referred to as developmental delay) may neglect her children, but not all mentally retarded mothers do so. When these mothers do neglect, it is usually because they lack the necessary supports to compensate for their own impaired functioning.

5. A *psychotic mother* may be hampered in her ability to parent by her thought disturbances, severe anxiety, withdrawal, or bizarre behavior.



Diversity and Difference in Practice

Behavior: *Apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies.*

Critical Thinking Question: Consider Eulalia's situation. How would working with her make you feel? How would you help her to identify the choices she has made that have involved her with protective services while attempting to open up new and realistic choices for her life? Does her lifestyle and parenting differ from what is often typical for her cultural background? (Refer back to Chapter 2).

Case Example Leanna

Leanna had been a fairly consistent mother with her first child. She found her second more difficult, but she settled in to the task of mothering. She took pride in her parenting and saw her children as important extensions of herself. Her young husband, too, found parenthood to his liking. The couple managed to weather several financial and emotional storms early in their marriage, and their future promised to be bright.

One hot summer day, Leanna took 3-year-old Sam and 2-year-old Jessie to the beach. She had hardly looked away when she noticed that Sam was gone. Frantically she searched for him, screaming for others to help. He was found caught between two rocks, face down in the water. Efforts to revive him were fruitless, and Leanna became hysterical. Once calmed, she slipped into an almost catatonic depression. No amount of coaxing by her husband or professionals could bring her out of her passiveness. She was hospitalized and put on antidepressants. Her husband, feeling that the drugs were making her worse, insisted she be taken off them. "She'll be okay," he insisted. "Her brother drowned when he was a baby, too. It's just too much for her." But Leanna never

fully emerged from her depression. She could not care for her remaining child, a fact that her concerned husband denied. Again and again he would return home to find that his wife had not moved from her bed. His own immaturity and frustration finally drove him away, and Leanna and Jessie were left alone until protective services finally intervened.

Although some theorists now feel that the research of Polansky and his colleagues is outdated, there is still some difficulty in categorizing neglectful parents adequately. Newer studies seek to understand neglect in order to combat what is a chronic and generational treatment issue. Crittenden (1999) suggests that neglect has to do with the processing of information. Neglectful mothers have difficulty processing cognitively (thinking) and/or affectively (feeling). Crittenden fits these mothers into several categories. Mothers who practice **disorganized neglect** live from crisis to crisis, feeling rather than problem solving. Their children learn that crisis is a way of life and may actually use extremes of emotion to manipulate their parents and, later, others. Caregivers who show **emotional neglect** process cognitively; feeling seems to be diminished or absent. These parents appear to their children as cold and uncaring or emotionally unavailable. Children may feel rejected and withdraw, often adopting this diminished affect themselves. This type of neglect is seen at all socioeconomic levels. Finally, families demonstrating **depressed neglect** guard against expressing both affect and cognition. For them, nothing is worth doing; they, too, become withdrawn and lack in emotion.

All of these categories produce families who, for whatever reason, are unable to meet the needs of their children. Many lack the insight into their own actions that is required in order to use the help they might be given. It should also be noted that although neglect spans all socioeconomic levels, it is the lower socioeconomic groups that tend to be identified. This may be because higher-income groups have the resources to mask their neglect of their children. By the same token, it is often assumed that minorities make up a higher proportion of neglectful parents. This too is untrue, although it is often the minority parents who are reported.

Impact of Neglect

The impact of neglect can be significant. When children are malnourished and under-stimulated, they are not able to develop normally. They may be at risk for a variety of physical problems in childhood as well as adulthood. For example, under-stimulated children may fail to thrive or develop poor attachment to caretakers. Children who are victims of physical and medical neglect may develop health problems like persistent infections, malnourishment, illnesses, poor teeth, and other health-related issues. Perhaps, one of the most significant issues highlighted in recent years is the failure of adequate brain development when children are subjected to any type of trauma (see Chapter 6 for a discussion of the physiological impact of trauma on the brain). Since the brain is crucial for both everyday survival as well as for learning, children whose brains are impeded from developing normally suffer significant disadvantages.

Sexual Abuse

Sexual abuse refers to sexual activity with a child who is being used for sexual stimulation by the other person, usually an adult (Greenbaum and Myers, 2010; Crosson-Tower, 2014). It is assumed that the abuser is older than the child and therefore has more power and resources. Due to this power differential, it is believed that the child is enticed, cajoled,

entrapped, threatened, or forced into the abuse. The abuse is progressive, progressing from the least-intrusive behaviors, such as observation or exposure, to more-intrusive behaviors such as vaginal or rectal penetration. During this progression, the abuser gauges the reactions of the child and grooms her or him for further abuse. In addition to being touched sexually or being compelled to touch the abuser, a sexually abused child may be used in the production of pornography or be encouraged to view pornography or other sexual acts (McCarthy, 2010; Crosson-Tower, 2013, 2014).

Types of Sexual Abuse

Sexual abuse may be divided into several categories: incest or familial abuse; extrafamilial molestation; exploitation through pornography, prostitution, sex rings, or cults; and abuse within institutions.

Experts in the area of incest caution that most children are abused by family members rather than strangers, as was once supposed. In fact, an estimated 60–70 percent of all abuse is perpetrated within the family (Faller, 2002). Abusers might be fathers, older siblings, mothers (although less commonly), or stepfathers. Finkelhor (1984) suggests that girls who have stepfathers are statistically more likely to be sexually abused even if the abuse is not perpetrated by the stepfather. Incest between father and daughter is thought to be the most common type, although some studies suggest that older siblings perpetrate much more abuse than was previously assumed (Wiehe, 1997; Crosson-Tower, 2014).

Incestuous relationships have usually gone on for years before they stop or are discovered. Offenders typically groom children by initiating a process of wearing down their defenses and desensitizing them to sexual activity. Although the current term for this is **grooming**, Lanning (2010) argues that it was originally referred to as *seduction*, which he believes is more accurate. The sexual contact progresses from seemingly benign tickling or observing the child in the bath to more obvious sexual activities such as mutual masturbation or vaginal or rectal intercourse. Children have usually been compelled to secrecy by admonishments ranging from "This is our special relationship, and no one would understand or believe you" to "They will send me (or you) away if you tell." Sometimes, albeit the exception rather than the rule, children are threatened or physically hurt to prevent them from telling.

Sexual abuse is often perpetrated within the family—termed **incest or intra-familial abuse**. Many perpetrators in an incestuous situation lack the social and communication skills to negotiate effective relationships with other adults. In the case of father–daughter incest, this adult is his wife. The father, therefore, seeks a non-conflictual partner and finds this in his daughter. In his daughter, he finds someone over whom he can exercise power in order to mold her into a sexual partner. This father, a master at denial and manipulation, can rationalize this arrangement's inappropriateness and illegality, often telling himself and his daughter that he is "teaching" her lessons for later life (Crosson-Tower, 2014).

Not every incestuous father fits this profile. There are some offenders who seek opportunities to have access to children and may join an already existing family where there are potential victims who appeal to him. These men usually have limited social skills and appear more like children than adults. They bond easily with the children of the family while the female adult who may have been hoping for an adult partner to share her interests and her bed may be quite frustrated by the arrangement. Other women are relieved that little is expected of them. The perpetrator is often a classic **pedophile**—someone who prefers and is sexually attracted to children—searching for an environment to meet his fantasies.

Extrafamilial abuse is abuse perpetrated outside the immediate family. This can be by a friend, an acquaintance, or a stranger. Although it is a common myth that most

abuse is perpetrated by strangers, children actually are more often abused by someone they know. Children may be abused individually or become part of prostitution rings. In these, children are bribed, blackmailed, or forced to participate in sexual acts for money. The money is then kept by those who have involved them. Some sex rings are dedicated to the production of child pornography. These groups create photos, films, and videos that are sold at a significant profit.

Today, the Internet has made the engagement of children for sexual exploitation by those unknown to them extremely easy. Because of technology, the abuser has a wider geographical range of children whom he or she might engage in sexual activity and has better access to them than ever before. Perpetrators can contact children who are under the seemingly watchful eyes of parents, stimulate them and desensitize them through pornography, engage them in discussions, and even arrange meetings with them for sexual activities. Many abusers pose as children or teens in order to "chat" more convincingly with unsuspecting victims. Not all of those who engage children sexually via the Internet are interested in meeting and sexually molesting them, but even exposing children to sexual advances is considered abusive.

McLaughlin (2000) suggests the term "technophilia" to refer to those who use cyberspace to engage in sexual exploitation of children. Perpetrators may collect child pornography over the Internet; produce their own, often through using pictures of real children; or "chat" with children for the purpose of engaging them in sexual activity either through online discussions or by arranging to meet them.

Although there is consensus among child abuse experts that the use of the Internet by perpetrators places children at risk (Foley, 2002), the general public often argues that the dissemination of pornography is part of their right to free speech. Although the 1996 **Child Pornography Prevention Act** outlawed the production or sharing of child pornography over the Internet, the Supreme Court's 2002 overturning of that ban gave rise to much discussion (Jeffrey, 2002). According to that court decision, **virtual pornography** (images of children in sexual acts or poses) cannot be equated with actual pictures and therefore is not banned under the 1996 law. This splitting of legal hairs concerns experts who recognize that child pornography, even in fantasy form, stimulates the sexual abuser (Foley, 2002; Gillespie, 2011).

In addition to finding their victims on the Internet, perpetrators have other methods of finding children. Sometimes the perpetrator has a bond with the parent, as in the case of a family friend. Or the parent may need services from the perpetrator, such as childcare. Parents may not be supervising closely and the child wanders off or is home alone, or parents may be otherwise occupied (Crosson-Tower, 2013; Crosson-Tower, 2014). For example, one survivor recounted that she used to help her mother in the family bookstore. A customer used to come in and ask her (the child) for certain books. Invariably they would be on top shelves. While her mother waited on customers, the child would go in search of the books, followed by the customer. "The first time he put his hand up my skirt when I was on the stepladder, I was very surprised. I jumped down, but he smiled and I thought it must have been my imagination." The stranger continued to fondle the child over the next few weeks. He threatened that if she told her mother, she would never work in the store again. Liking her job, the girl kept quiet. "Finally, he just stopped coming in," she continued, "but I was afraid that he would, and the job lost much of its enjoyment for me."

There has been some attention to the abuse of children in cults. In these instances, the perpetrators are usually multiple, and the techniques used to confuse the victim often render her or his story suspect to anyone she or he tells. The victim reports have made reference to specific indicators such as unusual and sadistic sexual behaviors, the use of satanic or supernatural symbols, consumption of bodily fluids, torture or sacrifice of animals and

a variety of rituals. The bizarre nature of the practices creates a degree of trauma in the victim that renders his or her story unbelievable to clinicians and others who might intervene. As a result, it is difficult for victims to be believed and the incidence of **ritualized abuse** is unknown (Noblitt and Noblitt, 2008). Hayden's *Ghost Girl (1992)*, the story of a special education teacher faced with a child who chooses elective mutism as a way to cope with the abuse, gives an excellent portrayal of the dilemma of the professional faced with the possibility of a cult-abused child.

Institutional abuse has gained attention over the last few years. Childcare centers and childcare institutions provide an excellent opportunity for a perpetrator to have access to children. One of the most publicized childcare cases was in Manhattan Beach, California, where the McMartin trials stimulated numerous legal proceedings and much debate (see Eberle and Eberle, 2003). Such situations have inspired institutions to screen staff more effectively and to take precautions so that staff do not have many opportunities to be alone with children.

Symptoms

Sexually abused children demonstrate a variety of symptoms, some of which may also be associated with other types of problems. Sexual abuse may not always be physically visible. When children do have physical symptoms, they take the form of rectal or vaginal tears, urinary tract or yeast infections, and burns or bruises in the genital or rectal area. Children may also have sexually transmitted diseases such as gonorrhea, syphilis, genital warts, herpes, chlamydia, and AIDS; these can be contracted only through contact with infected mucous membranes.

Behaviorally, sexually abused children may seem secretive or withdrawn. Their school work may suffer, or, conversely, they may see school as the only safe place in which they can excel. They may suffer mood swings, cry without provocation, or engage in such self-injurious behavior as bulimia, anorexia, maiming or cutting, or suicide attempts. Some sexually abused youths use drugs or alcohol to dull the pain. These behaviors can also indicate nonsexual disorders and must be seen as possible indicators rather than definite signs. By the same token, not all sexually abused children demonstrate symptoms. When there are no symptoms, it usually means that either the reaction is delayed or the child has repressed the material to the point that he or she is unable to feel it (Faller, 2002; Wickham and West, 2003).

There are a few symptoms that, in and of themselves, point strongly to the child having been sexually abused. It is not unusual for molested children to act out their inappropriate sexual knowledge in their behavior by sexually molesting younger children. Usually this acting out demonstrates knowledge that they would not normally have. Chronic, compulsive masturbation also can indicate a disturbance of a sexual nature. Older children may become extremely promiscuous. These types of sexual acting out, as well as behaviors such as setting fires and mutilating animals, should always raise suspicions of sexual abuse (Wickham and West, 2003).

Perpetrators

A significant number of theories have emerged as to why adults sexually abuse children. It is estimated that 95–98 percent of the perpetrators are males, although theorists argue that women perpetrators are more likely to disguise their abusive behavior as caretaking tasks (e.g., washing or comforting a child). Fifty to seventy percent of sexual abusers were themselves subjected to physical, sexual, and emotional abuse or family dysfunction as children. Poor attachment is also felt to contribute to the likelihood that a person will become abusive (Rich, 2006; Crosson-Tower, 2013, 2014; Flora and Keohane, 2013).

Those engaged in the assessment and treatment of male perpetrators of child sexual abuse suggest that they may have some characteristics in common. The most frequently identified have been difficulty forming true intimate relationships, inability to feel empathy, low self-esteem, and poor social skills. Most perpetrators collect pornography and use this to construct a fantasy life that feeds into their desire to abuse. They may also demonstrate other paraphilias (sexually deviant thoughts, fetishes, or actions) in addition to pedophilia (McLaughlin, 1999; Karson, 2001; Groth, 2002; Rich, 2006; Crosson-Tower, 2013; Flora and Keohane, 2013).

One of the first theories that attempted to explain male abusers was that of A. Nicholas Groth, a psychologist working with incarcerated sexual offenders. Groth postulated that these offenders fell into two groups: fixated (emotionally stuck in childhood with respect to their sexual interests) and regressed (having sexual interests that revert back to childhood due to the stresses of their life in the adult world).

The **fixated offender** is primarily interested in boys, and he comes down to the child's level in his engagement of that child. His primary orientation is toward children; he has little sexual interest in people his own age. His first sexual offense is premeditated, and there is a compulsive nature to his acts. He is not motivated by stress, nor is he probably under the influence of drugs or alcohol. Instead he demonstrates a sociosexual immaturity and has failed to resolve his life issues (Groth, 2002).

The **regressed offender**, on the other hand, may appear to function fairly well as an adult. In reality, he finds that his adult life is too conflictual, especially his relations with peers. He therefore turns to a non-conflictual partner, a girl with whom he has a sexual relationship. In the process he elevates this child to the level of an adult by treating her like one. Although he may continue to participate in peer relationships, perhaps even sexually, he depends on the child to feel powerful. He may be under a great deal of stress, and his first offense is often impulsive in nature. This is the father who goes a bit too far in washing his daughter's genitals or the grandfather who ends up fondling his granddaughter when she sits on his lap. Neither may have planned the event initially, but after the first incident they may engineer circumstances to give them the opportunity to abuse again. This man may also use or abuse substances, but these do not cause his behavior. Rather, he uses them as an excuse to abuse children (Groth, 2002; Salter, 2004).

The problem with Groth's typology is that offenders do not always fit neatly into a category. Lanning (2010) suggests that rather than categories, sexual offending should be seen on a continuum.

Carnes (2002) postulates that sexual abuse is an addiction (this theory is sometimes referred to as **Addiction Theory**). In this addiction the addict develops a faulty belief system that leads to impaired thinking. He denies, rationalizes, and blames others for his actions and thoughts. He becomes preoccupied with his fantasies and ritualizes his behavior. Therefore, the offender who uses one strategy on a child will probably continue that strategy with others. Finally his behavior becomes compulsive; he feels that he has to abuse children. Some child sexual abusers feel despair afterward, and some do not. Again, not all offenders fit neatly into the addiction category.

Multifactor theories have developed that revised or disputed Groth's typology. Ward et al. (2006) suggest that these theories can be divided into three categories: multifactor theories, single-factor theories, and process theories.

Multifactor theories include theories that suggest that numerous variables account for a perpetrator's propensity to abuse. The oldest of these theories, and the one still considered most useful, is Finkelhor's Preconditions Model. Finkelhor (1984) theorizes that in order for the sexual abuse of a child to occur, four factors must be operating: (1) the

perpetrator must be motivated to abuse, (2) the internal inhibitors that would tell most people not to abuse must not be working, (3) the external inhibitors that normally protect children must not be in place, and (4) the child's resistance must not be sufficiently strong. Motivation to sexually abuse involves three components. First, the perpetrator must feel an emotional congruence with children—that is, display a pathology in which being around children satisfies the perpetrator's emotional needs. Second, the perpetrator must be sexually aroused by children. Once again, a childhood trauma may be at the root of this response. Or the perpetrator may have grown up observing another's sexual involvement with children. Some sexual abusers are aroused by child pornography; such abusers often misinterpret children's behavior as sexual and therefore inviting sexual contact. Finally, perpetrators are motivated to turn to children because their normal outlets for sexual expression are blocked. Blockage may be a result of marital problems, inadequate social skills, fear of women, or some previous traumatic sexual experience with an adult (Finkelhor, 1984).

Most of us have an internal voice that lets us know that certain behavior is unacceptable. Internal inhibitors are not operating efficiently for sexual abusers. They may be hampered by the influence of alcohol, senility, an impulse disorder, or psychosis or may not have developed at all.

External inhibitors, things that rob the perpetrator of opportunity, also can protect children. When these external inhibitors are not operating, children are at risk. Mothers often play key roles in protecting their children. When mothers are absent or unavailable, either physically or emotionally, they may not be able to protect their children. Many mothers lack social supports. The societal concept of family sanctity, although functional for the autonomy of a healthy family system, leaves the abusive family isolated and the children at risk for the continuation of abuse (Finkelhor, 1984).

Finally, in order to abuse a child, the perpetrator must overcome the child's resistance. Children who are emotionally needy or unaware of the potential for being sexually abused are usually easier targets (Finkelhor, 1984).

Single-factor theories point to one characteristic as the prime motivator for sexual offenders. The most widely recognized motivating factors are *cognitive distortions,* faulty information processing by which the perpetrator rationalizes the abuse; *lack of empathy for victims*; and *deviant sexual interest in children* (Flora and Keohane, 2013; Ward et al., 2006).

Process models suggest that understanding abusers is not just about knowing why they abuse children, but also how they go about doing so. Perhaps, the best-known process model is the Relapse Prevention Model, widely used because it allows clinicians to train perpetrators to interrupt their cycle of abuse. Using this model, the cycle of offending is traced and the offender helped to learn methods by which he can stop future offending behaviors (Ward et al., 2006; Flora and Keohane, 2013).

Numerous other models fit into all of these theoretical categories.

Most of the research done on perpetrators refers to males. However, women, too, have been found to be abusive, often in larger numbers than we realize. In 1984, Finkelhor postulated that women were not abusive as often because of their enculturation. Our culture teaches women to prefer older and stronger partners, whereas men learn to look for smaller, weaker partners. Women also tend to be more nurturing and therefore more capable of relating to the whole child. Women are less likely than men to sexualize affection. Also, because women themselves have been victimized for centuries, they are more likely to empathize with a victim and therefore less likely to victimize.

Since Finkelhor first espoused this theory, which somewhat exonerated women as perpetrators, reports of female abusers have increased. Little research has been published on

female offenders. Mathews and colleagues (1990) have argued that women are motivated to abuse for several reasons: (1) they repeat the abuse they themselves experienced as children; (2) they go along with abuse perpetrated by their male partners; (3) they are seeking closeness, affection, attention, or acceptance from their victims; (4) they are displacing anger, a need for power, or feelings of rejection onto their victims; or (5) they see children as safe targets for their displaced feelings.

Other researchers have compared the motivations and characteristics of male versus female offenders. They have found that female offenders are more likely than male offenders to engage in abuse with another perpetrator, thus supporting Mathews' hypothesis that women act as accomplices in the abuse. Males and females just as often use threats or other types of coercion as well as pornographic materials, but women are more prone to use devices or foreign objects in the abusive act. Kaufman et al. (1995) found little difference between men and women with regard to their relationship to the victim and the location of the abuse, although 31 percent of the women (compared to only 8% of the men) were the victim's teacher or babysitter. Despite similarities in the methods of male and female offenders, the motivations appear to differ. Men more often abuse for sexual satisfaction, whereas women abuse to meet nonsexual needs such as emotional gratification (Ogilvie, 2004).

Over the last few years, increasing attention has been given to **juvenile offenders**, children who sexually abuse other (usually younger) children (see Erooga and Masson, 2006; Rich, 2011). We know that almost all of these children have themselves been victims of sexual abuse. Many children are what Gil and Johnson (1993) term "reactive"; these children will not necessarily be abusers in the future, provided they receive treatment. Except in retrospect, it is difficult to determine which children will abuse later and which will not. It is doubly important, then, that intervention be undertaken early to try to ensure that some of the juvenile offenders will not go on to become adult abusers.

Events over the last decade have also brought to our attention the prevalence of child sexual abuse by authority figures outside the home: teachers, coaches, childcare providers, and even the clergy (Crosson-Tower, 2014). Sexual abuse within churches especially rocked the public's confidence in church leaders and has the potential to bring about major changes in the Catholic Church as we know it and the way in which the Church will respond to future abuse. In fact, the Roman Catholic Church dedicated the 2002 Conference of Catholic Bishops to addressing the discovery that a number of its clergy had been accused of abusing children. Out of this meeting came the *Charter for the Protection of Children and Young People* (United States Conference of Catholic Bishops, 2002), which outlined the steps the Church would take to respond to the crisis and react to future allegations of sexual abuse by clergy.

Why might clergy sexually abuse children? Ministers, priests, or rabbis who are abusive might fit within any of the previously mentioned typologies. Crosson-Tower (2014) suggests that it is not so much that clergy are abusive as it is that individuals who have the potential to be abusive are attracted to life in the church. She postulates that the best way to look at the question of motivation among clergy is to consider what religious life offers and how it fits into the needs of a perpetrator. She goes on to point out that the respect and unquestioned authority given to clergy would appeal to the insecure potential perpetrator. The community's trust and sanction, along with the nurturing and protection of both the "mother church" and the church members, add to the attraction and give clergy the opportunity to be alone with their victims. And, for some, life as a celibate provides a reason for not becoming sexually involved with peers. (See Crosson-Tower, 2006 or Crosson-Tower, 2014, for more in-depth discussion.)

Other Family Members in Incestuous Families

The non-abusive parent in an incestuous family is often held partially responsible for the abuse. Some authors feel that, instead of blaming the non-abusive parent (usually the mother) for not knowing about the abuse, we should support her efforts to intervene once she does know. Yet, not all mothers feel able to intervene.

Johnson (1992) categorizes mothers in father–daughter incest situations as collusive, powerless, or protective. The *collusive mother* is withdrawn, cold, or psychologically absent and pushes her daughter into her own role in the family. The *powerless mother* feels victimized, powerless, defeated, and unable to protect herself, let alone her child. The *protective mother* provides protection once she learns of the abuse. Many theorists now contend that the mother should not be blamed for the abuse within her family. She is already the victim of the societal expectation that women are responsible for maintaining family balance. Often, devoid of adequate nurturing in their own backgrounds, mothers in incestuous families are usually ill-equipped for this task. They are often financially or emotionally dependent on their perpetrator husbands and therefore unable to perceive that they have choices (Peterson et al., 1993; Ogilvie, 2004).

Case Example Nora

Nora grew up the youngest of 10 children. The next youngest child was 10 when Nora was born. Nora's mother made it clear that she had not planned on Nora's birth. As a child, Nora was withdrawn; her siblings somewhat derisively nicknamed her "the mouse." When Nora was 5, one of her uncles began to sexually abuse her. Nora told no one. She was sure no one would believe her. Nora drifted through school with few friends. In high school, a boy named Jake began to ask her out, and she was immediately enthralled with him. He seemed to be everything she wanted. When he told her that his family had had problems, too, Nora felt even closer to him. They were married when they graduated from high school, and Jake went to work at the local mill. Their son, Tim, was born within the year. From his birth, Nora knew that something was wrong. When the doctors told her that Tim had Down syndrome, she was not surprised. Jake, on the other hand, was very upset and refused to believe that their son would not be normal. He urged Nora to have another child, and she soon did. The child was a girl, and the births of two more girls followed. Meanwhile, Nora strove to care for Tim, but Jake virtually ignored their son. He chided Nora for coddling him and making a baby of him. Nora felt angry that Jake could not see how much Tim needed her. She withdrew more and more from her husband and her other children.

Sally, her third child, was 8 years old when a social worker came to the house and said that Sally had told her teacher that her father was sexually abusing her. Nora was horrified and accused Sally of lying until the oldest daughter confirmed that she, too, had been sexually abused by her father.

Nora, plagued by her own insecurities, was ill-equipped to handle her family's needs. Despite the care she gave her son, her daughters described her as cold and unavailable. She was, however, eventually able to believe her daughters and stood by them as the family sought help from the social service system.

The non-abused siblings in the incestuous family are often forgotten as the family copes with the crisis of disclosure. Yet, they too are in crisis. The boys in a father–daughter incest family may perceive that there is something amiss but may also be too fearful to face the situation or intervene. They often do not recognize that, as children, it is not their responsibility to intervene. They may instead feel very guilty. Many male siblings handle their guilt by totally denying the situation. Others identify with the aggressor; too fearful

to oppose their abusive father, these children adopt his abusive stance and target their sister, abuse other children, or molest their own children when they become adults (Crosson-Tower, 2014). Girls in situations of father–son or mother–son incest often either deny the incest or appear to be unaware of it.

When a father abuses one son or daughter, siblings of the same sex who are old enough to suspect the sexual abuse may wonder why they were not "chosen." One sibling explains, "I knew Dad was after my younger sister. It was not that I wanted to be abused, too; I didn't. But Dad and my sister seemed awfully close, and I really resented it. Dad had actually approached me a year or so before. I thought he was kidding and laughed at him. He was hurt and never bothered me again. Then when I saw him being so chummy with my kid sister, I was at first horrified and then jealous, as awful as that may sound." For other siblings, recognition that abuse is occurring is too threatening to deal with. Instead, they live with the cloud of family dysfunction hanging over their heads. Some incest survivors feel that the situation was as difficult for their siblings as it was for them.

Emotional or Psychological Abuse

Emotional abuse refers to undermining a child's self-esteem or humiliating, belittling, rejecting, isolating, or terrorizing a child. Some authors suggest that the term "emotional abuse" be changed to "psychological abuse" because this type of abuse is psychically destructive (Binggeli and Hart, 2001; Iwaniec, 2006). Although psychological abuse is an integral part of neglect and physical and sexual abuse, it is one type of abuse that can also stand alone.

Case Example Sandy

Sandy remembers feeling that his parents never had time for him. They both worked, and he was a latch-key child. Sandy didn't really mind. He actually liked being alone in the house. When his parents were at home, they always yelled at him. Nothing he did seemed to please them. "You are so stupid!" his father told him. "Can't you ever learn?" his mother screamed. But the punishments were the worst. Sandy dared not tell them he was fond of something. If he did, that thing would be taken from him. At the first infringement, his father would destroy anything that Sandy loved, such as the baseball cards he had saved for over a year. He loved their shiny pictures. Some of the cards were quite rare. But one day he had not cleaned his room fast enough, and his father had burned the cards. "This will make a man out of you!" his father had said. "No," Sandy thought, "it will just make me hate you more."

The definition of emotional/psychological abuse is sometimes complicated by cultural variations. For example, many Asian families use shame to socialize their children to do what is expected of them (Mass and Yap, 2002; Fontes, 2008). Shame may be seen as belittling a child in other cultures. And some Native American and African American families employ the cultural equivalent of the bogeyman to frighten children into compliance. Such practices are construed by others as terrorizing children.

Symptoms

Emotionally or psychologically abused children demonstrate a variety of behaviors. Burdened by low self-esteem, they may belittle themselves or engage in self-destructive behaviors either passively, through using drugs or alcohol, or actively through suicide attempts or eating disorders (Binggeli and Hart, 2001; Iwaniec, 2006; Crosson-Tower,

2014). Some exhibit physical symptoms such as headaches, asthma, ulcers, hyperactivity, or hypochondria. Children may withdraw, or they may fight back by being openly aggressive.

Emotionally Abusive Parents

Parents who abuse their children psychologically are often disillusioned with their own lives. They may be frustrated by unmet needs and unfulfilled expectations. In response, they lash out at the most vulnerable of their family members—their children (Iwaniec, 2006). Some parents abuse drugs or alcohol, and some have learned their abusive patterns at the hands of their own parents. Other parents suffer from their own personality problems. The parent with a diagnosis of borderline personality disorder (BPD), for example, may be so caught up in his or her own pathology that it impossible to parent effectively. Closely related to BPD, the narcissistic parent, is equally as unpredictable and emotionally needy. Emotionally volatile, the behavior of these parents often prevents their children from bonding appropriately (Brown, 2008).

Today, in an era when the incidence of divorce is extremely high, children sometimes suffer. Some children become symbols of one parent to the other and are emotionally battered by that person. Even well-meaning parents, embittered by divorce proceedings, can forget that the child should not be compelled to take sides and that criticizing the child's other parent reflects on the child.

Finally, some adolescents who are ill prepared for and overwhelmed by parenthood may find themselves emotionally abusing their children.

Case Example Dinah

Dinah had had no idea how demanding a baby could be. She found that she was unable to do any of the things she enjoyed. The baby cried and cried until Dinah wanted to cry, too. "Shut up, you stupid little jerk!" she found herself screaming. It wasn't long before her frustration was felt by her infant daughter, who cringed when her mother touched her.

Summary of This Section

- Child maltreatment can be divided into four categories: physical abuse, physical neglect, sexual abuse, and emotional or psychological abuse.
- Physical abuse refers to non-accidental injury perpetrated on a child by an adult, usually a parent or caretaker. The way that abuse is defined may have cultural implications. The symptoms include bruises, burns, lacerations, and fractures. Behaviorally, children may do poorly at school, shrink from contact, become pugnacious, and harm other children or even themselves. The abuser may be influenced by his/her own childhood experiences, substance abuse, emotional stress, social stressors, or the individual child's personality.
- One unique form of child abuse is called Munchausen-by-proxy, but more recently termed Factitious or Fabricated Disorder by Proxy (FDP). In this type of abuse, the parent—most often the mother—provides a picture of a concerned parent who is always involved in the resolution of the child's health problem while at the same time causing the child's medical issues. The parent's need is for the attention of the hospital staff.

- Neglect refers to the inability of a parent or caretaker to meet a child's needs. Neglect can be further broken down into physical neglect; medical neglect; inadequate supervision; and environmental, emotional, and educational neglect. Also considered in the category of neglect is when newborns are addicted to drugs at birth. Cultures defined neglect differently. The symptoms of neglect include consistent hunger and malnutrition, consistently dirty, with body odor and lice, unattended medical issues, and being inappropriately clothed for the weather. Neglectful parents were often neglected themselves as children. They may not have learned to parent or even to conceptualize in ways that allow them to parent effectively. Several experts have proposed categories of neglectful parents including Polansky and Crittenden. Neglect is especially problematic since it impacts healthy brain development.
- Sexual abuse is the use of children by adults and older children for sexual stimulation. Sexual offenders use grooming techniques—progressing from the least to more intrusive and sexualized behaviors—to engage children and desensitize them to the abuse. Incest or intra-familial abuse refers to abuse within the family as opposed to extra-familial, which is abuse perpetrated by non-family members or strangers. Children may be engaged into sexual abuse through contact on the Internet. Sexually abused children may demonstrate physical symptoms such as rectal or vaginal tears, urinary tract or yeast infections, and burns or bruises in the genital or rectal area. Children may also have sexually transmitted diseases such as gonorrhea, syphilis, genital warts, herpes, Chlamydia, and AIDS. Behaviorally children may be secretive or withdrawn, have mood springs, cry without provocation, and engage in self-injurious behaviors. There have been theories that describe sexual abusers by experts such a Groth, Finkelhor, and Carnes. More recently sexual abuse theories have been categorized as multifactor theories, single-factor theories, and process models. These theories often apply to men although women can also be abusive.
- The non-abusing parent is often caught in the web of the abuser. Mothers in father-daughter incest are often abused themselves or so plagued with insecurities that they cannot meet the family's needs. The important factor is what this mother does when she learns of the abuse.
- The non-abused siblings in the incestuous family are often forgotten as the family copes with the crisis of disclosure. Yet, they too are in crisis and have a variety of problems.

Emotional or psychological abuse involves undermining a child's self-esteem or humiliating, belittling, rejecting, isolating, or terrorizing a child. These children demonstrate low self-esteem, belittle themselves or engage in self-destructive behaviors either passively, through using drugs or alcohol, or actively through suicide attempts or eating disorders. Emotionally abusive parents are often frustrated or disillusions and strike out at their children. Other parents suffer from their own personal problems.

REPORTING CHILD MALTREATMENT

As a result of the 1974 Child Abuse Prevention and Treatment Act, every U.S. state requires that instances of child abuse and neglect be reported to the state's child protective agency. Some states name specific **mandated reporters**—that is, individuals who, in their

professional capacity, are obligated to report suspected abuse. For example, Massachusetts law lists certain professionals—such as physicians, dentists, social workers, police, educators, and, most recently, clergy—as mandated reporters. Other states dictate that any individual must report. In addition, state laws indicate to whom the report should be made (child protective services [CPS], police, etc.); under what conditions the report should be made (suspicion, reasonable cause to believe, etc.); the time period during which the report must be investigated by the child protection agency (between 2 hours and 30 days, depending on the state and the urgency of the situation); the action taken if a mandated reporter does not report (anything from a fine to imprisonment); and the type of immunity provided to mandated reporters who do report (Crosson-Tower, 2013).

This question always arises: Does a reporter have to give his or her name? It is always helpful for an agency to know the reporter's identity. This enables the worker to contact the reporter for additional information. In states in which there is a penalty for not reporting abuse, the mandated reporter who reports anonymously may not be protected from the penalty if his or her identity is unknown. The reporter who identifies himself or herself in good faith cannot be held liable.

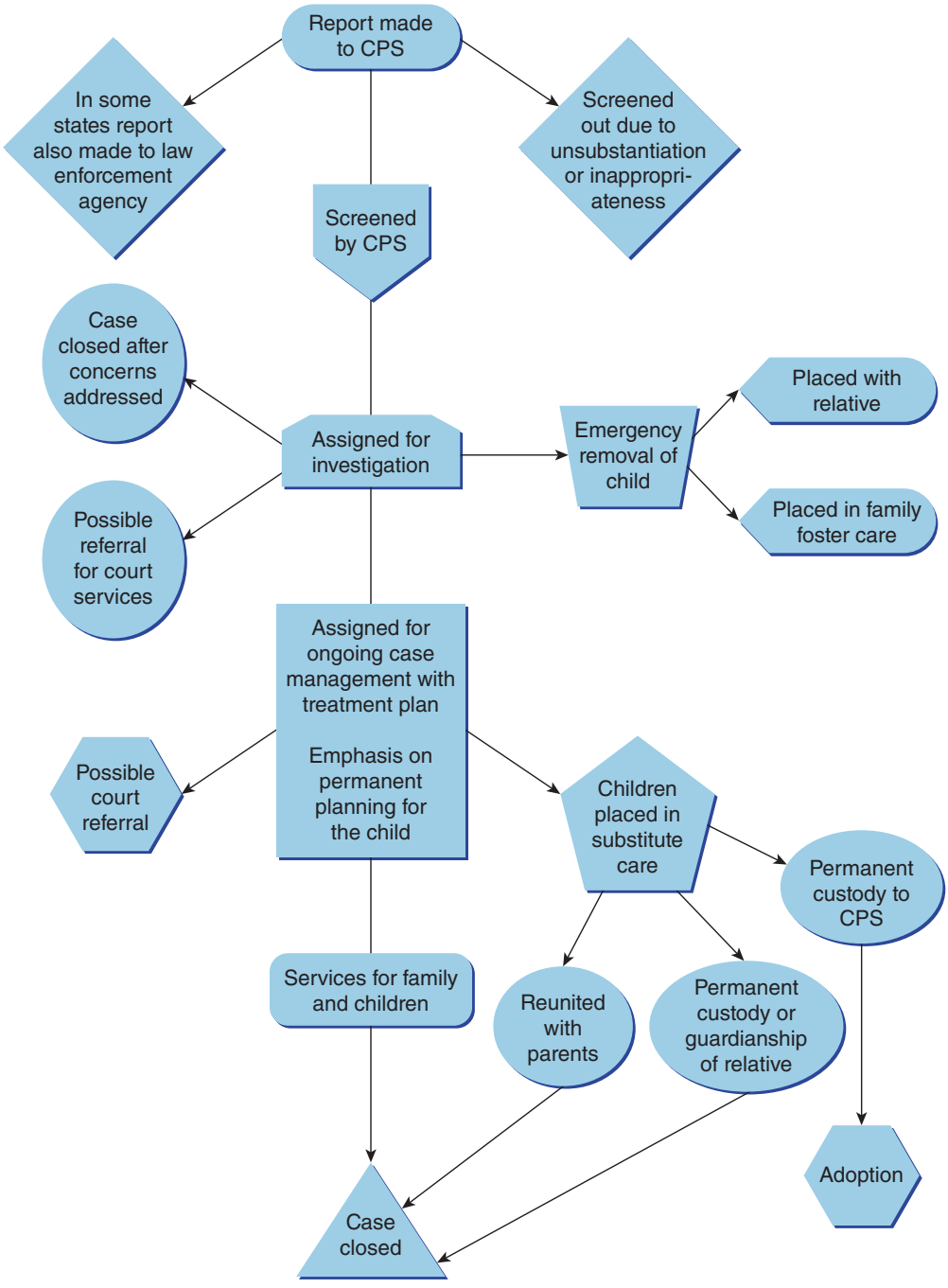
Intake

Once the report has been made to a child protection agency, by phone or sometimes in writing, the situation is screened. Most agencies use a risk factor formula. By looking at certain factors, they determine how much danger the child is in. For example, a situation that involves alcohol, a previous report of abuse, and an especially young child might be considered a higher risk than a situation in which the parents are substance-free, the abuse has never been reported before, and the child is older. The **intake** social worker looks at patterns in the risk factors rather than just one variable. If the intake worker feels that there is sufficient indication that there was abuse and the child is at further risk, the case usually will be substantiated or screened into the system (see Figure 7.1). If there are concerns about the family's ability to function or services the family needs but the case is not appropriate for protective services, a referral will be made to a more appropriate agency. For example, a family that needs counseling or assistance with housing issues would be directed to someone who could help them. Although not the procedure in the past, more and more children's protective agencies are screening in situations of domestic violence. Although a child might not have been hit in a violent home, witnessing a parent being hit has significant impact.

Case Example The Farmer Family

For the Farmer children, watching their mother being battered was a way of life. The call that there was yet another bout of abuse by Mr. Farmer came in to CPS from a concerned neighbor. She had called the police earlier in the week but was concerned that "nothing had been done." Ironically, the CPS office had received a call earlier that day from Gail Farmer's first-grade teacher, who was concerned that the girl was being sexually abused. After considering the reports, the intake worker, in conference with his supervisor, felt that there was enough evidence to screen in the report.

Figure7.1 • The Process for Child Maltreatment Case After a Report to Child Protective Services



Source: © Cynthia Crosson-Tower.

Assessment

If a case is screened in by the intake worker or team, the next step is diagnostic assessment or investigation. The assessment worker uses this time to gather pertinent data through interviews, previous reports, or piecing together facts to determine if the maltreatment has in fact occurred and how serious the risk of future maltreatment is for the child (Greenbaum and Myers, 2010).

Case Example The Farmer Family (Continued)

Once the report had been screened in, a worker was sent to the Farmer home. Because there was a potential for violence on Mr. Farmer's part, the police accompanied the worker. Had Mr. Farmer still been in the act of abusing his wife, the police might have removed him. However, he was not at home. Mrs. Farmer was badly bruised, and 3-year-old Laura and 5-year-old Jake were cowering in a corner. The worker talked with the mother, encouraged her to seek medical attention, and also talked with the children. Mrs. Farmer tearfully recounted that she suspected that her husband had sexually abused Gail and possibly also Laura, but she had been too frightened of him to tell anyone. Now she agreed to go to a shelter until plans could be made for her and her children.

Now it was the role of the assessment worker to gather additional information. Toward this end, she spoke with Gail's teacher, interviewed Gail at school, and talked with the concerned neighbor. Further, she checked with the police department and found that, although there had been other complaints of abusive behavior, Mr. Farmer had never been arrested. She also discovered that he had a drinking problem that seemed to have worsened when he was laid off from his last job. For this assessment worker, the Farmer case began to evolve into a readable pattern that told her that the children were in danger.

As in this case, law-enforcement officers may be involved from the outset. Most states encourage or mandate law-enforcement involvement in cases of domestic violence, sexual abuse, or serious injury. It is the primary role of officers to conduct criminal investigations, remove children, or offer protection for social workers in volatile situations.

Cooperation among a variety of agencies dealing with protective situations is crucial. Toward this end, some states have established child advocacy centers. Such centers are multidimensional, providing, often under one roof, such services as social service and criminal investigation, legal intervention, counseling, case management, and other treatment needs. Instead of being taken from place to place and seen by a wide variety of people, children are seen for validation of the abuse, counseling about court involvement, and treatment in one area by fewer professionals.

Once the assessment worker creates a picture of the family through facts and impressions gleaned from those involved in the case, she or he determines whether the family needs additional intervention or service. Some agencies require the formation of a treatment plan, which is a blueprint of the problems manifested by the family, the services they need, and the services that the agency can provide (Greenbaum and Myers, 2010).

Case Example The Farmer Family (Continued)

The assessment worker on the Farmer case concluded that the children and their mother continued to be in danger. She learned that Mr. Farmer worked steadily in the past and was searching for work again. When he was not drinking, he was amenable to help. Initially he did not admit that he had sexually abused Gail or Laura, but when questioned by the police, he finally broke down and admitted the abuse. He was arrested and removed from the home. The police referred the case to the district attorney's office pending prosecution for sexual abuse. The assessment worker realized, however, that this father would soon be released on bail, leaving his wife and children again vulnerable. The worker encouraged Mrs. Farmer, who had returned home after her husband's arrest, to seek a restraining order against him. She agreed to do this.

Case Management and Treatment

The Farmer case was then transferred to a case manager who would work with the family and oversee the provision of service to them.

Case Example The Farmer Family (Continued)

Provision of service to the Farmers involved support for Mrs. Farmer and her children, legal aid, job training, and finding childcare services while she trained or worked. In the meantime, the case manager kept in contact with the district attorney's office to determine what was happening with Mr. Farmer. It was finally decided that Mr. Farmer would be put on probation while he sought treatment for his alcoholism and attended group and individual treatment for sexual offenders. His supervised visits with his children were also monitored by the protective agency.

The case manager's role differs from agency to agency. In some agencies, the **case manager** is no more than a referral person who coordinates the various services provided. Other agencies expect their case managers to have clinical skills with which they can provide supportive counseling. The term "treatment" can refer to any service, from counseling to contracting with another agency for the provision of some service. The services provided can be medical services, legal services, childcare, remedial help, parent aids, counseling, substance abuse treatment, or a variety of other services (Crosson-Tower, 2013).

Of course, not all cases assessed by protective services continue to be serviced by the agency. It is certainly possible for the case to be closed as a result of inconclusive evidence or the recognition that the situation was not as serious as was first assumed. Maltreatment may be unsubstantiated at this time and the case closed.

Summary of This Section

- As a result of the 1974 Child Abuse Prevention and Treatment Act, every U.S. state requires that instances of child abuse and neglect be reported to the state's child protective agency or law enforcement. Certain individuals are named as mandated reporters—those who are required by law to report child maltreatment. The identity or the mandated reporters differs from state to state. A report must be made when the reporter has reasonable cause to believe that there is child maltreatment.
- Intake refers to the process through which an abuse report is accepted and screened. If the report seems viable, it will be screened in for further action. Decisions are made on the basis of how much risk there is to the child.
- Following intake, a screened-in case undergoes assessment to determine what services can be offered to the family. The assessment worker uses this time to gather pertinent data through interviews, previous reports, or piecing together facts to determine if the maltreatment has in fact occurred and how serious the risk of future maltreatment is for the child. Law enforcement may be involved at various stages of the case.
- Service provision and monitoring is referred to as case management and treatment. Actual treatment is usually contracted out to treatment agencies or practitioners.

COURT INTERVENTION IN PROTECTIVE CASES

Chapter 9 will discuss the court system in depth. For the purposes of our discussion of protective services cases, it is important to know how a situation might involve the court system.

Child protection cases might involve the civil court, the criminal court, or both. The civil court, usually the juvenile or family division, is designed to protect children when parents are either abusing them or are unable to care for them. The emphasis is not on the parents' guilt or innocence but on how the children can be protected from further harm. In contrast, criminal court seeks to prove that someone, usually the abuser, is guilty "beyond a reasonable doubt." Whereas the children and their needs are paramount in juvenile court, criminal court focuses on proving whether the alleged offender is at fault (Davidson, 1999; Jones, 2006).

In both types of court, everyone involved (children and parents) are entitled to due process rights, which include rights to

1. Formal notice of the hearing
2. Legal counsel
3. A hearing in which evidence is presented
4. A defense and cross-examination of witnesses

Juvenile or Civil Court

A protective services case might involve the **juvenile or family division** of the civil court system at any point in its progress through social services. When a situation is first reported to protective services, the intake worker determines whether the parents will work with the agency. If they seem amenable, CPS may investigate and provide services without court involvement. However, if the parents are unwilling to cooperate with the investigation or treatment plan, and/or the children are in imminent danger, court involvement might be sought. Sometimes it appears that the parents will cooperate, but further along in the investigation this cooperation ceases. An investigative social worker or even a case manager might feel it necessary to involve the juvenile court. A few states automatically refer cases to the juvenile court. This, they feel, gives them more control over protecting the children. If, during the investigation, the children appear to be in immediate danger, they can be removed without going back to court.

Case Example The Farmer Family (Continued)

Initially, Mrs. Farmer agreed to work with CPS while they completed their investigation. The worker was confident that Mr. Farmer was no threat to his wife due to the restraining order, which Mrs. Farmer believed he would respect. But as time went on, she became lonely and contacted Mr. Farmer herself. She begged him to come home. Knowing that continuing with his treatment meant staying out of jail, Mr. Farmer at first refused her requests. However, the worker soon learned that the couple was meeting secretly, often in the company of the children. When confronted with this, Mrs. Farmer became angry and said that she would not stop seeing her husband. She began missing appointments with her social worker, and the worker became concerned that the children were again at risk. The decision was then made to file a petition on the children's behalf in juvenile court.

Filing a petition necessitates that a social worker, or other concerned party, sign a petition on behalf of the children. The petition is reviewed, usually by the clerk of the court, to determine if there is enough evidence to go forward. A hearing may be scheduled to review evidence and determine what will be required. (See Chapter 9 for an in-depth explanation.) Involvement of the juvenile court ceases when either the conditions set down by the court are met or there is insufficient evidence to continue.

Criminal Court

Criminal court involvement is sought most often when a parent has been found to be criminally negligent or neglectful, has severely injured or killed a child, or has sexually abused a child. Criminal negligence is exemplified by the following case.

Case Example Roxanne

Roxanne was a 25-year-old woman who had been prostituting for the last 10 years. She had had a variety of different "business managers," or pimps, three of whom had fathered her three children. Her children, now ages 3 years, 2 years, and 3 months, were left in the next room while she "entertained" her clients. She also drank heavily and had used various drugs. She often left her children alone while she went out to get new supplies. The 3-year-old had taken to wandering down the hall while Roxanne was out. The neighbors complained. The next time Roxanne went out, she tied the child to a chair and the 2-year-old in his crib. In her absence, a grossly overloaded electrical socket caught on fire. The fire department was summoned, and they found the children alone. By the time the children were rescued, the 2- and 3-year-olds were badly burned, and the baby had died of smoke inhalation. Roxanne was charged with criminal neglect.

Some parents abuse their children to the point of severe injury or even death.

Case Example Jeremy

Four-year-old Jeremy's father had high standards for his children. He expected them to mind him immediately and would not tolerate any "fresh talk." Jeremy, an active child, taxed his father's minimal patience. On several occasions, his father struck him with such force that he left bruises. Neighbors noticed the bruises but could not believe that a "nice family like Jeremy's" could have caused them. One night, Jeremy talked back to his father. Angered by an especially bad day at work and a fight with Jeremy's mother, the irate father slapped his son hard in the head. The blow sent the small body into the wall and left the child unconscious. Frantic, his mother rushed him to the hospital. The child was diagnosed with a subdural hematoma (blood collecting on the brain) and brain damage. The boy lapsed into a coma and died soon after admission. His father was charged with his death.

In the earlier Farmer case, Mr. Farmer was charged with sexual abuse. In that situation, the court agreed to put him on probation while he attended treatment. When he violated probation by seeing his wife and children secretly, he was eventually incarcerated.

Criminal procedures differ depending on the court. In some instances the parties reach agreements (plea bargains) to minimize the charges, sometimes allowing the accused, like Mr. Farmer, to become involved in treatment instead of being incarcerated. Obviously, the accused is hoping for the best deal; it may require vigilance to ensure that the children's interests are not neglected as this deal is being made.

Criminal court does provide leverage in dealing with the offender. Because power is an issue, especially for violent offenders and sexual abusers, such leverage may be what is needed. For the children and family, however, involvement in criminal court can seem to pervade their lives.

The Effect of Court Involvement on Children

When children are abused and neglected, the damage can be profound. One hopes that the intervention will be swift and competent. Unfortunately, that is not always the case. Court involvement can seem like one more assault to traumatized children. How children are able to cope with court procedures depends largely on the support systems available to them. Victim witness advocates now provide families with the support they need to survive the legal process. The court often appoints **guardians ad litem** (discussed in Chapter 9), who represent the interests of the children. Fortunately, many more attorneys and judges assigned to juvenile and criminal court cases involving children are becoming aware of the need to shelter them from additional trauma (Crosson-Tower, 2013).

In *Unspeakable Acts* (1986), Hollingsworth describes an interesting approach to protecting the psyches of children in court cases. She writes of the so-called Country Walk Case in Miami, Florida, in which a group of children were sexually abused by the owners of the babysitting service their parents used. The children were so traumatized that child psychologists Joe and Laurie Braga were called in to help both parents and children deal with the court process. The case set a precedent for the protection of children in such situations.

Summary of This Section

- Child protection cases might involve the civil court, the criminal court, or both. The civil court, usually the juvenile or family division, is designed to protect children when parents are either abusing them or are unable to care for them. The emphasis is on the protection of the child rather than parental guilt.
- In both civil and criminal court, there is due process including formal notice of the hearing, legal counsel, a hearing to present the evidence, and the cross-examination of witnesses.
- Juvenile or family court is used as leverage by CPS when the family of an abused or neglected is unwilling to cooperate with investigation or treatment.
- Criminal court is often used when a parent has been found to be criminally negligent or neglectful, has severely injured or killed a child, or has sexually abused a child.
- Some courts appoint a *guardian ad litem*—a professional whose role it is to protect the rights and best interests of the child.

THE ROLE OF THE PROTECTIVE SERVICES WORKER

A protective services worker might provide one or more of a variety of services. It is the role of this individual, along with the agency employing him or her, to protect children but also to seek family preservation whenever possible. A child's family is the best place for him or her if that family is able to meet the child's basic needs and protect him or her. To new workers especially, it sometimes seems that a child would be better off removed from a family that is less than ideal. But separation is another form of trauma for children. Thus, the decision to remove must be carefully considered (Greenbaum and Myers, 2010).

The role of the child protection worker depends on the particular agency in which he or she is employed and perhaps on the state's regulations. Child protection agencies are usually run by the state or county and are therefore influenced by the political climate. "Every time there's a new governor, things change a bit," explained one protective services worker. "Sometimes we find ourselves trying to protect our clients' best interests amidst these changes."

Some workers are assigned to intake; they screen cases as they come in. This can be a high-stress role because referrals often peak at certain times of the year. For example, the holidays seem to correlate with more reports of abuse; parents and children become more stressed as the contrast between their pain and others' perceived happiness becomes more pronounced. Intake requires that one think quickly and not be afraid to be assertive when necessary. Both intake and assessment require that a worker be creative in discovering information and skilled in putting that information together. These roles do not allow the worker to form long-term relationships with clients.

The role of ongoing worker or case manager does allow one to get to know clients. Workers learn to support clients and help them capitalize on their strengths. It can be a challenging and frustrating job. Clients may not be able to maintain their growth, and watching them slip back into old patterns sometimes makes one wonder why the effort was made in the first place. Moved from place to place, many of these children and parents lack the ability to form healthy relationships without considerable time, patience, and consistency. But there are success stories, which tend to sustain protective services workers.

Caseworkers in protective services require excellent engagement skills, patience, and perseverance. They must learn to distinguish between immediate harm and cumulative harm to children. Social workers must learn to assess family strengths on which they can build to protect the child in the future and must be able to identify and use both formal and informal social supports and networks. Those intervening in situations of neglect will find the work especially challenging, given that parents often have little psychic energy to draw upon (Child Welfare Information Gateway, 2013).

First person accounts of working in protective services (see Richards, 1999 and Crosson-Tower, 2015) attest to the difficulty and complexity of the job. For example, on one hand social workers are trained not to allow themselves to become overly emotionally involved with cases, but working with children whose lives depend upon intervention can tug at the heart strings.

It is hearing the stories of children who have been helped that provide hope in what can be taxing and discouraging work.

Case Example Reflections of an Abused Child: A Consumer Perspective

When I was asked to write this for a book to be read by potential social workers, I wondered what I could possibly say. But when I thought more about it, I realized that I had a great deal to say.

I was the oldest of five kids and the only girl. Sometimes, I think my mother had me just so she would have someone to take care of us, because that is what I did from as early as I can remember. Someone once asked me if I was neglected as a child. Neglect? How does one define that? Did we have enough to eat? No. Did anyone care about us? No. Did we have what kids need to grow up emotionally healthy? No. If that's neglect, I guess I was neglected, but I never really thought about it. I was too busy surviving.

We had a lot of contact with the social service system—some good, some not so good. My father left us when I was three years old. I never asked who was the father of my three youngest brothers. I am not sure my mother knows. She had a lot of boyfriends

when I was younger. She worked as a waitress in a bar, and she often brought guys home. They would just sort of move in. Some were great, and I liked them. But some were creeps. Like Jasper, who used to beat my mother and me and tell my little brothers that that was what men did to women. And another guy, I can't even remember his name, who messed with me sexually until my mother found out and kicked him out. I can't really blame my mother, I guess. I think she was always looking for someone to love her. She got pregnant with me at age fifteen. I think she hoped I would love her. But I found out when I had my baby at age sixteen that babies aren't like that right away.

Right after Jasper beat me up—I was ten, I think—a social worker started coming to our house. It really scared my mother. She did love us and was afraid we would be taken away. The social worker said that Jasper had to leave and my mother had to see her on a regular basis. So for a while she did. But then one weekend, my mom took off with Harry (I think that was his name), a guy she met at work. I was eleven, and she left me with the other kids. The next thing I know, the social worker came and told us we were abandoned and had to go to a foster home. They put me and my oldest brother in one home and the three littlest ones in another. That really upset me because I worried about them. I was so used to taking care of them. I cried and cried, and the foster mother thought I "wasn't adjusting to foster care." So then they put me in a group home for girls. That was okay, I guess, but I still missed the other kids. My mom used to visit, and we'd cry together. Finally, she must have convinced them she could take care of us because we all went back home again.

That lasted for a few years. When I was fifteen, my brother, who was thirteen, stole our landlord's car. The guy pressed charges, and my brother went to court. He ended up in a home for delinquent kids, and my mother got real upset. She took off again, and we all went to juvenile court. Again, we ended up in foster homes. After moving in and out of six different foster homes, I was really mad at the whole deal. I dated this guy while I was at one home and got pregnant. So they put me in another home, where the foster mother was great. She helped me through my pregnancy and showed me how to take care of the baby. I stayed there until I was eighteen.

Now my son and I live on our own. He's five, and I'm twenty. I work at a diner, but I don't take guys home with me like my mom did. I haven't seen her for years. I don't know where my younger brothers are, but I see my oldest brother once in a while. I still call my last foster home my home. I don't know what I would do without Pam (my foster mother).

What would I say to people who are going to be social workers? Maybe I'd say, "Be careful not to judge." My mom did the best she could, and I still love her. She didn't have the breaks I had. She thought men would solve her problems. And I'd say, "Listen to kids. We know what's happening, and we'll tell you if you listen." I had a couple of good social workers. I've actually thought of going to college to be one. Wouldn't that be something? If I became a social worker?

Summary of This Section

- A protective services worker might provide one or more of a variety of services. It is the role of this individual, along with the agency employing him or her, to protect children but also to seek family preservation whenever possible.
- The role of the worker differs from agency to agency. Workers may specialize in intake, assessment, or case management or may assume some or all of these roles in a given case.
- Caseworkers in protective services require excellent engagement skills, patience, and perseverance. They must learn to distinguish between immediate harm and cumulative harm to children. They must discern the strengths of the family and build on those strengths to help the child.

FUTURE OF PROTECTIVE SERVICES

As resources become more limited and children continue to be abused and neglected, there is a need to consider how to improve existing services or develop new paradigms for services in the future.

Waldfogel (2001) discusses the need to "narrow" the services provided by CPS. Such a move would dictate that CPS take only the most severe cases of abuse and neglect while filtering less serious situations into other services or agencies. Currently, CPS is mandated to protect the child, but the national emphasis on strengthening families means that the role of CPS becomes a mixture of family preservation as well as maltreatment screening and investigation. These activities are not always compatible.

There has already been a move to narrow services in some states. For example, the abundance of reported cases have resulted in some CPS agencies' screening in only the most severe situations. Some agencies have developed risk management matrixes to ensure consistency of service among cases (Dawson and Berry, 2002). Agencies have also made greater use of kinship placements, encouraging extended family members to take some of the responsibility.

Waldfogel (2001) suggests that CPS could best be implemented in the future by (1) customizing CPS response to families, (2) developing community-based child protection, and (3) promoting a larger role for informal and natural helpers.

Customized Response and the Necessity of Training

"Starting where the client is" has traditionally been a tenet of social work practice, yet in protective services the worker, overwhelmed perhaps by the job's magnitude, sometimes finds himself or herself approaching families who abuse or neglect their children in a similar manner. In fact, agencies' policies perpetuate this tendency. Attention must be given not only to changing agency policy but also to the staff who will serve clients.

It is important to remember that almost every client seen by CPS has experienced some type of trauma. It could also be said that the very fact that CPS is involved creates additional trauma for most parents and potentially for their children. Therefore, it is crucial that social workers understand the nature of trauma at the same time recognizing that each individual experiences trauma differently.

The hiring of social workers must be attended to as never before, especially given the cutbacks that may reduce the number of workers hired. Agencies that develop screening procedures to assess suitability for the field (e.g., protective services workers come from a variety of different educational backgrounds) will reap the benefits of better service. Assessing and providing services to families on an individual basis require that workers be more effectively trained in casework skills and challenges administrators to ensure that such training is available.

Once they are hired by the agency, new workers can receive anywhere from a day to a week of initial training. Again there should be an emphasis on the nature of trauma and the responses that individuals might have. Many agencies feel that on-the-job training is the best teacher, leaving new and inexperienced workers at a loss when they first enter the field. More agencies now are recognizing the need for formal training before allowing workers to go out into the field. Adequate training, not only

initially but periodically, is vital to the worker's ability to provide appropriate services to families.

One way to achieve such advanced training is to require universities and colleges to become more involved in **trauma-informed** and skill-based protective training. In addition to understanding trauma, and training in casework skills, educational institutions should provide instruction in community analysis, cultural competence, political systems, and the workings of local, state, and federal government so that potential social workers might use this knowledge to advocate individually for clients.

Beyond training, competent supervision is vital.

"When I first began my role as a protective services specialist," one veteran social worker explained, "the agency's policy was to send you out into the field, initially with an experienced worker and then by yourself. It was in supervision that I got to put all the pieces together. One of the first abusive parents I worked with was constantly blowing off our appointments and if she did meet with me, she was very resistant and difficult. It really got to me and I did not like working with her at all. My supervisor suggested that I tell her about this woman's past. I knew that she had been moved from one foster home to another and was a product of the system herself. My supervisor challenged me to look at how she might be feeling in the face of dealing with CPS for her own child. It really altered the way that I approached her and turned around my feelings about working with this client."

Although supervisors may have been trained on the job themselves, they should also receive training subsequent to their promotion to help them to supervise effectively.

Community-Based Child Protection

It is vital that agencies work together to serve protective service families and those who have the potential to come to the attention of CPS. If CPS screens for the most serious cases, some families will be left without the services they need. Some of these consumers might be served by other agencies. In addition, agencies providing similar services are recognizing the need to prevent duplication and the need to communicate with each other in order to enhance services to families. Not only is there an issue of not duplicating efforts, but agencies must recognize that people who are in psychological pain or confusion will often "shop" for services that will meet their needs. Collaboration between agencies prevents giving client conflicting messages and perhaps doing more harm than good.

Collaboration between agencies in the interest of customized services will require crossing boundaries between the public and private sectors. Barriers to such collaboration are many, and its implementation will necessitate creative responses (Waldfogel, 2001).

Agencies might also take on different roles in the total picture. For example, strengthening prevention efforts within communities might reduce the number of cases requiring CPS intervention. Prevention programs instituted in schools and agencies have been found to reduce the amount of later abuse. Early intervention programs provide parents with the skills they need to improve their child-rearing.

The future must also bring built-in evaluation of services to families. The current child protection system is not effectively serving families or protecting children. A new paradigm must look at how services would be evaluated. This necessitates provisions and funds for ongoing research on the efficacy of service.

Encouraging Informal and Natural Helpers

Part of customized service for families should be assessing and using the network of **informal and natural helpers** that is in place. For example, individuals within the community, church groups, and civic associations are often in the position to help. Also, just because caregivers in a family have abused or neglected their children does not mean that their extended family members condone or practice this maltreatment. Involving extended family members can increase the resources for children's care and protection and lead to the abusive family's becoming more reliant on, accepted by, or intimate with other family members.

The use of informal and natural helpers will admittedly require commitment and training from the agency. And the burden of identifying such available resources will fall on the social worker. However, providing encouragement and training to these community and family members, while helping them see themselves as part of the team, may lessen the mistrust that plagues CPS in the greater community. Only through such cooperation and trust can families be effectively served.

Summary of This Section

- There has been some discussion of narrowing the services that CPS provides to clients. However, over the last few decades CPS has already reorganized in ways that have narrowed services. Risk management matrixes for example strive to identify the neediest of clients.
- It is crucial that child protection workers are screened and once hired receive adequate training, in a formal setting rather than on the job. The increased emphasis on trauma-informed practice necessitates worker training in trauma and its effects as almost all CPS clients have experienced some type of trauma. In addition, workers require skill-based training to do their jobs.
- Clients served by CPS are often involved with multiple service agencies. For this reason, it is important for agencies to collaborate and coordinate their services with one another. Prevention and evaluation are valuable pieces that CPS cannot always accomplish, but might be done in cooperation of other community agencies.
    - Workers are also learning the importance of using informal or natural helpers (e.g., extended family, church, civic groups) to better serve and support their clients.

SUMMARY

- In early times, children were the property of their parents who determined their fate. Children of poor parents might accompany their parents into almshouses, while orphaned, abandoned, or children whose parents could not care for them would be relegated to orphan asylums. Children might also be apprenticed to tradesman to labor under their tutelage. The industrial revolution brought both worse conditions for child labor as well as such reformers as Jane Adams intent upon bettering their lives. Children might also be used sexually in a variety of ways.

The first attempts to help maltreated children came with the case of Mary Ellen Wilson whose maltreatment sparked her removal from her abusive home and the establishment of the SPCC. Despite efforts of other reformers such as C. Henry Kempe, legislation to protect children was not enacted until 100 years after Mary Ellen's plight. The Child Abuse Prevention and Treatment Act of 1975 changes the course of services for children.

- Child maltreatment can be broken into physical abuse, the non-accidental injury of children usually perpetrated by parents: neglect or the failure to meet children's basic needs; sexual abuse, the use of children sexually by adults or other juveniles; and emotional or psychological abuse, which involves demeaning a child's self concept through belittling, rejecting, isolating, or terrorizing a child. Physical abuse is characterized by unexplained fractures, bruises especially in different stages of healing, burns, and a variety of behavior symptoms such as withdrawal, fear, anxiety, harming other children or animals, anger, soreness, or destructive behaviors. Parents abuse due to an inability to handle stress, their own dysfunctional childhoods, or a variety of personal and environmental stressors. Neglect is further broken down into physical neglect, expulsion, shuttling, nutritional neglect, educational neglect, medical neglect, emotional neglect, and inadequate supervision. Neglected children may be dirty, have lice, withdrawn, have difficulty learning, and have muted affect. Parents neglect due to lack of psychic energy to parent, learned lifestyles, and an inability to process accurately.
- Sexual abuse may take place at home or by someone who may or may not know the child outside the home. Offenders typically groom children by exposing them to increasing intrusive activities to desensitize them to sexual contact. Offenders abuse children due to various types of pathology.
- The Child Prevention and Treatment Act designated certain adults as mandated reporters requiring that they report child abuse to CPS or law enforcement. The identity of mandated reporters differs from state to state. Once a report has been made to CPS, it is screened as to its validity through an intake process. After being screened-in, the case is assessed to determine what services must be provided. Case management and treatment involves arranging services for families and monitoring the cases.
- Courts may be involved with protective cases in a variety of ways. Cases are sometimes seen in juvenile or family court where it is determined what is in the best interests of the child. Sexual offenders might be seen in criminal court as their offenses are deemed to be crimes. A *guardian ad litem* might be appointed for a child to insure that the child's rights are protected and his or her needs are addressed.
- The role of the child protection worker depends on the particular agency in which he or she is employed and perhaps on the state's regulations. Workers might cover intake, assessment, or case management. Caseworkers in protective services require excellent engagement skills, patience,

perseverance, and the ability to distinguish between immediate and long-term harm to a child.

- As resources become more limited and children continue to be abused and neglected, there is a need to consider how to improve existing services or develop new paradigms for services in the future. It is vital that CPS workers recognize that almost every client—both parents and children—have experienced some type of trauma and may be reacting as a result of that experience. Formal training for both workers and their supervisors is vital to good casework. Agencies must cooperate in the interest of effective service provision and to prevent duplication of effort. They should also be able to assess the competence of and use informal or natural helpers to provide the best service to clients.



8

Family Preservation or Child Placement? Serving the Child's Best Interests

By Lynne Kellner and Cynthia Crosson-Tower

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Trace the history of family-based services and the underlying philosophical beliefs.
- Describe the types of services offered to help families at risk of child placement.
- Discuss the issues that emerge in assessing the effectiveness of family-based services.
- Discuss the factors that impact the decision of whether to help preserve the family or remove the child from the home.
- Describe the key issues that emerge in designing intervention programs and the future of family support/preservation services.

Ask most people about where a child should be raised, and the answer would probably be the same—in a family. Families are the basic unit that provides nurturance, offers protection to the child, and passes on the values of the culture (see Chapter 2). We also know from research over the years that removing a child from his or her family of birth can cause separation trauma. Therefore, strengthening the birth family is the

CHAPTER OUTLINE

BRIEF HISTORY OF FAMILY-BASED SERVICES 188

Colonial America to 1875 188

The Emergence of Charitable and Private Organizations 189

Public Child Welfare Services 190

The Emerging Concept of Permanency Planning 190

Children in Care Today 192

TYPES OF FAMILY-BASED SERVICES 193

Theories That Underlie Family-Based Services 193

Family Support Services 195

Family Preservation Services 195

Preservation or Child Placement? 198

ASSESSING EFFECTIVENESS OF FAMILY-BASED SERVICES 201

Family Preservation Workers 203

PRESERVE THE FAMILY OR PLACE THE CHILD? 204
SHAPING THE FUTURE OF FAMILY-BASED SERVICES 209
Attention to Cultural Diversity 211
Program Design, Evaluation, and Continuing Research 212
SUMMARY 213

initial goal that has been adopted by child protection agencies across the country. But how do we accomplish this often challenging goal? And when do we decide that the child's best interests would be better served by admitting that his or her birth family may never be able to meet the child's needs? The decision of when to remove children from their homes is not an easy one to make and has myriad political, social, emotional, and casework implications.

This chapter will consider the family-based services movement, primarily from the perspective of family preservation. In this context, we will consider some of the programs that have been part of that movement, the success of family preservation, and when family services must give way to child placement.

BRIEF HISTORY OF FAMILY-BASED SERVICES

Families are so much a part of our daily lives that we cannot imagine being without them. Our images of the family are informed by the media—from television shows in which all problems are solved within the hour timeframe to those of hopelessly dysfunctional families. Yet, family life is much more complex and has greater subtlety than those shows depict. Many families have difficulty meeting the needs of their members, particularly their children; being a parent is one of the most important jobs one can undertake, but it comes with no training manual. Today the stresses on parents and families are significant. The current economy, with rising fuel costs and higher food prices, coupled with high rates of un- and underemployment, stretches the family's budget and adds stress. Military families face unique challenges, such as supporting a member with PTSD, physical injuries, and/or permanent disabilities. Many families find support in their natural and relational support systems, such as extended family, friends, church, neighborhood, and community. However, for other families these systems either do not exist or have not been fully developed, so they feel isolated and have fewer resources to draw from. Such families often come to the attention of the social service system.

The history of services to protect children and, later, to meet family needs can be conceptualized into three eras: colonial times to 1875, the emergence of charitable and private child protection from 1875 to 1962, and government-sponsored interventions from 1962 to the present.

Colonial America to 1875

Chapter 1 discusses the fate of children whose parents were poor or could not care for them. Adults were dependent on either the charity of their communities or placement in publicly supported institutions—**almshouses** or workhouses. Children were at the mercy of the system that dealt with their parents, often ending up in almshouses, which considered them, much like their parents, the dregs of society and stigmatized them as lazy and unworthy (Askeland, 2006).

The belief that some parents may not be capable of raising their young goes back millennia. It first legally emerged in the colonies in 1648 when the Massachusetts Bay Colony legislature established that foster parents might be better equipped to raise a child who is "rude, stubborn, and unruly" than birth parents (Moe, 2007, 124). On the whole, children endured hardship without anyone stepping in to help; only the most egregious abuses came under criminal prosecution such as when an Illinois father confined his blind

son to a cold cellar in the middle of winter in 1869 (Myers, 2006). Among poor families, the very young often stayed with their parents, but the older children might be indentured to learn a trade, thus lessening financial pressures on the family. In short, the method of dealing with the poor during this country's early history taxed the resources of those who could or would provide for them while demeaning the socioeconomically deprived because of their need to take such charity. The strain of such an arrangement soon became the subject of controversy.

The Emergence of Charitable and Private Organizations

Charitable and private organizations can be divided into several categories: **scientific philanthropy**, **settlement house** influence, and the development of mother's pensions.

Scientific Philanthropy

Critics of the conditions of almshouses argued that children should not be subjected to their parents' fate. The prevailing sentiment was that children should be "rescued" from undeserving parents. **Charles Loring Brace** (1872) blamed parents who drank, abused their children, neglected them, drove them out, or were financially unable to care for them for the fact that many of their children ended up on the street or in public facilities like orphanages. This situation, in turn, caused problems for the rest of society. Brace explained that bad education and neglect would result in children becoming "ruffians and criminals," what Brace called the "dangerous classes." Brace and like-minded people believed that benevolent societies and churches could "save the children" by finding them suitable homes away from cities' negative influences. To this end, Brace founded the Children's Aid Society, the first formal child placement agency in the country, in 1853. Brace's philosophy of removing children and finding homes to care for them, often in exchange for helping on the farm or around the house, was that of the Charity Organization Societies (COS). Centered in large cities, these organizations emphasized hard work and personal initiative as a means to end poverty. The COS felt that the poor could be encouraged, through a "friendly" approach, to give up their dependence on charity and almshouses and to make their own way.

By 1929, the Children's Aid Society had transported more than 150,000 poor, neglected, and homeless (but not necessary orphaned) children on trains from New York City slums to live with families in the West (DellaCava et al., 2004). Many of these foster families did not legally adopt the children, many of whom were treated barely better than servants (Friedman, 2004; Moe, 2007).

When social work began to emerge as a discipline in the late 1890s, it questioned how the COS had decided to remove children from their families. Newly trained child welfare workers, having emerged from social work programs, took a more scientific approach to developing knowledge of families' needs and motivations and how to assess and meet these needs (Askeland, 2006). Juvenile courts, the first of which was established in Chicago in 1899, provided a legal means to intervene in cases of abuse and neglect; by 1919 all but three states had established juvenile courts (Myers, 2011).

Settlement House Influence

The settlement house movement, which served the poor and immigrants in many large cities (also discussed in Chapter 1), greatly influenced family-based services (Glowacki and Hendry, 2004). The first settlement house in this country, Hull House, was founded by Jane Addams in Chicago in 1889. This movement was founded on the beliefs that all people, regardless of circumstances, should be treated with fundamental dignity and respect; that poverty and lack of opportunity, rather than moral shortcomings, were the

cause of the problems of the disenfranchised; and that helpers and those in need are equal partners (Social Welfare History Project, 2014). Settlement workers often lived with those they serviced and helped connect them to needed support and community resources to enable families to become less dependent on formal and institutional services (Alstein and McRoy, 2000; Social Welfare History Project, 2014).

Mothers' Pensions

During the Progressive Era in the early twentieth century, many became critical of the large number of children who were in foster care, often simply because their widowed or single mothers could not afford to care for them. In 1909, the White House Conference on Children determined, after much debate, that children should never be removed "for reasons of poverty" (Lindsey, 2004, 21). Therefore, mothers in economic need were provided **mothers' pensions** on the premise that the best way to "save the child" was to "save the family," and in 1910, the first pensions were administered; these were the forerunners of the various entitlements for needy families that have emerged over the last century.

Public Child Welfare Services

In the 1960s, child welfare shifted philosophically toward viewing family problems as deficiencies within individual parents. The emphasis was on protecting children, and removing them from the home, rather than helping parents so they could take care of their children. As a crisis-driven model, it intervened after families had fallen into dysfunction. Increased investigations to determine if there was maltreatment led, in turn, to an increased number of removals and placements of children in foster care. Despite the allotment of additional funds to states through Title XX of the Social Security Act, in the late 1970s, 75 percent of these funds were still being used for foster care services instead of strengthening or preserving families. By 1977, over 500,000 children were living in foster care, with limited efforts by child welfare agencies to work with their birth families. In addition, the average stay in care had lengthened to almost 2.5 years (Pittman and Burt, 1985; MacDonald, 1994; Alstein and McRoy, 2000).

The Child Abuse Prevention and Treatment Act of 1974 mandated the reporting of child maltreatment and further emphasized the state's responsibility to protect and care for children when their parents could or would not. The children, not their families, were the targets of treatment programs. Slowly, attitudes started to change in the 1980s and the child welfare system began to once again look at the systemic handicaps many families encounter (Lindsey, 2004). When the CAPTA legislation was reauthorized and amended in 2003, it shifted national policy to intervening with the family, rather than removing the child from the home, perhaps unnecessarily. The goal became to provide support and needed services to the family to improve its functioning to an adequate level to care for the child (Child Welfare Information Gateway, 2012).

The Emerging Concept of Permanency Planning

Two areas of research would help change the focus of child welfare practice. The first was spearheaded by the work of **John Bowlby**, who found that children who did not have the advantage of a consistent caregiver failed to develop healthy attachments that would carry them through later life. From this research, experts began to question the practice of removing children from their birth families, suggesting that separation would have a significant negative influence on these children's development.

In the late 1950s and early 1960s, there was also an extensive movement to study the efficacy of foster care. The results of several studies suggested that birth families were not given sufficient services to support them in their parenting and that children who were removed from their birth family and placed in foster care often existed in limbo, drifting with no clear picture of their future. Little attempt was made to connect such children with their birth families or place them in a permanent adoptive home. In 1973, Gruber and associates found that 83 percent of the children in Massachusetts' foster care had never had a trial visit with their birth families, and 31 percent of the parents had never seen a social worker. This study highlighted the fragmentation of the child welfare system of the time.

The concept of **permanency planning** emerged from this research. Proponents of permanency planning argued that children had a right to a permanent arrangement as soon as possible in order to lessen their trauma and ensure their normal development. The first way to gain permanency for children was clearly to offer better services to their birth families and hopefully prevent the need for other placements. However, at the time, there was a dearth of services available to help parents gain the skills for successful reunification (Fanshel and Shinn, 1973).

The trend now became to keep children out of foster care whenever possible, an idea strengthened by the redefinition of child welfare services in the Adoption Assistance and Child Welfare Act (PL 96-272) in 1980. This act stipulated that child protection workers make "reasonable efforts" to help birth parents to provide at least adequate care so that their children could be allowed to remain in the home. If a family was unable to care for a child, another permanent option, such as adoption or long-term foster care, should be sought (Child Welfare Information Gateway, 2012). But some social workers and agencies feared that children would be harmed by keeping them in dysfunctional homes. And would these services be effective? As a result of this questioning, as well as the lack of community resources and supports, the provision of services based on "reasonable efforts" was inconsistent from agency to agency and state to state. Foster care statistics remained high, and family advocates complained that families were not being given a chance.

Due to the failure of PL 96-272 to fully meet the needs of children and their families, Congress introduced legislation in 1990 to help strengthen the role of families in children's lives, but it was defeated. The following year, the National Commission on Children, an influential body of children's advocates, published the report *Beyond Rhetoric: A New American Agenda for Children and Families* (1991). Influenced by this report, the Omnibus Reconciliation Act of 1993, containing the Family Preservation and Family Support Act (PL 103-66), was passed. This act more clearly indicated support for children remaining with, or being returned to, their families whenever possible. After years of debate, there was now a mandate to fund a continuum of family-focused services to help children remain with their birth families (Child Information Welfare Gateway, n.d.a).

Nevertheless, some children remained in foster care for extended periods. Out of concern, Congress passed the **Adoption and Safe Families Act** in 1997, mandating time guidelines for permanency planning of children in care. When a child enters care, families are offered an array of services, including counseling, educational, and supportive services to try to stabilize and reunite children with their families. However, when a family is unable to make necessary changes to ensure the child's health and safety, and the child has been in care for 15 consecutive months, or 15 of the last 22 months, the state is mandated to seek termination of parental rights and begin permanency planning (Child Welfare Information Gateway, 2012).

Recently, Congress has broadened its view on both contributing factors to child welfare issues and possible interventions. Recognizing that various issues impact a family's ability to care for its children, Congress passed the Child Abuse Protection and Treatment

Act Reauthorization in 2010 to incorporate elements of previous laws targeting child abuse, family violence, and abandoned infants. States or Tribes, with the benefit of citizen advisory boards, were charged with developing, implementing, and evaluating community-based programs targeting child abuse, domestic violence, and substance abuse (Child Welfare Information Gateway, 2012). To help encourage innovative programs, Congress passed the Child and Family Services Improvement and Innovation Act, Public Law 112–34, on September 30, 2011, as part of an amendment to Part B of Title IV of the Social Security Act. This granted authority to the Department of Health and Human Services to waive certain previous funding requirements in exchange for proposals for innovative programs that implement at least one significant policy change and include a program evaluation at the end of the 3-year grant. This law mandated that states reduce the length of out-of-home placements for children under 5 in particular, monitor and treat the emotional trauma caused by out-of-home placements, address children's developmental needs, ensure that caseworkers visit 90 percent of the children they are charged with monthly, and improve and standardize data collection (American Humane Society, n.d.; Child Welfare Information Gateway, 2012).

Children in Care Today

The **Adoption and Foster Care Analysis and Reporting System** (AFCARS) provides annual statistics on children in care every September 30th. For the reporting year ending in 2013, state child welfare agencies were supervising an estimated 402,378 children in out-of-home placements. Nearly half (47%) lived with non-relative foster families and slightly more than a quarter (28%) lived in relatives' homes. Other placements included institutions (8%), group homes (6%), preadoptive homes (4%), and supervised independent living arrangements (1%). The median age for a child to enter care was 6.4 years, and for exiting foster care was 8.1 years. Males slightly outnumbered females (52% vs. 48%). At the end of September 2013, 45 percent of the children in foster care were white/non-Hispanic, 22 percent were black or African American, 21 percent were Hispanic, and 12 percent were multiracial, of other races or of unknown racial background (Administration for Children and Families/Children's Bureau, 2014). It is interesting that the percentage of African American/non-Hispanic children in care has decreased from 39 percent in 2000 to 22 percent in 2013; perhaps, this reflects increasing sensitivity to cultural biases by white social workers.



Policy Practice

Behavior: *Assess how social welfare and economic policies impact the delivery of and access to social services.*

Critical Thinking Question: Permanency planning is at the root of all current social practice with children. What issues do you feel might impede the attainment of permanency for a child? Is permanency always in the child's best interests?

When possible, child welfare agencies set a permanency goal of returning the child to the family. For the reporting year 2013, 51 percent of children were reunited with their families, usually within 13.5 months, just shy of the treatment goal of 53 percent set by child welfare agencies. Another 21 percent were adopted, 10 percent became emancipated minors, and 8 percent and 7 percent moved in with a relative or guardian respectively (Administration for Children and Families/Children's Bureau, 2014). Of the children reunited with their families, the median rate of children returning to care across the states is 11.9 percent. Youth aged 12 or older have higher rates of re-entry into care; therefore, targeted strategies for this age group are needed to address their particular needs and added supports that foster parents may need (Children's Bureau, 2014, 21).

Summary of This Section

- The history of services to protect children can be conceptualized into three eras: colonial times to 1875, the charitable and private child protection agency movement from 1875 to 1962, and the era of government-sponsored programs beginning in 1962 to present time.
- Colonial children whose parents could not care for them were considered unworthy and lazy and often sentenced to almshouses.
- Charles Loring Brace argued that children should not be blamed for their parents' shortcomings and arranged to have destitute children sent to more stable families, often on farms. This ushered in attempts by charitable and private organizations to provide better homes for poor, though not always orphaned, children.
- The emerging practice of social work in the 1890s questioned the practice of removing children from their families.
- The settlement house movement, begun in 1889, advocated that poverty and lack of opportunity, not moral failing, contributed to most families' problems.
- Mothers' Pensions, first administered in 1910, provided the first entitlement to needy families, allowing more children to stay in their homes.

TYPES OF FAMILY-BASED SERVICES

Family-based services target the family and see the client as the total family system. These services are all-encompassing and multidisciplinary and fall along a continuum from least intrusive to most comprehensive. Community-based Family Support Services help families build on their strengths in order to resolve problems that might have otherwise lead to child maltreatment, developmental delays, or family dysfunction. When out-of-home placement appears imminent, short-term crisis focused family preservation service may help address significant stressors that interfere with the family's ability to care for its children; the goal is to maintain or reunify, if safe, the family (Child Welfare Information Gateway, n.d.). Most **family support services** are embedded within a **strength-based model**, which emphasizes the importance of self-determination and client empowerment. Only when families actively participate in their own change process can these changes last. Such an approach urges workers to make use of a client's strengths and abilities to accomplish change (De Jong and Berg, 2013). Family support services often target families in which various stressors make it likely that a child will need to be removed from the home, while **family preservation services** target families in which an out-of-home placement is imminent.

Theories That Underlie Family-Based Services

Family-based services integrate several theoretical bases, including crisis intervention, family systems, social learning, ecological, attachment, and strength-based theories. Crisis intervention theory helps one to understand the behavior of families that need preservation services. In crisis, one's defenses are down, one feels vulnerable and in a state of disequilibrium. At such a time, family members may be open to trying new behaviors (Kanel, 2014). As a system, each family is a complex network of roles and has its own methods of communicating (see Chapter 2), however dysfunctional this communication may appear

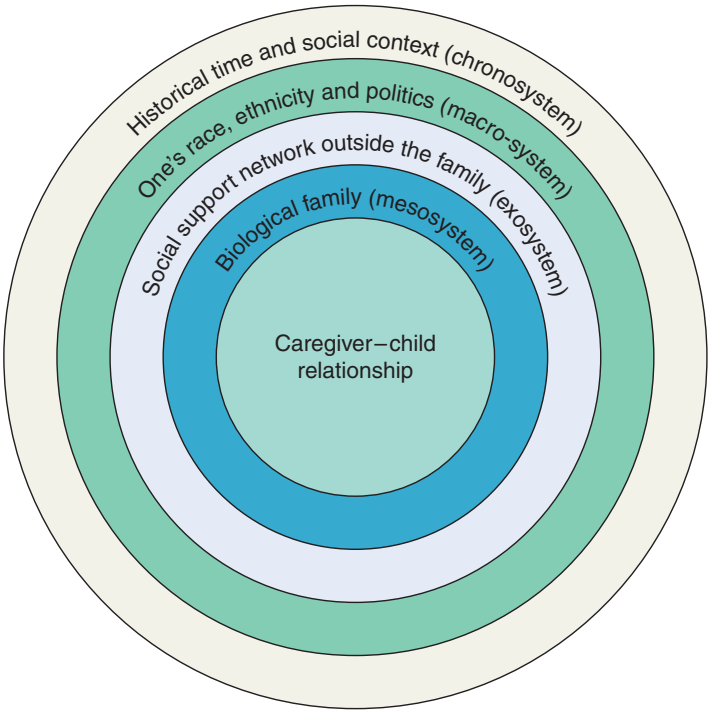
to be. Understanding family systems theory enables workers to know where and how to intervene (Fontes, 2005).

Family preservation is about enabling families to replace dysfunctional behaviors with ones that promote family stability and healthy child rearing. **Social learning theory** involves the examination of expectations and cognitions and the ways in which behavior can be changed. Interventions that include problem solving, role playing, and behavior modification—elements inherent in social learning theory—may be used in these family services, and many family preservation models rely heavily on such techniques (Alstein and McRoy, 2000; Child Welfare Information Gateway, 2011a).

Ecological systems theory focuses on the interaction of various environmental factors impacting the child's development. Each person is influenced through one's interactions with five progressively more expansive systems. One can imagine these as five concentric circles (see Figure 8.1), starting with the microsystem of the caregiver-child relationship and attachment patterns. This functions within the other systems of the biological family (mesosystem), social support network outside the family (exosystem), one's race, ethnicity and politics (macro-system), and finally within the influence of historical time and social context (chronosystem). For instance, policy changes over time (chronosystem), such as welfare reform, have impacted services families have received and expectations for receiving benefits (Hong et al., 2011). A person can experience stressors in any or all of these subsystems. By understanding the impact of one's family system and larger environmental, cultural and political contexts, workers can help plug the family into supports that will compensate for their deficits (Fontes, 2005).

Attachment theory, although preceding the emphasis on family preservation, has been recognized as an important influence in the development of children, especially those who face separation from their families of birth. It describes how children use their early

Figure 8.1 • Ecological Systems



relationships with caregivers to model all subsequent personal relationships (Wamser-Nanney and Vandenberg, 2013; Zilberstein et al., 2014). Through early interactions with caregivers, children learn how to manage distress, communicate and empathize with others, and establish appropriate boundaries. When the caregiver does not model these skills, the child is unable to internalize them. The child whose caretaker is inconsistent or abusive will experience distress and attempt to resolve this discomfort in a number of ways, either by ignoring and avoiding the caregiver, alternately seeking out and rejecting the caregiver, or expressing one's confusion through various erratic interactions with the caregiver and others (Goodman et al., 2010). Children must develop healthy attachments to their earliest caregivers in order to form relationships later in life. When this early bonding is undermined by inconsistent or abusive parenting, children are adversely affected. Separation from parents may also have a negative impact on child development (Alstein and McRoy, 2000).

Family Support Services

Family support services are designed to help families resolve significant problems that may lead to unmanageable stress making the child more vulnerable to maltreatment and/or out-of-home placement. The explicit purpose is not always to prevent removal, but by providing crises intervention services the likelihood of placement is reduced.

Individual models of family support differ widely. The Administration for Children and Families provides funding to states to design and implement individualized "Promoting Safe and Stable Families" programs that aim to prevent unnecessary separation of children and parents, and improve the quality of care and services for children and their families (U.S. Department of Health and Human Services, n.d.). Whether some services are home-based or offered at centers, all are designed to offer programs that prevent family stress, provide education, and promote family unity and health. The goals of individual programs often depend on the missions of the agencies that sponsor the programs. But whatever these goals, the services are based on a strengths-based model that encourages families to feel more competent and acknowledges their right to self-determination.

Family Support services may target particular cultural or ethnic groups or be designed to address particular areas of concern, such as substance abuse or physical and/or mental health issues. Some programs work specifically with teen parents, kinships caregivers, or families of prison inmates (Child Welfare Information Gateway, n.d., b). There is growing emphasis on working with families within a culturally and linguistically appropriate manner to support and empower parents to learn more effective ways to respond to their children and access community supports.

Family Preservation Services

Family preservation services differ from family support services in that they are usually mandatory and are used when an out-of-home placement is imminent or has already occurred. Although models differ, intensive services are usually provided in the home with the expectation that change needs to happen quickly. Typically, the first contact is within 24 hours of referral, and a worker only carries one or two cases at a time. The worker sees the family between 4 and 20 hours a week and is on-call at all times. If there is any question of danger to the children still in the home, they are removed (Martens, 2009; SAMHSA, 2011).



Assessment

Behavior: *Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks to engage with clients and constituencies.*

Critical Thinking Question: How would you feel coming into the home of the Johns family? Is family preservation the best for these children? Why or why not?

Case Example The Johns Family

Entering the Johns family's apartment brought to mind a carnival. The noise and chaos of the home were almost overwhelming. Jennifer Johns's love of unusual "treasures," as she would call them, dictated furnishings; although colorful, many were neither functional nor attractive. Myriad smells, not all pleasing, assaulted the nose as soon as the front door was opened. The five children were undisciplined and did pretty much what they wanted. Neighbors had complained about the children and about trash that flowed out the back door and onto the fire escape; Mrs. Johns described this as her storage room for all the special things she had found but did not have places for yet. The older children's erratic attendance and unkempt appearances had prompted a report for neglect from the concerned school. Ms. Johns was a single mother, at least at the moment. Neighbors reported that she had had a number of partners who had been in residence there at different times.

Despite the chaos of the Johns home and the neglect of the children, ages 2 to 12+, it became clear to the worker that Ms. Johns loved her children and was concerned about them. Her neglect was more a result of her inability to problem-solve or prioritize, combined with the fact that she had had no parenting models in her dysfunctional childhood. She was an excellent candidate for the services of an agency that provided family preservation services. After several months of visits three times a week from a social worker, regular visits from a homemaker, and parenting classes, Ms. Johns was able to improve both her housekeeping and her parenting; the child protection agency agreed that her children need not be removed.

Types of Service Provision in Family Preservation

In order to respond effectively to the family's many needs, the caseworker, should consider concrete, educational, and clinical services. **Concrete resources** address environmental problems such as lack of adequate housing, food, transportation, and/or clothing. These are provided not only because it is difficult for families to concentrate on improving communication, parenting, and other interpersonal skills when they are concerned about their basic needs or stressed by their physical environment, but also because families can be more effectively engaged when they can see tangible proof that the worker is concerned about their welfare by helping them access such resources (Cheng, 2010). In some **HOMEBUILDER** programs, families are awarded up to $500 to help them get over such humps as car repairs or insurance so they may more effectively search for employment (Martens, 2009).

Providing *educational services* helps the family to learn how to more effectively impact one's environment by accessing both internal and external resources. Caseworkers can model life and parenting skills, such as showing more appropriate ways to respond to a demanding or out-of-control child. Research shows that educational services are most effective when they are implemented from a combination of strength-based and ecological models by qualified staff; incorporate activities for parents to do with their children; respect the values, cultural backgrounds, and learning styles of the parents; and have clear goals. Individual sessions tend to be more effective when there is a high risk of child maltreatment; a combination of individual and group sessions, with a potential parent co-leader, tend to result in more significant changes in attitudes regarding childrearing (Child Welfare Information Gateway, 2013).

Clinical Services may be used to address parenting, mental health, and substance abuse issues as well as teach problem solving and coping skills. In particular, motivational interviewing, cognitive-behavioral therapy (CBT), rational emotive behavioral therapy (REBT), relapse prevention strategies, and harm reduction strategies have been found

helpful (Martens, 2009). CBT has been found particularly effective in reducing parental anger, and it is even more effective when children participate in an age-appropriate group to learn skills as well (Runyon et al., 2010). In addition to learning skills to control their behaviors, children can benefit from learning new interpretations of their parent's behavior (i.e., frustration vs. lack of love) that may help reduce their disruptive behaviors and consequently make parenting easier for the stressed parent.

Difficulty Working with Substance Abusing Families

There is a high correlation between parental substance abuse and child maltreatment, and caseworkers often find these families frustrating to work with. Children are three times more likely to be abused, and four times more likely to be neglected, if their parents are substance abusers; 40–80 percent of maltreated children live with parents who abuse substances (National Council on Child Abuse and Family Violence, 2010). These families often suffer additional environmental stressors, and parents tend to have poor parenting skills and offer little emotional support (Scannapieco and Connell-Carrick, 2007).

Family Drug Courts (FDC) have been created to address the poor outcomes of traditional programs to reunify children who are removed from parents due to substance abuse issues. Developed as an expansion of adult drug courts, the FDC provides case management to coordinate substance abuse treatment with child protective services. Through frequent court hearings, the judge monitors the parent's progress and regularly provides incentives, such as earlier unification dates, or sanctions such as longer foster care placements. A review of FDCs in eight states and London found that participants had 20–30 percent higher rates of substance abuse treatment completion, and 20–40 percent higher rates of family reunification, than a comparable group of non-FDC participants respectively (Marlow and Carey, 2012, 2). When the FDC offered on-site parenting skills classes, it reduced the parental criminal recidivism rate by 65 percent, therefore, decreasing the amount of time children spent in out-of-home care and lowering the cost for treatment for the families by 52 percent (7). Program costs for FDC families were $5,000–13,000 less than for families that did not participate in FDC, mostly due to decreased use of foster care, protective services, and community corrections systems (4). Perhaps most promising of all is that FDC participants are five times more likely to be reunited with their children than substance abusing parents who do not enter the program (7).

Another program that has proven to have better-than-average success rates is the START program: Sobriety Treatment and Recovery Teams (Huebner et al., 2012). Families entering the START program first begin by participating in a collaborative team meeting with the Child Protection Worker, a Family Mentor who had sustained at least 3 years of sobriety and is sensitive to protective issues, a Substance Abuse Treatment Coordinator, and any interested relatives; special efforts are made to include fathers. Family Mentors assist parents with getting to treatment appointments and provide coaching on relapse prevention and sober parenting. The program has been implemented in both rural and urban areas; 85 percent of the participants are poly-substance users (198). Average length of program engagement is 14.2 months. Mothers completing the program achieved a 66 percent sobriety rate, which is 1.8 times higher than the expected rate; fathers did not fare as well, achieving 40 percent sobriety rate, which is close to the expected average (199). Participation in START decreased the rate of out-of-home placements to about one-half of that of a matched comparison group (200).

Whatever type of service is provided, the bottom line is that it empowers the family. Four elements have been found as effective in promoting family reunification: a positive and consistent relationship with the caseworker, regular visitation between parent and child, foster parents who support family reunification, and a peer mentor or advocate who can assist the parent in navigating the legal and social service system after losing custody of one's child (Child Welfare Information Gateway, 2011a).

Preservation or Child Placement?

Kinship care is a concept that dates back to well before child welfare services. Early kinship care arrangements were informal; aunts, uncles, grandparents, and older siblings cared for children when their parents could not (Walton et al., 2001; Wilson and Crewe, 2007). According to the Kinship Care Resource Center (2013), currently most kinship caregivers are grandparents; 6.8 million American children are being cared for in the households of grandparents or other relatives. Such arrangements benefit children because it allows them to stay with relatives they already know and trust; remaining in the family circle helps diminish the children's trauma of separation from their parents and may allow siblings to stay together. It does not hold the stigma of being involved with child protective services. This stability positively influences their identity and self-esteem (Walton, 2001; Child Welfare Information Gateway, 2013; Michigan State University School of Social Work, 2013) Placement with family members who share cultural norms positively influences the child's sense of identity (Hong et al., 2011; Ayón et al., 2013).

In 2012, 4.6 percent of American Households were comprised of three or more generations, with higher rates among blacks and Hispanics (8%) and Asians (6%) and lower rates among white Non-Hispanics (3%) (Vespa et al., 2013, 7). Multigenerational households are more likely to have members who are foreign born; only 29 percent of Latino multigenerational families and 11 percent of Asian ones do not have a foreign-born member living in the household (Vespa et al., 9). This is not surprising given current immigration patterns. However, if the foreign-born member is also un-documented, it can negate the family's ability to receive services through the state's child protection agencies. Consequently, families that provide unofficial kinship care often suffer financially, as evidenced by the fact that 19 percent of multigenerational families full below the poverty line compared to the national average of 12 percent of all families (Vespa et al., 9).



Ethical and Professional Behavior

Behavior: *Use reflection and self-regulation to manage personal values and maintain professionalism in practice situations.*

Critical Thinking Question: What ethical dilemmas would you see in working toward family preservation with some families? How would you resolve them?

Despite the many advantages to kinship care, research on its merits and challenges is scant. Some of the concerns raised about kinship care focus on its impact on extended family dynamics and how child protective agencies view it as an option for servicing families. Informal kinship care provides a lower cost alternative to formal state-subsidized care while potentially lowering the number of children on the roles of the foster care system (Blakey, 2012). When child protection agencies allow informal kinship arrangements, the host family often does not receive the benefit of a full range of services and entitlements that formal kinship providers do, such as counseling, home visits, and financial support for the child's needs (CWIG, 2013). Kinship providers tend to be older than non-relative providers and tend to have less financial resources at their disposal (Hong et al., 2011).

Children in kinship care are less likely to be reunited with their biological parents than those in other foster care arrangements (24.7% vs. 32.7%) and less likely to be

adopted (Blakey, 2012, 103). When the foster parent is a family member, conflictual family dynamics can impede the likelihood of reunification. Since many parents do not view having their children live with relatives with the same seriousness of they do when their children are placed in non-kin foster care, they may minimize the protective issues and not work to address them. Relatives caring for children, out of family loyalty, may pressure children to recant allegations of maltreatment or allow unsupervised contact with an abusing or neglectful parent. When the foster family provides enabling support that essentially takes all responsibility away from the parent, it is counterproductive to reunification. Parents can continue to be involved in their children's lives regularly, often helping with parenting tasks or homework, as they work toward reunification (Blakely, 2012). Relatives providing kinship care may shy away from adopting children in fear of causing rifts within the larger family system or appearing that they are punishing the parents (Geen, 2003). Pre-placement meetings with the biological parents, kinship providers, protective services worker, and extended family, if appropriate, can clarify the purpose of the placement and help all family members to work toward a common goal (Ayón et al., 2013).

When children are placed with relatives, parents tend to be less insistent on reunification. Although it is often easier for parents to visit their children, it also may decrease a parent's motivation to make the necessary changes for full unification. For some parents, particularly those consumed by substance abuse issues, knowing that a loving relative is caring for the child eases the guilt and shame of not being able to care for one's children. Consequently, children living with relatives, particularly older ones, tend to remain there longer than those in non-kin foster homes. Given the hesitancy of relatives to adopt, some states have offered family members financial assistance through subsidized guardianships to enable children to remain with them (Geen, 2003).

While kinship is a viable model of intervention; further research is needed to evaluate parameters of when and how it should be used. The Annie E. Casey Foundation (2013) recommends a model for helping Child Protection Agencies evaluate whether kinship placement is appropriate for a particular child; this includes (1) completing a thorough risk assessment of the current family situation, (2) conducting a team decision making process in which all stakeholders are allowed to have meaningful input and receive a full disclosure of available treatment options, (3) providing support for parents with the goal of reunification, (4) providing the caregiver the legal and financial status to provide adequately for the child, and (5) tracking the child's progress during placement.

The question then arises "Is kinship care a form of family preservation or a type of foster care?" It is both, as will be discussed further in Chapter 11. Blakey (2012) suggest that kinship care provides an Africentric paradigm for child welfare practice. As a consequence of the many times that African American slave children were taken in by extended family or the larger community after the death or sale of their parents, the African American community has developed a well-entrenched belief in the necessity of stepping in to help children. Such a perspective, that does not view the nuclear family as the exclusive familial unit, shows how the question of whether or not kinship care is family preservation or foster care is culturally bound.

Case Example The Jackson Family

Nadine Jackson was 14 years old when Sara was born. Her mother tried to convince her to place the child for adoption. Nadine refused and insisted that she would care for Sara in her mother's home—an arrangement to which Mrs. Jackson finally reluctantly agreed. She also consented to watch Sara while Nadine attended school. The arrangement

continued until Nadine was almost 16, at which time she became involved with a 25-year-old man. Mrs. Jackson tried to convince her daughter that this was not a good match, but Nadine insisted that as long as she (Nadine) cared for Sara, her mother had no right to interfere in her life. The dispute finally came to a head. Nadine quit school and moved into an apartment with her boyfriend and Sara.

Mrs. Jackson had no contact with Nadine, although she received sporadic reports from a neighbor with whom Nadine kept in touch. The neighbor reported that Nadine was drinking. Mrs. Jackson wondered what she could do for her granddaughter. Before she had a chance to act, she encountered Nadine in a mall. Sara was dirty and thin, and Nadine was obviously under the influence. After trying to talk with Nadine, Mrs. Jackson concluded that there was little that she could do. However, she was not surprised when the neighbor soon reported that protective services had placed Sara in a foster home.

Mrs. Jackson contacted child protective services and requested to have Sara placed with her. Concerned about this grandmother's own housekeeping standards, and difficulties she was having with her six younger children, the agency was reluctant to comply. They finally agreed to make the placement if Mrs. Jackson would agree to the services of a social worker.

Whether the services that the Jackson family received could be described as family preservation or not depends on both the young parents' and the grandmother's intentions. Given the strain in their relationship, mother and grandmother may have difficulty working together on a common goal. The child welfare worker will need to take extra care to understand how each views this situation and assess the resources needed to help each so that Sara is well cared for.

With the 1997 passage of the Adoption and Safe Families Act, which stipulates that extended family placement be considered, what was once an informal arrangement became the first option explored by child welfare workers when a child is in need of out-of-home care. As kinship care becomes a more widely used option, there is a move toward studying how all constituents, including biological parents, kinship foster parents, children, and child welfare workers view these placements and how they can better meet the needs of the children.

Summary of This Section

- Family support and preservation services fall along a continuum of comprehensiveness based on the likelihood that the child will be, or has been, placed outside the home.
- Family preservation services are intensive, crisis-oriented, and comprehensive; workers respond quickly and may spend many hours each week with a family.
- Services may include helping a family access concrete and clinical services and provide parenting skills training.
- Kinship care allows children to remain in the family circle and may be more appropriate for some cultural groups emphasizing the role of extended family.
    - Critics of kinship care note that extended family dynamics may be problematic and that children in such arrangements are less likely to be reunited with their biological parent(s).
    - Research has shown that family preservation programs are most effective when they incorporate strength-based model and ecological models.

ASSESSING EFFECTIVENESS OF FAMILY-BASED SERVICES

A comprehensive, workable assessment forms the backbone of the treatment contract between caseworker and family. The **North Carolina Family Assessment Scales for Reunification (NCFAS-R)** is the only empirically validated instrument designed to assess potential for family reunification. The instrument uses a six-point scaling strategy: two strength ratings (including clear and mild), one baseline/adequate rating, and three problem ratings (mild, moderate, and serious) to identify seven domains of family functioning: environment, parental capabilities, family interactions, family safety, child well-being, caregiver/child ambivalence, and readiness for reunification. The "baseline/adequate" rating indicates that the family is functioning at a level above which there is a legal, moral, or ethical reason to mandate intervention; families may or may not choose to work on these areas while the treatment is focused on the domains that fall within the problem ratings. Strengths are noted and used to motivate families. The instrument may be used for initial assessment, for case planning and review purposes, service prioritizing and resource allocation, and upon closing a case to help identify aftercare services (Martens, 2009; National Family Preservation Network, 2011).

In a survey of Intensive Family Preservation 20 exemplary programs in 44 states, the National Family identified the following characteristics:

- Programs are implemented on a statewide level to ensure uniformity of program design and to allow sharing of knowledge and technology;
- Well-established programs, having been implemented for at least 5 years, tend to be more effective;
- Safety is the key concern;
- Workers meet the client family within 24 hours of referral and are on-call around the clock;
- Services are provided by one worker, using a clinical model, with team backup;
- Aftercare services are provided;
- Workers complete mandatory trainings to become familiar with program philosophy and to learn how to implement interventions;
- There is high face-to-face contact, averaging 47 hours over the first 4–6 weeks, between caseworker and client family (3);
- Programs have clear written standards, monitor compliance with such, and conduct program evaluations;
- Provide services to at least a quarter of families containing an older youth, ages 12–17 (3); and
- Reimbursement rates are based on families served rather than hourly rates for workers.

Of these exemplary programs, an average of 91 percent of the families remained intact at case closure; this declined slightly over the next 6–12 months (National Family Preservation Network, 2011, 3). Follow-up research is needed to better understand the reasons for the declines over time. Intensive family preservation programs have a cost benefit of $2.54 for every dollar invested in services (NFPN, 24). Despite what may appear to be the initial high cost of the program, it is less than maintaining a child in an out-of-home placement with associated costs of ongoing protection services, foster parents, and courts. While the level of risk to the child and possibility of an out-of-home placement

is one common determinant in choosing the level of intensity of the program for each, sometimes, however, the choice of model is influenced by budgetary concerns rather than clinical ones (NFPN, 2011).

Several programs illustrate how services are delivered to families. The HOMEBUILDER Model, now considered the "gold standard," emerged in 1974 to assist "multi-problem" families avoid foster care placement or obtain family reunification; the publication of *Keeping Families Together: The HOMEBUILDER Model* (Kinney and Haapala 1994) helped to operationalize the model for others to implement. Twenty-three states and several foreign countries have implemented the model with fidelity (SAMHSA, 2011). Families receive concrete (i.e., transportation, budgeting, household management), case management and advocacy skills; parent skills modeling; and therapeutic services intensively upon referral. HOMEBUILDER attempts to reunite families within 4–6 weeks after initiation of services, pending court approval. Services may be provided up to 40 hours a week, usually for a maximum of 4–6 weeks, with the option of a couple of booster sessions over the next 6 months. The expectation is that change can occur rapidly, and that the short time period reinforces the need to use time productively. A therapist works directly with the family while having the support of a backup team. Written materials provide a springboard for discussions and help reinforce information. After completion of the intensive portion of the program, families are provided step-down services and follow-up monthly visits after the case is closed (Martens, 2009).

Family preservation programs that adhere to the HOMEBUILDER model are most effective in preventing out-of-home placement and in helping to reunify families. An analysis of programs in five states (Michigan, California, North Carolina, Minnesota, and Utah & Washington combined) showed that programs that faithfully followed the HOMEBUILDER model consistently lowered the number of children in placement after 1 year compared to a control group; decreases ranged from 35 percent to 53 percent (National Coalition for Child Protection Reform, 2011, 1). A study of HOMEBUILDER-type programs in Utah found that children who were reunited with their families were significantly more likely to remain with their birth families compared to a control group: 77.2 percent versus 49.1 percent (National Coalition for Child Protection Reform, 2011, 2).

> Less intensive services are chosen when there is no imminent risk of out-of-home placement. Although such programs may provide similar services to that of HOMEBUILDER programs, they vary in the level of intensity. Workers typically meet with families within 48 hours of referral to offer supervision and case management, but they spend no more than half as much face-to-face time with families. Workers carry caseloads varying from 4 to 20 families; they are less likely to implement a clinical model in their work. Services are less concentrated and often span as long as 40 weeks compared to the crisis focus of HOMEBUILDER program and are less likely to provide aftercare services (one-third of programs vs. two-thirds of HOMEBUILDER programs) (NFPN, 2011).

The Intensive Reunification Program tries to facilitate reunification by improving the quality of continued parent–child contact, a critical indicator of whether a child will return home. The program provides parents and children multiple opportunities to enjoy one another's company and to learn new skills. Over the course of 36 weeks, parents and children meet for a 2-hour group session. During the first half hour, parents provide a meal that they eat together; this is followed by 30 minutes of fun time in which parent and child do a craft activity, play a game, or read together. During the final hour, the parents attend an educational support group while their children, within age-appropriate groups,

do activities based on the *Chicken Soup for the Soul* series. Parents may also request a 90-minute weekly home visitation with a prearranged fun activity planned. Parents learn from one another through sharing experiences of both frustration and success. One parent commented: "I don't get judged here. That made me feel better; my stress level went way down. I didn't need therapy—I needed someone to hear me out" (488). After completion of the program, 59 percent of the children returned home compared to 29 percent of a comparison group (Berry et al., 2006, 487).

Family Preservation Workers

The attitude and skills of the family service worker play a crucial role in ensuring that families become empowered and can continue to maintain the changes that they make. Engaging in a collaborative process and believing in the family's ability to face its challenges, rather than just seeking client compliance with a service plan, is the key to success. It is essential that caseworkers support and compliment the family as they obtain mutually agreed-upon goals, however small. The frequent contact that is tied to success can be difficult to maintain if the worker has a heavy caseload (Child Welfare Information Gateway, 2011a). Caseworkers supervising parent/child visits should have the clinical skills to help model and facilitate parenting skills and improved communication (Martens, 2009; Runyon et al., 2010).

There is no question that work in family preservation is demanding and taxes one's energies. Rick found that 18 months of such work was enough:

> I loved the work at first. I was employed by a pilot project that provided intensive family services to at-risk families. We had two client families at a time, and we worked intensively with them for six to eight weeks. By that time, it was assumed that they would have learned how to take better care of themselves and we could move on to another family. The families I served had so many problems—not just that they were at risk for abusing their children. In two of the families I had, the kids were the only ones who spoke English. This gave them incredible power over their families, and I think that was part of the problem.

I think I was hired because I speak Spanish even though there were other people with more experience. Since most of my colleagues did not speak Spanish, they were constantly asking me to translate. I didn't mind helping, but it made it difficult for me to keep up with my own caseload. Most of the families were great to work with; it's just hard finding the services they need, especially when they don't have cars. We have also had budget cuts, and with the stressors in the economy more and more families were referred. Since our contract stipulates that we have to contact a new family within 48 hours, I had no choice but to take on more clients. To make things even more difficult, a few weeks ago a child in our program wound up in the hospital. The parents weren't watching closely enough and the child badly burned himself. It's terrible; he will be in the hospital for weeks. Now, our funding source is requiring a full case review of each of our client families; each one takes about an hour. I asked my supervisor, "Do you want me seeing families or going to case reviews? I already am working 50 hours a week." She answered, "Both!" I have no social life—no life really except my work. I don't know how long I can continue this.

Training is essential to enhance the effectiveness of the family preservation worker; it should cover the philosophy of family-based services as well as the specific skills, techniques, and therapeutic options previously mentioned. Training in community analysis and advocacy might help one to impact the environment as well. It is also vital that family preservation workers be competently supervised. Collins-Camargo and Royse (2010)

found that effective supervision increased workers' sense of self-efficacy, especially along those with less than 2 years' experience. This manifested itself in (1) a commitment to tasks even when faced with great challenges, (2) a belief that they could accomplish these tasks, and (3) a belief that their efforts would result in desired change. Supervisors also can help new workers to learn the culture of the organization and become familiar with current evidence-based practices (Sprang et al., 2011).

Given the demands of the job, a team approach is often helpful for both clients and professionals. Exposure to large amounts of trauma, poor organizational support, and a lack of observing progress in families can lead to burnout (Sprang et al., 2011). This stress results in high turnover rates of workers, and a team approach of child welfare workers, teachers, therapists, and others allows for some continuity of services and relationships when one member of the team leaves a position as well as provides collegial support for workers (Gresson et al., 2011). Although the division of labor is helpful and provides families with multiple role models, agencies know that the negatives can outweigh the benefits if the team is not well-matched. A poorly communicating team may actually defeat its own efforts as it strives to enhance communication and cooperation within the family.

Concerns about secondary stress for child welfare workers inspired the National Child Traumatic Stress Network (2008) to develop the Child Welfare Training Toolkit. It uses a number of modules to help workers manage both personal and professional stress in an attempt to promote resiliency and self-care.

Summary of This Section

- A comprehensive, workable treatment plan forms the contract between the worker and family.
- The North Carolina Family Assessment Scales is an empirically validated tool that incorporates scales of adequate functioning, problems, and family strengths.
- Exemplary family preservation programs provide consistent, timely, intensive, strength-based services. They are typically well-established programs with clearly formulated models of care.
    - The HOMEBUILDER program is considered the gold standard. It is founded on the premise that change can happen quickly with adequate supports.
    - Child preservation work can be demanding; the National Child Traumatic Stress Network has created a Child Welfare Training Toolkit to help workers learn to manage both personal and professional stress.

PRESERVE THE FAMILY OR PLACE THE CHILD?

Child welfare practitioners and researchers continue to debate the efficacy of family preservation. Those stressing family preservation comment that keeping families together is more humane. Separation traumatizes children, damages relationships, and often hampers family members in building healthy relationships, later, with others (Berrick, 2009).

Foster care is not necessarily better than the homes children are removed from and can negatively impact the child (Berrick, 2009). Compared to children subjected to maltreatment who remain with their biological families, foster children exhibit significantly more behavior problems (Martens, 2009). Later in life they have higher rates of delinquency and teen births and lower earnings. They are two to three times more likely to be

arrested, convicted, or imprisoned as adults. One in four children in care is diagnosed with PTSD, twice the rate of returning Iraqi veterans (Martens, 2009, 4). Unaddressed mental health and behavioral problems contributes to the fact that so many foster children endure multiple placements, have delayed permanency achievement, and have negative developmental outcomes that persist into adulthood. It is essential that case workers find appropriate services for foster children to help ameliorate these problems; this is particularly significant for Latino children who currently are less likely to receive needed behavioral health services due to lack of Spanish-speaking clinicians (Garcia et al., 2012). Given the potentially negative impact of foster care, it is incumbent on the caseworker to be able to justify that removal from the home is preferable to remaining with the family, not just that the home leaves much to be desired.

The instability provided by foster care can have devastating effects. In a survey of three Midwestern states, one-quarter of children in care experienced five or more different placements (Courtney et al., 2010, 3) and one-third attend five or more different schools as a result of foster care moves (7). Not surprising, this impacts their mental health (31.4% are diagnosed with affective or substance abuse disorders), and their physical health (increased levels of pregnancy and serious injuries than the national average). Even though most of the youth voiced high educational aspirations, they were often ill prepared to meet these goals. A combination of factors, including increased learning disabilities, and high rates of grade retention and suspensions result in poor academic performance; the average reading grade level of the sample of 17- to 18-year-olds was seventh grade (7). The instability of frequent moves often necessitates changes in schools, which most likely contributes to their academic difficulties. Rates of delinquency consistently exceeded national norms, particularly in crimes of theft, serious fighting causing injury, and running away (8). On a positive note, foster children were slightly more likely to be employed than teens living with their birth families, often as a result of job training programs (8). Fortunately, 90 percent said they were "fairly" to "very" optimistic about their futures (6).

An understanding of human development also impacts how decisions about family preservation and foster care are made, particularly for the youngest children. Bruskas (2010) notes the difficulty assessing the impact of foster care placement on the youngest children, and urges child welfare workers to learn to understand the unique world of infants and toddlers. Although preverbal, they do express their grief at losing a parent when placed outside the home behaviorally by crying, lethargy, and/or irritability. These early years serve as a crucial time during which the individual develops a template of the world, and attention should be paid to the sense of loss and uncertainty the young child may experience, even when the parent was unable to adequately provide. Without the benefit of language to help navigate the world, the child may believe that the parent has died or otherwise abandoned him or her.



Intervention

Behavior: *Critically choose and implement interventions to achieve practice goals and enhance capacities of clients and constituencies.*

Critical Thinking Question: How would you know when it is more appropriate to place a child than to preserve the family? How would you feel about having to make this choice?

In their survey of over 4,500 families, Orsi and colleagues (2012, 45) identified six factors that distinguish which families have successful outcomes from their interactions with child protective services. From this large sample, Orsi and colleagues determined that following patterns: Families with two caregivers were twice as likely to be successful, and families with low- to moderate-risk levels for neglect and abuse were 1.7 times and 1.5 times more likely to be successful than those with high levels of risk, respectively. When the caregiver was 26 or older, families were 1.4 times more likely to be successful than when the caregiver was 25 or younger. The lack of substance abuse issues increased the chances of

success by 1.2 percent. Families that did not struggle with poverty were 1.6 times more likely to be successful (50).

Despite the efforts of the family preservation worker, some families continue to struggle. One reason for some programs' limited success may be that the various forms of social injustice that bring families into the child welfare system may not be solved in short term. Children in families whose incomes are below $15,000 are 22 times more likely to be mistreated than those whose families earn at least $30,000 (Berrick, 2009). While a caseworker may have the power to remove a child from the home in an attempt to provide more care, she or he does not have the power to ameliorate the negative impact of poverty that may have overtaxed the family's ability to cope (Fontes, 2005). Often improving a family's physical setting and financial resources will improve their self-concept and engagement with the caseworker, which in turn may help the worker to remain positive and believe that further improvements are possible (Mullins et al., 2011).

Research has indicated that the decision to place children in foster care may be influenced by the worker's negative perception of the child's physical environment and family economic stability. While a caseworker may have the power to remove a child from the home in an attempt to provide more care, she or he does not have the power to ameliorate the negative impact of poverty that may have overtaxed the family's ability to cope (Fontes, 2005). However, often improving a family's physical setting and financial resources will improve their self-concept and willingness to cooperate and also give workers hope that further improvements are possible.

Another creative option that has been gaining momentum is the **crisis nursery**. The City of Phoenix first opened and has maintained one since 1977. These residences, furnished to meet the needs of young children, provide a safe haven for at-risk children and a lifeline for parents who cannot cope with the daily challenges of parenting. The shelter provides both overnight stays and day respite services for children from birth to 8 years of age on an emergency or planned basis. Children are given a medical checkup and any needed treatments or immunizations, developmental screenings, and age-appropriate recreational/play activities. Younger children participate in on-site early childhood programs, and school-aged children are either transported to their school or attend the local school. Staff provide crisis counseling to parents and help connect them to community services and resources. Crisis nurseries allow parents to leave their children before the state intervenes and maintain regular visits in a caring environment designed for the needs of young children while they work toward reunification (Crisis Nursery, n.d.).

Sometimes it is not clear whether a family will be able to adequately care for the child by the end of the 15 months dictated by the Adoption and Safe Families Act; therefore, many agencies engage in **concurrent planning** in which they hope to reunite the family but also have a backup permanency plan. The ambiguity of two plans can be confusing to caseworkers, child, and birth and foster parents; timelines for reunification may lead some parents, believing there is no hope, to voluntarily relinquish their children or agree to an open adoption. The foster parents are in a paradoxical position of considering adopting the child while also being expected to support the birth parents' efforts at reunification. To address these problems, child welfare agencies have found the following practices helpful when considering concurrent planning: Provide adequate services for parents to meet their goals for reunification; provide agency-wide support and training for caseworkers; integrate child welfare and adoption services; and develop a collaborative relationship with the court and legal systems; and institutionalize practices (Child Welfare Information Gateway, 2012). Nevertheless, concurrent planning can be confusing and emotionally charged for caseworker, birth parent, foster parent, and child.

Of course, safety must be the primary concern, and while hindsight is 20-20, the decision of whether to remove a child can be confusing. The importance of making as accurate a risk assessment as possible is highlighted by the fact that slightly over 10 percent of children who were not removed from the home following reports of child maltreatment sustained serious injuries within the 15 months (Schneiderman et al., 2010). Additionally, it is important to avoid unnecessary trauma and only remove children when necessary. In over three decades of Intensive Family Preservation programs, less than a handful of child deaths have been directly linked to the choice of service, perhaps because workers generally see families within 24 hours, provide 24/7 crisis availability, and provide services in a natural environment (Martens, 2009).

Baumann and colleagues (2011) offer an ecological model to help child welfare workers make informed, less reactive, decisions when considering removing the child from the home. They note that many factors underlie how decisions are made; an individual caseworker may attribute poverty to short comings in the individual rather than to a societal context, or base a decision on knowledge of available community resources or the capacity of the agency to respond in a timely manner. To help the child welfare worker make as informed and unbiased decision as possible, a comprehensive assessment of the family should be completed to determine if the evidence of risk meets a clearly defined threshold for intervention. Different stakeholders may have different thresholds of risk due to different roles and agendas. While a therapist may have a higher threshold of risk due to wanting to preserve a working relationship with the parents, the child protection worker or judge may have a lower one due to their primary mandates to ensure the safety of the child. Since there are no crystal balls to tell child welfare workers if their decisions will be correct, they must evaluate the likelihood and consequences of their decisions being wrong. If they over attribute risk, the child may be removed unnecessarily (false positive of risk), or if they underestimate the risk, the child may potentially sustain more harm (false negative).

The key question is whether a parent can overcome the problems that threatened or necessitated the out-of-home placement. To that end, it is important to understand the pathways that parents have traveled and how their parenting behaviors over time have contributed to protective services involvement. The Illinois Department of Children and Family Services conducted a study of 85 families randomly selected from its caseload of 1764 that had a child immediately placed outside the home upon initiation of services; the Department hoped to determine if the parents' previous childhood trauma was linked to their current parenting difficulties. The sample included 140 biological parents (80 mothers and 60 fathers) and 176 children ages 0–17 (Smithgall et al., 2012, 10). The parents reported significantly high levels on the Adverse Childhood Experience (ACE) scale, including emotional abuse (15%), physical abuse (29%), sexual abuse (28%), emotional neglect (21%), physical neglect (21%), parental separation or divorce (66%), violence toward the mother (29%), substance abuse in family (42%), family mental illness (23%) and criminal behavior in the household (21%) (15). Thirty-seven percentage of the parents reported four or more adverse childhood experiences, and one-fifth of those parents reported having witnessed extreme violence such as murder or attempted murder (18). Parents with higher ACE scores were also more likely to have their children removed from the home again after a reunification attempt (20). Illinois now includes the impact of the parent(s)' previous childhood trauma in its Comprehensive Family Assessment, a family-centered, trauma-informed, strengths-based practice model.

Such traumatic childhood experiences can have a lasting negative impact on the individual, which later impacts one's parenting. Many of the parents in the Illinois survey recalled responding to the lack of protection and trust they perceived as children by drinking, often as early as in pre-adolescence, or by becoming drug addicted in early adolescence. While substance use is a well-known attempt to escape negative feelings, there is mounting research to show that childhood trauma has a pervasive impact on the individual, impacting multiple levels of functioning, including affect regulation, behavioral control, attention, memory, self-perception, attachment styles, and interpersonal behaviors. Individuals who experienced multiple trauma, particularly interpersonal in nature, tend to continue to experience unsatisfying relationships due to difficulties with trust, insecure attachment patterns, poor social skills, lack of self-efficacy, and negative cognitive patterns predicting harm from others. Not surprisingly, as adults they have difficulty meeting the demands of parenthood (D'Andrea et al., 2012). Instability in the family, and sometimes residence, often resulted in poor academic performance that ultimately decreased their job and career possibilities and limits the parent's ability to later provide for one's own family. The National Child Traumatic Stress Network (2011) has found that the lack of trust and unwillingness to reach out to others negatively impacts the traumatized parent's working relationship with the caseworker. Given that parents with extensive histories of trauma tend to be hesitant to engage in services, it is essential that the caseworker help the parent prioritize services to identify those most helpful (Smithgall et al., 2012). Multi-problem families often have extensive service plans that can seem overwhelming.

Moving to a trauma-informed model of child welfare will take a paradigm shift. Generally, instead of focusing on what's wrong with the child or family, the inquiry will focus on what happened to the child or family that resulted in such dysregulation. The Child Welfare Information Gateway (2015) suggests the following shifts in thinking for agencies trying to incorporate more trauma-informed approaches:

- Adapting a trauma lens: reinterpreting problematic behaviors as the result of trauma rather than as caused by mental illness or as evidenced that the child is "bad" and looking at the potentially reversible consequences of trauma;
- Broadening treatment goals to include healing the impact of the trauma and improving the child's social and emotional well-being in addition to the more traditional goals of safety of permanency;
- Increased collaboration with other agencies to achieve the goals of enhancing the child's well-being;
- Increased focus on early identification and intervention of trauma to help mitigate some of the long-term effects;
- Clearly articulating the boundary between involuntary participation in the child welfare system and voluntary participation in services targeted to help the child and/or family heal from the trauma;
- Maintain an awareness of the possibility of intergenerational trauma and understand how the parent's behaviors may be a response to their own trauma;
- Expand the role of child welfare worker to screen for trauma; and
- Be cognizant of the role of secondary trauma on other family members and on service providers.

But, after safety, it is often a very difficult judgment call to decide what is in the **best interest of the child**. Children in care usually want to return home, no matter how dismal the caseworker may find the home environment. Given most children's allegiance to their families, and barring significant safety or health issues, Berrick (2009) urges that "child welfare agencies have an obligation to support parents' efforts at reunification" (7).

Cash and Berry (2003) urge policymakers to remember that family preservation is not a panacea; it is one option among a continuum of services. It does not work for all at-risk families. To assume otherwise is to invite failure and put children in danger of maltreatment.

Summary of This Section

- Some argue that family preservation is a more humane alternative while others argue that the safety of the child is paramount and out-home placement is necessary.
- Many children who endure multiple foster care placements manifest negative outcomes, including legal, substance abuse, mental and physical health concerns, educational/future occupational difficulties, and poor parenting later in life.
- The social injustices that often bring families into the child welfare system continue and sometimes make it difficult for them to adequately resolve their problems.
- Workers need to be cognizant of what they are basing decisions on to remove a child. They must justify the intervention based on the level of risk to the child, not subjective impressions of the home environment.
- The American Safe Families Act (ASFA) attempts to limit the time a child spends in care so that permanency planning can be implemented.

SHAPING THE FUTURE OF FAMILY-BASED SERVICES

In this age of increasing fiscal accountability, family preservation services must show that they are cost effective and accomplish the goals that they set out to reach. In fiscal year 2014, federal, state, and local agencies allocated nearly $4.3 billion to fund foster care placements, and only $338 million on family preservation services (National Foster Care Coalition, 2013, 1–2). Although it costs more to keep a child in foster care than to provide family preservation services, it appears that family preservation is not viewed as a viable alternative in many cases.

Each state is mandated to report on the outcomes of children in care through what are called Child and Family Services Reviews (CFSRs), and, if there is a goal of reunification, each state is to aim for the national standard of a 76.2 percent reunification rate within 12 months of the placement. While this may be commendable, such guidelines may result in reunifying families prematurely, thus risking subsequent placement, and/or the child's safety (Child Welfare Information Gateway, 2011a, 3).

The Child Welfare Information Gateway (2011a) found three elements that contribute to the success of family preservation programs: quality of family engagement, comprehensive assessment and case planning, and quality of service delivery. Meaningful family engagement includes involving the family in team meetings, collaborating with supportive foster parents who encourage the child's contact with birth parents, and early and diligent attempts to include extended family in planning. Comprehensive assessments should address both individual and family strengths as well as needs and place an early emphasis on reunification. Service delivery refers to the availability of services, coordination of service providers, and integrating trial home visits before returning the child permanently to the birth parents.

Family preservation programs do not exist in a vacuum. Dawson and Berry (2002) found that the most successful ones help the family to become self-sustaining by

providing links to community supports and resources. Yet, as services are cut, and local offices merge into more distant regional offices to help save money, the caseworker may find it harder to refer to available resources. As the country struggles with the issue of how much it wants to publicly support social services, it may re-invent some of the solutions of the past in which religious organizations and the larger community step up to the plate to compensate for dwindling public dollars to fund child welfare services. Berrick (2009) suggests that educational, health, criminal justice, and cash assistance programs all have much to gain when families meet the needs of their children, and that these systems should conceptualize themselves as serving child welfare needs and contribute much needed dollars to child welfare initiatives. A meta-analysis of 20 studies of brief in-home intensive family preservation services with over 31,000 participants found that services had a medium positive effect on family functioning (Al et al., 2012). Programs helped prevent out-of-home placement for multi-problem families, but only if there were no issue of child abuse or neglect.

Although there are some factors that the child welfare worker cannot change in a family, they need to be creative in trying to assist. While the child protective worker cannot change the character of the neighborhood, he or she may be able to help the parent identify natural supports, join a safety circle, or access respite care. Agencies need to have the flexibility to offer financial assistance in crisis situations without undo bureaucracy. Additionally, workers should be diligent in searching for fathers and offering services to kept them involved. Working from a strength-based model emphasizing long-term success rather than short-term problem solving helps families to identify their resources (Orsi, 2012).

With increasing awareness of how trauma impacts people, it is imperative that Child Welfare programs integrate a **trauma-informed** focus. Interpersonal trauma is more devastating than trauma resulting from external events such as natural disasters. It is easier to accept the randomness of an earthquake than the deliberate maltreatment in the hands of another human being, particularly a parent or other loved one who is supposed to protect the child (van der Kolk, 2005). When a child experiences recurrent interpersonal trauma perpetrated by a caregiver, it is considered **Complex Trauma** (van der Kolk, 2005). Compared to single-event traumas or external ones, complex trauma results in increased internalizing problems, higher rates of PTSD, and typically at least one clinical diagnosis for the child. Child welfare workers should be trained to understand the context of problematic behaviors they see in children and to screen for the impact of previous trauma. Trauma-informed care may help to stabilize the child and prevent foster care drift in which children go from one home to another, or entry into the criminal justice system (Greeson et al., 2011).

High numbers of post 9-11 veterans experience ongoing problems that add stress to their families. While advanced medical care on the field helped save many lives, many veterans continue to struggle with Post-Traumatic Stress Disorder, Traumatic Brain Injury, and/or other enduring physical disabilities. This places significant stress on the veteran and family members. The Pentagon has noted that domestic violence among veterans and their partners increased 33 percent, and child abuse increased 43 percent from the period of 2006–2011 (Carroll, 2012). Yet many veterans resist services, citing that they do not feel civilian providers can understand their experiences. The Wounded Warrior Project is one such program that employs the support of other service members and their families along with professional services. The Project offers free family support weekend retreats for post 9-11 veterans and their families to relax, have fun, gain support, and learn new coping skills within small groups (Wounded Warrior Project, 2015).

Attention to Cultural Diversity

Although family preservation has been adapted for a variety of families from culturally diverse backgrounds, it is vital that attention continue to be given to cultural competence not only at the program planning and implementation levels but also in the training of workers. **Cultural competency** is often misinterpreted as knowing everything about various groups, which is impossible given the complexity of human experience and intra-group differences. Rather, cultural competency is an ongoing skill set that encompasses the ability to have an open mind, and avoid making assumptions based on stereotypes so that one can gather appropriate information and drew conclusions that are grounded in an understanding of the family's larger context (Dettlaff and Fong, 2011).

Social workers going into a family home must be aware of ethnic family traditions, customs, and beliefs and how these may differ from his or her own values. There must be attention to and sensitivity to a family's feelings about allowing an outsider, especially one from a social agency, to become aware of personal family business. Fontes (2005) notes that a number of differences in traditions and beliefs can lead to misunderstandings between caseworkers and families, resulting in either normalizing a situation as "their way of doing things" and negating child maltreatment, or conversely believing a custom abusive or neglectful when in fact it is not. Different expectations regarding appropriate sleeping arrangements, boundaries within the family and/or with extended family, expectations for the child's physical appearance or hairstyling, understandings of the role of caseworker and what is being asked, disciplinary or medical practices, and linguistic differences can lead to cultural misunderstandings. For example, a caseworker may judge a parent as neglectful for not being able to recite the child's various developmental achievements, but if the child had lived with extended family, or remained behind in Mexico, while the parents settled in the United States first, they may not have witnessed the child accomplishing these tasks. On the other hand, if the caseworker is of the same basic cultural background as the client family, misunderstanding can develop as well. Fontes (2005) comments that the caseworker may minimize the negative actions of those who look "like me," or may not ask for more information, assuming that they understand what the family is saying. Given that how we see families is partially determined by our own experiences of families, it is essential to seek supervision and consultation in order to view the case through "other's eyes" and broaden one's perspective.

African American children are consistently over-represented in the child welfare system (Dettlaff and Fong, 2011). The disproportionate number of children of color in the child welfare system is concerning. Miller and colleagues (2013) argue that the interplay of (1) increased risk factors in families of color, (2) individual caseworker bias, and (3) systemic and structural bias interplay to contribute to this situation. The higher prevalence of risk factors, such as poverty, incarceration, substance abuse, single parenthood, and community violence creates stress that place families at risk. Individual biases, or assumptions that some workers make about various cultural or racial groups, impact the decision making process. Deltlaff and Rycraft (2010) found that some caseworkers use culturally biased language in court affidavits and have higher expectations for reuniting families of color than they do for those who are white. Systemic and structural bias refers to the child welfare agencies' routine practices that unintentionally but negatively impact people of color, such as staffing issues, hiring patterns, lack of culturally informed services, and barriers to an equitable outcome, such as lack of appropriate services or the inability to access services due to transportation issues (Miller et al., 2013). Including community stakeholders, such as teachers, other human services professionals, and court personnel, in discussions and plans can be helpful in addressing the disparate outcomes many families of color experience in the child welfare system (Miller and Ward, 2008).

Given that almost of quarter of children in this country are first- or second-generation immigrants (Child Trends, 2013), child protection assessments need to include immigration issues such as country of origin, level of acculturation, and socioeconomic status. It is not enough to describe a client family as Latino, given there are more than 20 countries that people immigrate from that fit this category, with a wide range of economic and educational levels, political concerns, immigration histories, and employment opportunities. Merely translating assessment tools from one language to another does not capture subtle understandings of cultural concepts and notions of appropriate behavior. While providing for the child's safety is not negotiable, a culturally informed assessment that incorporates values and community context will help engage to family to ensure the child's well-being (Dettlaff and Fong, 2011).

The acculturation process itself can lead to child protective concerns. Latino children are the fastest growing population in the child welfare system; children and teens often find themselves caught between two worlds while their parents continue to hold onto "old" views of their country of origin. The parent may react to the ensuing power struggle with attempts to regain control, including using physical discipline, a culturally acceptable, or even preferred, means of child rearing. The child, having been exposed to more Anglo ideas of child rearing and child maltreatment, may threaten to report the parent to authorities, inspiring more anger in the parent for negating his or her authority. If the child needs an out-of-home placement, and no extended family is available, the social worker may try to find a bi-cultural foster home but most likely will not find one. Once the child is placed in care, if the parents are monolingual Spanish speaking, they likely will have difficulty communicating with the foster parents and the larger child welfare system. If the child does not speak Spanish in the foster home, it is more likely he or she will lose some fluency in Spanish, thus creating more distance from the birth parents (Garcia et al., 2012). Miller and colleagues (2013) recommend that agencies (1) increase awareness of present biases in workers and agency structures, (2) create checks and balances in the decision making process, (3) contract with and hire culturally diverse staff, and (4) increase funding for training to help workers become more culturally competent.

Given that kinship care is becoming a mainstream tool of child protective services, it is important to evaluate its effectiveness and tailor services to the unique challenges it provides. A more culturally sensitive perspective is necessary; the concept of *familismo*, common in many Latino families, emphasizes the importance of the family unit to the well-being of all its members and often includes non-blood networks that help in the care and raising of children. Both *padrinos* (godparents) and *compadrazgo* (those who act as co-parents, much like godparents), may be willing to serve as kinship care providers, but many states ignore exploring non-blood networks for possible placement (Ayón et al., 2013). Current policies curtailing extended families from assuming care should be re-evaluated; perhaps current regulations that one must have no criminal record should be modified to infractions that directly impact the ability to care for the child. For instance, a 25-year-old charge of shoplifting when a grandmother had been 20 may not be an indication of the care she could provide her grandchildren.

As the population becomes more diverse, keeping family preservation services culturally competent will become even more of an issue and perhaps a greater challenge.

Program Design, Evaluation, and Continuing Research

Although various interventions may make intuitive sense, in order to prove that they are successful, one must know how success is defined. Families that come to the attention of child welfare agencies often have multiple problems, thus making it difficult for workers

to know where to begin. In response to this confusion, new programs emerge often without any research to back them up. Caseworkers have difficulty staying on top of the new theories in the field and emerging programs to know which ones are most effective (Berrick, 2009). The most effective way to know if the goal has been reached and to demonstrate a positive outcome is to use behavioral objectives, such as a series of measurable behavioral tasks that a family should be able to do at the end of a specific time period. Such concrete goals enable more careful, reliable evaluation and provide a family with tasks that they can recognize they have completed.

Evaluation of family-based services may not be as easy as one might suppose. The goal of such services has evolved from preventing the placement of children to encompassing more global goals related to child and parent well-being (Martens, 2009; Administration of Children and Families, 2012) In addition, there are now a variety of program models, which makes trying to compare and contrast these as to outcome very difficult (National Coalition for Child Protection Reform, 2011).

The debate about the efficacy of family preservation promises to continue, sometimes heatedly. In the meantime, child welfare agencies must make "reasonable efforts" to return the children to or keep them with their birth parents. At the same time, they must abide by the dictates of the Adoption and Safe Families Act, which requires them to initiate termination of parental rights once a child has remained in foster care for 15 of the last 22 months.

Summary of This Section

- In an age of increasing fiscal responsibility, states and agencies must show that their programs are fiscally sound and accomplish their goals.
- Each state is mandated to report outcomes on children in care to the federal government.
- Successful programs have three elements in common: high level of family engagement, comprehensive assessments and case planning, and high quality of service delivery.
- Programs are less successful if there are issues of child abuse or neglect in the home.
- Case workers should be informed on the tenants of trauma-informed care; this may be especially helpful with families with returning Veterans.
- Case workers entering a family's home must be aware of ethnic family traditions, customs and beliefs, and how these differ from their own.
- Systemic and structural biases in the child welfare system have resulted in a disproportionate number of African American children being removed from their homes.
- An increasing number of immigrant children mandate that case workers continue to develop their cultural competency skills.
- It is imperative that future research examines the causes that many families "drop out" of services in order to develop more targeted interventions.

SUMMARY

- Services to protect children and help their families can be conceptualized into three historical eras: colonial times to 1875 viewed poor children as the dregs of society and they were dependent on either the larger community's charity or placed in almshouses or workhouse; the charitable and private child

protection movement from 1875 to 1962, which believed that placing children in middle-class homes, often on farms, would help children learn how to be self-sustaining; and government-sponsored entitlements from 1962 to the present. The settlement house movement introduced the ideas that poor families fell into adversity due to lack of opportunity rather than moral failing and should be treated with fundamental dignity and respect. Mother's Pensions, established in the early twentieth century, became the forerunner of welfare. Growing acknowledgement of the important role of attachment in a child's life has moved child welfare toward preserving the family whenever possible.

- Services for families can be divided into family support services that help families that need supportive services, and family preservation services that aim to prevent out-of-home placements or reunify the family. Service models for at-risk families incorporate strength-based and ecosystemic models, and social learning and attachment theories. Family preservation services typically include providing concrete and psychoeducational services and makings referrals to clinical counselors. One promising intervention to address parental substance abuse, which is highly correlated with child maltreatment, is the Family Drug Court. Although kinship care can be less traumatic for children since they are staying with relatives they already know and trust who share their cultural background, it can delay reunification because biological parents may take a placement with family members seriously and it may allow dysfunctional family dynamics to continue. Whatever the intervention, safety must remain the primary concern.
- Evaluating the effectiveness of family preservation programs is difficult. A comprehensive, workable treatment plan, such as the North Carolina Family Assessment Scales, should be used to base decisions on whether or not to remove a child from the home, rather than subjective impressions of caseworkers. Exemplary family preservation programs, such as HOME-BUILDER, provide consistent, timely, intensive, strength-based services. They are founded on the premise that change can happen quickly with adequate supports. Caseworkers may learn how to handle stress from the job by referring to the Child Welfare Training Toolkit developed by the National Child Traumatic Stress Network.
- Some argue that family preservation is a humane way to help keep families intact while others view out-of-home placements as a safer alternative. However, foster placements have their risks as well, particularly for children who endure multiple placements; these include increased legal involvement, substance abuse, mental and physical health concerns, educational/future occupational difficulties; and poor parenting later in life. Programs sometimes fail because of the social injustices that families often encounter continue despite supportive and clinical interventions. When considering removing a child from the home, the worker must justify the decision based on the level of risk to the child, not subjective impressions of the home environment. Currently, child protection services attempt to limit the time a child spends in care before permanency planning begins, as stipulated under the ASFA.



9

Juvenile Court Justice: Promoting the Rights and Welfare of Children and Families

By Catherine C. Sinnott

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Describe the social and economic forces that led to the establishment of juvenile courts and discuss the purposes of the juvenile court.
- Discuss the different types of cases that may be brought in juvenile courts. Compare the ways that different types of cases brought in juvenile court may be resolved.
- Identify the role social workers can play in reducing trauma from juvenile court cases. Discuss the role of secondary trauma in juvenile court.
- Describe current legal trends in social justice and how they may affect juvenile courts and social workers' roles in the judicial system.

Children have unique rights and legal needs. Courts dealing with children and families must have personnel who are trained to work with children and their parents, to recognize the rights of children and their parents, and to understand the complexities of child development and family life in our changing society.

CHAPTER OUTLINE

THE ORIGINS AND PURPOSE OF THE JUVENILE COURT 216
JUVENILE COURT CASES 217
Delinquencies 218
Status Offenses 220
Care and Protection Cases 221
Disposition of Care and Protection Cases 222
Appeals Cases 223
TRAUMA IN THE JUVENILE COURT 224
Challenges in Juvenile Court Settings 225
Time Delays in Juvenile Court 226
Complexities of Social Work in the Juvenile Court 226
Coping with Trauma in Court 227
TRENDS IN JUVENILE JUSTICE AND CHILD WELFARE 228
SUMMARY 230

THE ORIGINS AND PURPOSE OF THE JUVENILE COURT

The juvenile court is a relative newcomer to court systems in the United States. The first American juvenile court was established by the Illinois legislature in 1899. The aim of the legislation, according to Timothy D. Hurley, one the authors of the legislation, was to recognize the state's responsibility to care for its dependent, neglected, and delinquent children and to keep them from being treated like adult criminals. In creating the juvenile court, the legislators also recognized the rights of parents to their children and the rights of children accused of crimes to have a trial. Chicago was the site of the first juvenile court (Hurley, 1925). John Altgeld, a governor of Illinois and court reformer, identified that nearly 9 percent of the population of the Chicago House of Corrections in 1888 was 17 or under, with the majority of them being arrested for homelessness or wandering the streets (Tanenhaus, 1999). The need to help homeless and aimless youth further fueled the charge for the establishment of a juvenile court.

The legislation establishing the first juvenile court reflected the growing empowerment of women in American society; women were the primary proponents of a special juvenile court for children. Chicago was the fulcrum for social change in America at the turn of the nineteenth century. Women suffragists renowned for their tireless work to get women the right to vote in 1920, also worked for social reform, including the care and protection of children, who were often used as cheap labor in the burgeoning industrial revolution. Chicago, a raw, new city compared to Boston, New York, and Philadelphia, was a goal of many poor immigrant families looking for a fresh start and sure employment. It is no surprise, then, that, Chicago was the site of the first juvenile court, or that women who fought for their own rights, fought for the rights of children as well (Tanenhaus, 1999).

The women whose work provided a catalyst for the juvenile court included such luminaries as Jane Addams, who co-founded Hull House, a settlement house situated in a poor immigrant neighborhood very close to the first juvenile court. Hull House provided many services for the poor of its neighborhood and served as a home and training center for some of the first social workers. Julia Lathrop was another member of Hull House whose work on behalf of poor women and children was monumental in establishing the juvenile court. Lathrop was the first woman appointed to the Illinois State Board of Charities and established important political connections that aided the cause of needy children and the establishment of the first juvenile court. Lathrop became the first director of the Children's Bureau established by President William Taft in 1912. The Children's Bureau, which celebrated its centennial in 2012, is the first federal agency in the world to focus exclusively on improving the lives of children and families (Tichi, 2007). Lucy Flower, another tireless social reformer for women and children, declared as early as 1888 that Chicago needed a special "parental court" to hear the cases of all dependent, neglected, and delinquent children in the city. She is recognized as the "Mother of the Juvenile Court," for her vision and her devotion to the children and families that the juvenile court serves (Tanenhaus, 1999).

Today, the juvenile court is the final resort for getting children and families the help they need. The ideal for children is to find such care and support in their families, but this is not always possible and this may require court intervention. When parents put their children at serious risk or cannot maintain the required welfare and safety of their children, the juvenile court is the final arbiter to decide whether the children's needs

are best served by severing their parents' rights to them. "The compelling work . . . of the juvenile court is . . . repairing families when it's possible, and protecting and saving children when it is not," according to Judge Stephen M. Limon, justice of the Boston Juvenile Court and author of "Massachusetts Juvenile Delinquency & Child Welfare Law" (Karp, Limon, and Wolf, 2015). The juvenile court has the authority to make decisions that will change families forever, for better or worse. In addition, when children's behavior is chronically dangerous or unlawful or puts them or others at serious risk, the court is the avenue to help and hold accountable. Social workers play a major role in informing the courts' decisions.

Juvenile courts have been established in every state, either as full-fledged trial courts to hear only matters regarding children and youth or as special sessions within other trial courts (Children's Defense Fund, 2014). Both state and federal governments recognize that children must obey their teachers and parents and the law, but that children also have rights including the procedural safeguards that a court must ensure in any case that comes before it. This means that children have the right to **due process**. Similarly, the Supreme Court and our lawmakers at the state and federal level have established that parents and children have rights, which must be procedurally respected when the government removes or threatens to remove children from their parents. The juvenile court started as a forum for ensuring that children and parents get respect and humane treatment; it has evolved into the arena for guaranteeing their legal rights as well.

Summary of This Section

- The juvenile court grew out of a societal need first recognized when the industrial revolution took place; rural dwellers and immigrants flocked to the cities with children and dire needs; children were housed in jails with adults often because of homelessness or petty infractions or were left on the street to fend for themselves.
- Many of the first proponents of juvenile courts were also champions of women's rights.
- The juvenile courts were established to help children who were being neglected or imprisoned. Gradually children's legal rights have developed and the court's role is to protect those legal rights and those of their parents.

JUVENILE COURT CASES

Juvenile courts typically have **jurisdiction**, that is authority, over cases that involve the behavior and welfare of children, most particularly when the behavior is criminal or causes harm or the risk of harm to the child or others, or when parents' behavior toward their child causes serious harm or the risk of serious harm to the child. Juvenile court has jurisdiction over delinquencies, status offenses, and child welfare cases. It does not typically hear divorce cases even though those cases often involve the welfare of children. In many case, the state is the party that brings the case to court, although in status offenses, the parent or school personnel instigate the case. All of these cases may be brought to a higher court, an appeals court, for review.



Human Rights and Justice

Behavior: *Apply understanding of social, economic, and environmental justice to advocate for human rights at the individual and system levels.*

Critical Thinking Question: What might you as a social worker do to protect the rights of each of the members of a court-involved family? How might you see that individual members are served? Are there agency policies that might prevent some ethnic, cultural, or diverse groups from being properly served in the court?

Case Example Philip

Philip is a 17-year-old African American youth. He hangs out with college kids because he is tall and can play basketball with them. Shannon is 15 years old and best friends with Jody, 17. Both told their mothers that they were sleeping over each other's houses and went to a party where they knew there would be drinking and possibly drugs. They were excited when they got there and the boys thought they were in college. Jody had a few drinks, then disappeared with one of the boys. Philip, who was at the party with his college friends, started making out with Shannon. She decided she wanted to have sex with him, and went with him to a bedroom. They "fooled around" but they didn't have sex, though she later told Jody she did. She hoped Philip would call her, but he didn't. Three days later, Shannon heard at school that a boy from the party was charged with statutory rape on a girl. She found out that Jody had told her mother about Shannon's sleeping with a boy and Jody's mother told Shannon's mother. Shannon's mother, who was angry with Shannon for lying to her, immediately called the police and filed a complaint against Philip.

Delinquencies

One of the chief purposes of the juvenile system is to prevent children from being treated as adult criminals, to prevent them from being incarcerated with adults, and to emphasize rehabilitation rather than punishment in dealing with their offenses against society (Hurley, 1925). The founders of the juvenile justice system recognized that children's needs differed from those of adults, even when their behavior was similar (Hurley, 1925). Balancing the goals of juvenile justice is a challenge: to hold youth accountable without criminalizing their behavior and to safeguard them personally as well as recognize and protect their legal rights (Bartollas and Miller, 2010; Siegel and Welsh, 2010, 2014). Psychologists and **neuroscientists** who study developmental psychology and the development of the brain are amassing a body of scientific literature that adds to our understanding of adolescent behavior (Steinberg, 2009). Studies indicate that brain development continues after physical maturity has been attained, and that, at least for some part of the developmental process, the brain is limited in its ability to control impulses and to identify consequences of behavior while simultaneously being predisposed to seek stimulation. While these studies do not excuse **aberrant** or criminal behavior, they can help to put youthful behavior in perspective and may inform treatment and **rehabilitation** that can be meaningful and prevent **recidivism**, that is re-offending (Steinberg, 2009).

A **delinquency** case in juvenile court follows a similar pattern to a criminal case in adult court. An individual is charged with an offense, and summoned to court, sometimes by means of a notice that is delivered to the person's residence, or sometimes by being arrested and transported to court by officers. On occasion, that person, whether an adult or a child, may be held by law-enforcement agencies, at a police station or in a jail or a children's holding facility, after arrest, while waiting to go before a judge to be told of the charges against him, which is called arraignment. One of the marks of progress in American juvenile justice is that children can no longer be held in the same space as adults whether convicted or awaiting trial (Bartollas and Miller, 2010; Siegel and Welch, 2010, 2014). Usually a person charged with a crime or a delinquency will be appointed an attorney to represent him or her. After **arraignment**, the individual may be held by the court while awaiting trial, may be told to come up with an amount of money to guaranty his return to court (bail), or may be released.

In a delinquency case, the defendant has all the safeguards of a criminal defendant: the right to remain silent, the right to an attorney, and the right to a jury trial, all

guaranteed by the Sixth Amendment of the U.S. Constitution. These are the "due process" rights (Blitzman, 2015). Blitzman, First Justice of the Middlesex County Juvenile Court in Massachusetts, argues that for children in the juvenile court system, "due process" must include recognition that children are not just small adults, and that they require the process that is due to them, in other words, recognition of the developmental theories of adolescent brain development as propounded by Steinberg, and treatment in accordance to the child's specific rehabilitative and developmental needs (Blitzman, 2015; Sternberg, 2009). *In re Gault*, 387 U.S. 1(1967), is the **seminal** case in establishing the rights of juveniles to due process. Recently the U.S. Supreme Court further distinguished children and youth from adults and recognized their further needs for due process in *Miller v. Alabama*, 132 S. Ct. 2455 (2012), which abolished mandatory juvenile life without **parole** sentences.

The consequences of a delinquency for an accused child are varied and may range from a settlement before trial ever happens, such as an agreement by the child to stay out of trouble for an agreed-upon period of time; an outright dismissal before trial; or a trial where the child may go before a jury if he so chooses, or before a judge. The outcome can be a finding of "delinquent" or "not delinquent," as determined by the judge or the jury. If a child is "committed" after a finding of delinquent, it means that the child will be sent to a facility for juveniles where the goal will be to rehabilitate the child. Unlike adults, children are not usually sentenced to prison; unless the sentence includes an adult portion, or because of the seriousness of the charge, the child is tried as an adult. The state legislatures have established commitment guidelines in accordance with the seriousness of the delinquency charge. In many states, a delinquency will become part of a person's legal history.

Parents are expected to be present and supportive of their children who are brought before the court or to the police for any reason, but in delinquency cases, parents are particularly required to help safeguard the child's legal rights. Sometimes, when a parent is not available or refuses to support a child who is being interviewed by the police, a social worker is called upon to act on behalf of the child in the role of parent and is expected to advocate for the child and to help the child assert his or her legal rights. This may require the adult to get legal counsel for the child if it is prior to arraignment, when the court usually assigns counsel (Ko and Kassam-Adams, 2008).

Children who are committed to a juvenile detention center continue to require the support and advocacy of adults who are not within the facility. Sometimes, however, the parents may not be available or are not suitable and the child may be in the underlying custody of the children's protection agency of that particular state. In such a case, a social worker may be the person who helps the child navigate the system, who attends conferences on the child's behalf, and who helps to advocate for necessary services for the child. That person has the responsibility for safeguarding the child's legal rights and best interests. Similarly, the authorities within the facility are required to continue to safeguard the child's rights and to ensure that his or her interests are being respected while receiving rehabilitative services (Lipsey and Howell, 2010).

Case Example Jane

Jane, 14, is in eighth grade and lives with her mom, Mary, who is a disabled veteran, and her father, Frank, who is also disabled. They live in a trailer in the woods, which has electricity, water, and plumbing but is just barely habitable. Jane's school filed a truancy petition because she has already missed eight days of school and it is only November. When Jane was asked why she had missed school, she replied that she needed to stay with her mom, who had suffered a recent stroke, while her father was undergoing chemotherapy. Jane said there was no one else who could take care of her mother.

Status Offenses

When a child's behavior is troubling, but does not implicate criminal acts *per se*, the child may be brought to juvenile court to get "help." Parents and guardians are empowered by the law to bring children in their care, usually teenagers, to court when they habitually refuse to obey and when they run away from home. School personnel similarly have the authority to file petitions against children when they are **truant** or when they "habitually" cause disturbances in school. Recently in some states the category of "sexually exploited" children has been added to the list of possible non-criminal juvenile cases, in an effort to decriminalize youth under 18 who have been prostituted or otherwise exploited for sex, and to provide services and assistance to them (Children's Defense Fund, 2014). Identifying children who have been exploited for sexual purposes and providing services for them through the statute is an effort to stem a burgeoning problem within our society, as the Internet is used more and more as a vehicle for procuring illegal sex and pornography.

While non-criminal in nature, **status offense cases** may be harbingers of trouble to come in the lives of children and can result in children being removed from their parents' custody. Since children may neither get the services they require nor the due process they deserve, the merit of cases based on status offenses is controversial (Elrod and Ryder, 2009; Bartollas and Miler, 2010; Siegel and Welsh, 2010, 2014; Noel, 2013). Status offense laws are determined on a state-by-state basis, and most states have some version of them. The emphasis in these cases is on finding ways to get the child and the family the necessary services within the community. Mental health disorders are underlying factors in many of the cases that come into juvenile court as status offenses (Shufelt and Cocozza, 2006). Courts are often empowered to provide "informal assistance" to the family that comes to court under the auspices of a status offense, so that the child and family can avoid a full-blown delinquency case, which is time-consuming, more expensive, and may stay on a child's legal record. Court personnel including judges, clerks, probation officers, court clinicians, and attorneys appointed by the court for the child may lead the family toward community services such as family counseling, temporary housing, and school counseling.

The goal of bringing a child to court as a status offender is to find help, usually resources outside of the court that can provide a basis of support for the family and child within the community. Probation officers assigned to these cases often assist in overseeing the recommendations and provide assistance in accessing services. The probation officers visit the child at the school if the school filed the petition or visit at home if the parent filed. Status offense cases often involve children's drug and alcohol abuse and, as noted, emerging mental health problems. If the mental health of a child is implicated, there may be a referral to a court clinic or other community-based mental health facility. Children who have been identified as being sexually exploited receive services that should be tailored to their needs, age, and gender (Saar and Epstein, 2015).

Status offense cases are challenges for social workers because they are on the cusp of delinquency and child welfare. Children charged with status offenses require the court's intervention because of their own acts or omissions, but they also need the court's protection and services (Simonsen, 1991). Sometimes their "offenses" are a reflection of a parent's abuse or neglect, rather than simply a child's non-compliant behavior.

Parents and school personnel are often challenged with the behaviors of children who cannot meet school or societal expectations. Status offenses are a legal mechanism for dealing with children who cannot meet those expectation, often through no fault of their own. However, courts do not have any magic formula to force a child to go to school or to obey a parent's household rules. The real challenge for child welfare professionals, whether associated with the court system, schools, or elsewhere, is to help families

find ways to help their children grow into educated, responsible individuals. These cases require many systems of care to work together to provide trauma-informed services for children and families who are on the brink of disaster (Ko and Kassam-Adams, 2008).

Acronyms

States vary in terms of names used in juvenile justice. As we have seen, some states refer to the courts that deal with child welfare as family courts; in other states, the court is called the juvenile court. Similarly, the names of the agencies that are responsible for ensuring that children are safe and well vary. In Massachusetts and Florida, the entity is the Department of Children and Families (DCF); in Arizona, it is called the Department of Child Safety (DCS); in California, it is called the Office of Child Protection (OCP). Status offense cases typically have special **acronyms** evolving from the statute name and description, such as Child in Need of Services (CHINS), Child Requiring Assistance (CRA), Families Requiring Assistance (FRA), and Minors in Need of Services (MINS). These all refer to the same kind of juvenile court case. Likewise, cases which seek the court's protection of children when their parents abuse or neglect have different terms depending upon how the state legislature wrote the statute. They may be referred to as care and protections (C & Ps), dependency cases, child welfare cases, family law cases, and termination of parental rights cases. Whatever moniker the court and agency and statutes have, their goals and legislative mandates are similar nationwide.

Care and Protection Cases

Care and protection cases involve a great deal of juvenile court time. Care and protection cases distinguish themselves from status offenses by placing the emphasis on the shortcomings of the parents in caring for the child, rather than on the child's inability to obey the parent or school authorities (Horne, 2005).

Care and protection cases can lead to the termination of parental rights, which would mean that the parent would no longer have any say in a child's upbringing and that the child could be adopted by someone else. Because the termination of parental rights is such a dire legal consequence, the path to that outcome includes legal safeguards for the parent and child, guaranteed by state and federal law. Care and protection cases begin in court when the state agency authorized to safeguard and protect children's safety and welfare files a petition in the juvenile court. These agencies are mandated to bring serious instances of parental abuse or neglect of children to the attention of the courts, so that the children can be legally removed from the parent and placed in safety, often in a foster home, which is licensed and paid by the agency to care for children in state custody or sometimes, if possible, in the home of a responsible relative.

Most states have a mandated reporter law, which requires those who have an official role or interest in the safety and welfare of children to report to the state child welfare agency or another state entity if they know of an instance of serious abuse or neglect of a child. Those who are required to report include teachers, clergy, counselors, medical personnel, police, and social workers. Once a child welfare agency receives such a report, it must investigate to determine whether it is substantive and if so, whether it must take emergency measures to protect the child's safety and welfare and bring the case to court.

Across the country, there is consensus that only cases of serious abuse or neglect should be brought to court. What is serious? That, of course, is subjective, but most state legislatures have attempted to write a definition that allows the judge to use his or her

discretion and at the same time protects the welfare of children. At the Federal level, the Child Abuse Prevention and Treatment Act (CAPTA) defines child abuse and neglect as:

Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm (CAPTA Reauthorization Act of 2010 P.L. 111-320, p 3).

The states tend to mirror the federal government. For instance, Massachusetts law states that, when the state agency authorized to protect children's welfare, the Department of Children and Families (DCF) files an emergency **petition** with the court to remove a child from his parents, the court must be "satisfied after the petitioner testifies under oath that there is reasonable cause to believe that (i) the child is suffering from serious abuse or neglect or is in immediate danger of serious abuse or neglect; and (ii) that immediate removal of the child is necessary to protect the child from serious abuse or neglect . . ." before placing the child in the emergency custody of the state (Massachusetts General Laws. Chap. 119, sec. 24).

Once a social worker has acted on an emergency basis to remove a child from home, the social worker files a petition to get the approval of the court for the removal, as above, and a care and protection case begins. If the child's welfare is at risk but not imminently threatened, the social worker may still file a petition with the court asking for permission for the removal of the child but wait for the court to authorize that removal.

Whether the child has been removed from the parents or remains with them, the parents are given official notice of the filing and the opportunity to have a hearing before a judge. The state must present sufficient evidence to convince the court that the removal from the parents' custody is necessary for the child's safety and welfare. In most states, the court must hear such a case within 3 days or 72 hours of the child's removal from the parents. Often parents and children will be appointed attorneys to represent them. Eventually, the case may go to trial for the judge to decide whether the children still need state protection or to terminate the parental rights and free the children for some other permanent life plan such adoption or guardianship (Horne, 2005).

Disposition of Care and Protection Cases

Care and protection cases are sometimes referred to as termination cases, although not every care and protection case results in, or aims at, a termination of parental rights. As in criminal cases, the state acts as a prosecutor (in this case, which is civil, the state is referred to as the petitioner) and has the burden of collecting evidence to prove its case to the judge. In most states, the same agency that files the petition and prosecutes the case continues as the custodian of the child and the parent's liaison to the child.

At trial the judge will determine whether the state agency has proven its case and will make a decision concerning the child's future. The court must approve a long-term plan for the child, which must be in the child's best interest. The possible plans include reunification with a parent or parents, adoption, guardianship, the grant of **custody** to a third party through the court, and for older children, independent living. It is ultimately up to the judge to determine whether parents are so unfit that the best interests of the child require that the parents' rights must be terminated. And the judges must exercise their **discretion** in coming to judgment in child welfare cases. Typically, state legislatures have enacted statutes that guide and direct how child welfare cases must be decided and those statutes must be adhered to in decisions (Horne, 2005).

In many cases, however, the written laws are not enough to govern the myriad situations presented by child welfare cases (Fraidin, 2012). That is why an extensive body of case law has developed over the years, which serves to guide legal practitioners in representing clients

and to direct and guide judges in deciding cases. The situations that arise vary with the characteristics of the child and family before the court; additionally, the problems presented in child welfare cases generally tend to mirror current issues within society.

When a judge makes a decision regarding a parent's rights to a child, the judge must also be ready to put in writing all the facts in evidence that brought the judge to that decision, and why those facts are backed by the law. That is called "Findings of Fact and Law."

Appeals Cases

Cases in juvenile court are appealable to a higher court. The appeals courts are made up of a different set of judges whose job is to review what the judge decided in the trial court, in order to determine whether the facts were correctly put into evidence, and whether the law was properly followed by the judge. In smaller states, like New Hampshire, there is only one appellate court, which reviews all cases. Larger states, such as New York and California, have multiple layers of **appellate courts**, with the highest court being the ultimate decider. Sometimes, a child welfare case or a delinquency case will go from one appellate level to a higher one. Cases that raise constitutional or federal issues may also be brought to U.S. District Courts and ultimately to the U.S. Supreme Court. While appeals cases are pending, the underlying case in the juvenile court must also remain open.

Like the trial courts, the appeals courts have procedural requirements to protect legal rights and ensure that all parties in a case are treated equally and fairly. The trial judge in the "lower court" must write the reasons for the decision and list the facts, which were presented at trial that led the judge (or, in a delinquency case, possibly the jury) to the conclusion, and identify the statutes and case law that the judge used in the decision. These are the "Findings of Fact and Law," mentioned earlier. The process is long. Attorneys who were usually not part of the original trial must be appointed to represent the parties in the appeal. The party seeking the appellate review must file the proper documents to begin the appeal and must order the recording of the proceedings to be typed and published as "transcripts." This may entail thousands of pages, and each attorney and each judge on the review panel must receive a copy of the transcripts. Those working on the appeal must familiarize themselves with the case, the parties' issues, and the transcripts. The attorneys must prepare briefs: They must summarize in writing what happened and what mistakes were made if they are appellants (appealing the case); if they represent appellees, the attorney's **brief** must explain why the judge's decision was correct.

The appellate judges, usually a panel of three or more, sometimes called a **tribunal**, review the transcripts, the evidence, and the presentations of all sides. Often there is oral argument, giving each party's attorney an opportunity to present the case from each respective client's perspective. The deciding tribunal may also ask questions about the case. The tribunal must decide whether to affirm the case, that is agree with the decision of the trial judge or to remand it, that is send it back to the trial court with special instructions on how to re-examine the evidence and how the law should be applied. In either case, the losing party may have the opportunity to appeal that decision as well, although it is up to the discretion of the next highest court whether to allow a further appeal.

Appellate cases take time. In delinquency cases or status offense appeals, it can be frustrating for parties to have to wait while an appellate court familiarizes itself with the facts of a case to decide whether justice, according to the rules, was accomplished. In child welfare cases, where the long-term fate of children may be at stake, the delays inherent in an appeal are even more frustrating. Social workers and foster families may be angry and impatient knowing that a new court may overturn a judge's decision to terminate a parent's rights, putting a child's future back in flux. Similarly, parents and children who do not want to

be permanently separated from their biological families, wait impatiently for another court to review the lower courts' decision, hoping that a longed-for reunification can be accomplished with an overturned appellate decision, a rare, but not unheard of, outcome.

The appeals court decides whether the decision is of enough public interest and use to instruct in other cases that may arise. If the court decides it is, then the decision is published. If the decision is published, it becomes available for the general public to read, and it may become the basis for decisions in other cases, part of the case law. If the case occurs in one of the states where the privacy rights of the parties prohibits the publication of the names, then the case will be published using pseudonyms for the parties and the name of the case.

Case law is made up of the published opinions of appeals courts. Case law is a very important part of cases in juvenile court, as noted, most particularly in child welfare cases. Although it takes time for case law to develop, it is important in cases where the safety and welfare of children and the rights of the children and their parents to familial integrity are in the balance. Case law recognizes, in general, that the state is not a vehicle for social engineering and that, barring truly egregious and harmful parenting, the best place for children, and the place they most often want to be, is with their parents, and that children do not lose the protection of the law because they are children who have come under the scrutiny of authorities.

Summary of This Section

- The juvenile court has jurisdiction over delinquency cases, status offenses, and child welfare cases, including care and protection cases and termination of parental rights cases. It has authority over all cases that involve the safety and welfare of children.
- Often the state brings the cases to juvenile court. In status offense cases, the parent or a school official brings the case to juvenile court.
- Delinquency cases involve the unlawful behavior of children and youth under a state mandated age, usually 17 or 18. The purpose behind a delinquency is to rehabilitate not to punish.
- Status offenses cases evolve from the child's status as a minor; for instance, being 15 and truant from school is a status offense because the law says that all children must go to school until 16, 17, or 18, depending upon the state.
- Care and Protection Cases arise when a state welfare agency files a petition in court saying that a parent is neglecting or abusing a child such that the child is seriously harmed or at risk of serious harm.
- Termination of parental rights cases arise from care and protection cases when the state agency seeks to prove that a parent is unfit to protect a child and that the best interest of the child is only served by terminating the parent's rights to the child.
    - Appellate cases can arise from any juvenile court case and require another court to review the juvenile court proceeding and determine whether grievous mistakes were made. They are lengthy. While an appeal is open, the underlying case must also remain open.

TRAUMA IN THE JUVENILE COURT

It is ironic that systems that are designed to bring relief and help to beleaguered and traumatized individuals and families often bring more trauma to those same individuals and those who set out to help them. This is true in medical settings like hospitals and schools, and it is also true of courts and, in particular, the juvenile court.

Challenges in Juvenile Court Settings

Going to court for anything can feel very daunting. The court setting, with its formality and ritual, its often old-fashioned language, as well as uniformed and armed court officers and robed judges sitting on high, is intimidating. Having to go to court because you are accused of a crime or a status offense, or having to go in front of a judge because someone outside of your family has said that you can't properly care for your children is nearly guaranteed to be a traumatizing ordeal (Marsil and Montoya, 2002).

Whether it is dealing with a criminal or child welfare case, the court system is slow and cumbersome. It is a slow process because it takes time and deliberate action to guarantee the legal rights of all parties. The rights include first and foremost, the right to have notice that a court case has been filed. Certain procedures are stringently adhered to so that the judge can certify that everyone who has rights under the law has been informed of the actions the state has taken and knows when the case will be heard in court and where. Court procedures are slow and cumbersome, but they are an important part of the effort to treat all parties equally and fairly under the law. The right to have notice of a court proceeding that concerns you or your child and the right to have your point of view heard are pillars of our justice system (Friedman, 2002; Horne, 2005).

Juvenile court cases are often even more challenging than other court cases because of their complexities and highly emotional issues. Most families in juvenile court are poor and have few financial resources (Goldberg, 2015). This has its own challenges. Courts are short on financial resources, often facing a shortage of the judges, probation officers, clerks, and attorneys necessary to the judicial process. Facilities for juvenile courts are sometimes wanting, with a shortage of courtrooms, so that even if there were enough personnel to hear cases, there would be no actual place to hear them (Horne, 2005).

Additionally, juvenile court cases often involve many individuals. A care and protection case may involve two or more parents and more than one child as well as the social workers who work with, and sometimes, against, the family. All, with the exception of the children, have separate attorneys, and if children have different legal positions, they will have separate attorneys, too. A delinquency case usually requires just two attorneys, one for the state and one for the child, but it may also require the assistance of a mental health professional to examine a child regarding the child's competency to stand trial. School officials are often part of juvenile court cases, notably in school status offense cases, and they must be present for certain cases to go forward. Some states require that a court-appointed guardian be present for the children, too.

Case Example Yolanda

Yolanda is a young Hispanic mother, living with her mother and two young children. She was raised by her grandmother, but had six foster care placements before her grandmother had housing to accommodate her. Yolanda and her mother had a difficult relationship. Yolanda's oldest child died of sudden infant death syndrome (SIDS). Her next child, Jason, was 3 when he started to leave the home unsupervised. He was found at a busy intersection once and in a near-by grocery store another time. When he was returned to Yolanda by the police, she hadn't noticed he was gone. The police filed a report with social services. Jason and his little sister, Flora, were both removed from Yolanda, although social services said they would return the children as soon as better locks were put on the doors. While the children were away, Yolanda got in a fight with another woman and was arrested for assault and battery. She resisted arrest because she said the other woman started it. Because her children were away and her mother had kicked her out of the apartment, Yolanda agreed to plead guilty for a reduced sentence

of 3 months. Her children did not visit her in jail, and when she was released, she was homeless for over 6 months. When Jason was placed in a foster home, he ran away, without the foster parents noticing he was gone. But by then Yolanda was already in jail. Yolanda's trial in juvenile court was delayed because the children's attorney had to withdraw and there were no attorneys available to represent them because of a shortage of attorneys willing to take the low pay of court-appointed work. The case was delayed for another half year. Yolanda obtained housing, but Yolanda's children were never returned to her and she eventually agreed to an open adoption. She sees her children twice a year. She respects the adoptive parents. Yolanda's most treasured items are the pictures she gets from the adoptive family, and the pictures she has of herself with Jason, Flora, and her grandmother.

Time Delays in Juvenile Court

Assembling all required individuals for a court hearing takes time. Often, cases going on in different courtrooms require all the same court personnel. For instance, interpreters for non-English speakers are required in multiple courtrooms at once, so each case has to await its turn. Attorneys, too, are sometimes required in multiple courtrooms at once, causing additional delays. Families and other witnesses like social workers can wait hours at court, only to be informed when they finally get before the judge, that the court has run out of time to hear them, or that the case cannot go forward because someone is missing. The case has to be re-scheduled, with the threat of the same outcome at the next date.

The burden of waiting in court is high, both economically and in terms of outcomes. For a parent with a job, an absence for a court date may mean the loss of the job. For a child waiting to be heard on a status offense case or delinquency, it often means loss of a day or days in school. This passage of time may erode the relationship among family members and sow seeds of doubt in the hearts of children who are anxious to be back with their parents. It causes anguish for the families waiting to adopt children. It delays the reunification of a family or the release of a child from custody. Having to wait for your life to go on can be demoralizing (Horne, 2005).

While the purpose of the juvenile court is to recognize and identify ways to help children, youth, and families in need, it also has the over-riding purpose of ensuring that those before the court receive all the protections afforded by the law. The courts do not receive the funding and support they need to serve their purposes well, or even to schedule cases efficiently. Even with the proper funding the courts face a difficult task. Without the proper resources, the task is compounded and good outcomes are put in jeopardy by the mere passage of time. The wheels of justice grind slowly, and in juvenile court, with its complexities and limited funding and highly emotional cases, the wheels of justice grind very fine as well. (Horne, 2005).

Complexities of Social Work in the Juvenile Court

The social worker's role with a court-involved family may be complicated by the worker's previous actions to protect the children of the family. If a social worker believes that the child is at **imminent risk of serious harm**, then the social worker is authorized under law to protect the child and take emergency custody of the child. Obviously, this is an extreme action and traumatizing in itself to the child, the parents, and the extended family. It disrupts the child's life within the family, school, and community. It causes an automatic

emotional rift between the child and the parent. It can also cause the child long-term psychological damage. Nevertheless, the social worker is mandated by law to ensure that a child is free from imminent serious risk or harm. This situation creates a tense environment when the parties come together during a juvenile child welfare proceeding in court, once the child is removed. Secondary trauma to the adults in court, including the social worker, may be a result (Child Welfare Information Gateway, 2015).

In child welfare cases, the social worker's dual role as petitioner—and collector of evidence against the parent—and child welfare provider—and confidante and advisor to the parent—leads to confusion, resentment, and distrust. It means that a parent must cooperate with the agency social worker, while knowing that the social worker may also be a witness against the parent in the case. It is a very difficult situation for the social worker, who may also hope to reunite the family, but needs the family's trust to do so. It calls for a very high level of professionalism from the social worker (Schultz, 1989; Cassels, 2013).

Once the department has custody, the agency social worker, or her team, determines the day-to-day life of the child, including how, where, and when the child may see the parent; where the child will go to school; and where and with whom the child will live. At the same time, the department social worker must interact with the parent to determine whether the parent is making the necessary strides toward reunification, or whether the parent has hit roadblocks. In court, this dichotomy of working with the parent and simultaneously collecting evidence against the parent creates a tense and even traumatic courtrooms. Many attorneys and judges involved in juvenile court cases are becoming aware that children and their families must be protected from the added trauma of court (National Child Traumatic Stress Network, Justice System Consortium, 2009; Buffington and Dierkhising, 2010; Crosson-Tower, 2013).

Coping with Trauma in Court

A social worker must work hard to maintain a sense of fairness and objectivity while recognizing a child's needs for safety and protection. This must be reflected in the social worker's attitude and approach to clients in juvenile court settings. The tenets of trauma-informed social work apply in the court setting as much as in any other (Ko and Kassam-Adams, 2008; National Association of Social Workers, 2008).

Social workers must recognize that for their clients in court, court usually does not feel like a safe place. Often the juvenile court is associated with a loss of control at best. While a social worker does not control the atmosphere in court, she or he can help. The social worker code of ethics provides guidelines, which apply in court and out, including recognizing the dignity and worth of the person, including court-involved parents (National Association of Social Workers, 2008).

If a social worker can demonstrate to the court-involved parent whose child is in state care, that she knows the child's needs and responds to them rapidly, then she is building a foundation of trust. Assuring a child's welfare and safety while in state custody is the key to the social worker's job, and the number one **corollary** to that is being able to honestly assure the parents of the child's welfare by responding to parents' requests and concerns. Without assurance



Ethical and Professional Behavior

Behavior: *Make ethical decisions by applying the standards of the NASW Code of Ethics, relevant laws and regulations, models for ethical decision-making, ethical conduct of research, and additional codes of ethics as appropriate to context.*

Critical Thinking Question: If the attorney representing your social services agency asks you to say during sworn testimony that a child said that her mother beat her, when the child did not say that to you, how do you handle that? What if the mother is, in your opinion, clearly unable to take care of the child, who is only 6? What kind of consequences could come from your testimony?

the parent will feel alienated and doubt the sincerity of the social worker's willingness to reunite, adding to the trauma for all involved. If called to testify, then the social worker will gain the respect of all by being prepared and answering all questions directly and honestly, as directed by the Code of Ethics (Schultz, 1989; National Association of Social Workers, 2008; Cassels, 2013).

If a case is appealed, it is helpful for social workers to know why appeals are time-consuming and the value of the cases. Social workers who understand the process can become the educators for others, foster families, pre-adoptive families, parents and children alike, and empower their clients to withstand the long process of an appellate case. They may also trouble spot along the way of the appeal, so that if roadblocks appear, they may help resolve issues that are impeding process. If the social worker is able to help sides come together for the welfare of the children and the family, and to avoid the appellate process by helping to settle the case rather than having a lengthy appellate process, then the social worker will have performed a service for all.



Intervention

Behavior: *Facilitate effective transitions and endings that advance mutually agreed-on goals in court cases.*

Critical Thinking Question: After a judge has terminated a mother's rights to her daughter, the mother appeals. When you supervise one of her last visits with her child, they have a good visit and the mother says she is so happy to see her daughter doing well, and would be very happy if she could just continue to see her a few times a year. How can you use this information to help establish goals that all parties might agree to? What might make transition easier for all?

Summary of This Section

- Juvenile courts have complex and highly emotional cases.
- The court process is slow because deliberate action must be taken to ensure that the due process rights of all the parties have been protected.
- Juvenile court processes often involve many individuals, which also slows down the process.
- Time delays in juvenile court are compounded by a lack of funding, which impacts the cases. Low funding often accounts for lack of space and personnel to have multiple cases go forward at once, contributing to the time problem.
- Juvenile court can present a traumatic experience for many, including clients and social workers.
- Social workers can help alleviate the trauma for all by being reliably professional, assuring the safety and welfare of the children in state custody, being respectful of the parents and honestly assuring them of their children's welfare, and by being prepared and dependably honest in testimony.
- Social workers must endeavor to understand the reasons for lengthy processes of both trial and appeals courts, be able to help clients withstand the demoralizing effects of time delays, and where possible, to find ways to help cases settle outside of court.

TRENDS IN JUVENILE JUSTICE AND CHILD WELFARE

The juvenile court has developed in tandem with American society and mirrors the current concerns and public and media interests. Similarly, the cases that are brought in juvenile court reflect changing societal norms and concerns. Issues that plague society such as sexism and racism are magnified in the child welfare and juvenile justice systems. (Marsil and Montoya, 2002; Sherman, 2012). Increasing opioid use in American communities is

reflected in more addiction problems among court-involved youth and families American Society of Addiction Medicine, 2016. Juvenile courts are in a constant state of flux. State legislatures enact laws in accordance with public opinion, and, sometimes, as a result of a perception of public outrage. The juvenile court deals with cases that attract public attention, whether in the child welfare arena, dealing with children who require the protection of the state to ensure their safety and welfare, or in the juvenile justice area, dealing with children and youth who are accused of delinquencies, crimes, or other offenses.

The **notoriety** of some juvenile court cases raises the question of whether juvenile court sessions should be open to the general public. Most states do not allow public access to the juvenile court, or to juvenile court documents, in order to protect the privacy of the families and youth. The cases are "impounded," that is the names and facts may not be released to the general public. Currently, 16 states allow public access to juvenile court sessions; the remaining states continue to protect the identity of parties to some extent (Horne, 2005).

Cases involving child abuse and gross negligence of children are often the fodder of news media, sometimes to the dismay of the child agency in charge of the case, and sometimes to its delight, as the agency feeds information to the new media Goldberg, 2015. Scandalous crimes committed by young people have heightened public dismay of youthful lawlessness; in onerous crimes, the right to privacy is breached in favor of the public's right to know how a case is handled. Families, both biological and foster or pre-adoptive, may also welcome public scrutiny of the court proceeding. Opening juvenile courts to public scrutiny would bring to light aspects of juvenile court that are not in the public domain now: Time delays due to absent attorneys, absent judges, no interpreters, no clerks, and no courtroom; the stress upon parents to show up to wait for cases while they lose jobs; the frustration of social workers while they are unable to do their jobs because of court delays, as well as the lack of funding for substantive help for children and families who are court-involved. Horne argues that breaching the right to privacy for individuals may be a necessary price to pay to gain public understanding of juvenile court proceedings and challenges (Horne, 2005).

Identifying the role of racial discrimination is a growing concern as our juvenile detention centers fill with a disproportionate number of minority children. African American children involved in the child welfare system are placed outside of their homes at a rate six times their representation in the population (Child Welfare League of America, 2011; Children's Defense Fund, 2014). Overt and implicit racial prejudice among otherwise well-meaning practitioners in the child welfare/juvenile justice system have far-reaching consequences for all children. In 2012, black children were twice as likely to be in foster care compared to the overall child population of the United States; by 2019, children of color will be in the majority in the American foster care system (Children's Defense Fund, 2014). Racial prejudice exists and must be recognized and obliterated.

Restorative justice is a promising trend making headway within the juvenile justice system especially for dealing with delinquencies. It is an effort to keep people, especially youth, out of court, to hold them accountable and to educate them in the consequences of their actions. One of its other benefits is giving the victims an opportunity to have a controlled dialogue with the offender to bring an understanding of the harm committed, a sense of closure, and a sense of being heard (Maiese, 2013).

Additionally, scientific studies are having an impact on our understanding of youthful crime and poor judgment. As noted earlier, recent studies demonstrate the lagging

development of the part of the brain that controls impulse and judgment. Studies by neuroscientists demonstrate that the brain is not fully mature until a person reaches the mid-20s, and the last part of the brain to develop is the center that controls impulse. This presents a challenge and an opportunity for those who work with young people to deal with the dilemma in today's fast driven society. It also raises further questions about how to best deal with youthful delinquents and how to help adolescents survive into their 20s despite immature impulse control (Steinberg, 2009; Blitzman, 2015). One of the answers is a positive trend to establish policy and practice that is developmentally centered and date-driven (Sherman, 2012).

Finally, as we have seen in other sections of this book, trauma-informed therapy and services are becoming a catchword in juvenile welfare across the country and juvenile courts are no exception.

Summary of This Section

- Juvenile court cases reflect changing norms within our society.
- Most juvenile courts are closed to the public; one recent approach is to have them open to the public.
- Restorative justice is a way to deal with delinquencies and crimes that is geared toward keeping offenders out of court and toward helping to bring understanding to the offender of the harm done and closure and restitution to the victim.
- Developmental neuroscience has given insight into the development of the adolescent brain. The lagging development of the part of the brain that controls impulse and judgment sheds light on the poor judgment of many young people into their 20s.
    - There is a current positive trend toward data-driven and developmentally informed practice and research in juvenile justice and child welfare.
    - Many courts are adopting a trauma-informed approach, to help young people and families with trauma, including mental health problems and addictions.

SUMMARY

- Juvenile courts developed in response to the mistreatment and neglect of children when the industrial revolution brought more families to industrial cities. Champions of women's rights also advocated for children to be protected and to have rights under the law. Central to the juvenile court's purpose is safeguarding the rights of children and their parents. Different states adopt different laws in regard to juvenile court cases.
- Juvenile court cases include delinquencies, status offenses, and child welfare cases, including care and protection cases and termination of parental rights cases. Delinquencies involve the unlawful behavior of those under 17 or 18, depending upon the state, status offenses refer to behavior that would be lawful except that it is prohibited for the age group of the defendant. Care and protection cases arise when the state files a petition on behalf of a child stating that the parent is not performing his duty in caring for the child or keeping the child safe. Termination of parental rights

cases usually stem from unresolved care and protection cases. If a case is appealed, the underlying case in juvenile court must remain open until the appeals court has made its decision.

- The juvenile court is a place to resolve problems and resolve troubling family issues but it is also a source of trauma for those who are already traumatized. The judicial system must guaranty that the rights of children and parents are protected but the process is slow and cumbersome, and many a times it leads to delays. The efficiency of the juvenile courts could be improved if more money were available for personnel, facilities, and services. Social workers who understand the court system will be better equipped to help themselves and their clients in court. Social workers who remember to be professional and to maintain professional boundaries will help minimize trauma for themselves and their clients.
- Juvenile justice is in flux just as society is. One current trend is to have juvenile court cases open to the general public, so that a greater public awareness can develop. Currently, most juvenile court cases are not open to the public. While society is taking a punitive look at serious juvenile offenses, it has also taken strides in recognizing that locking up offenders does not serve its intended purpose. Restorative justice seeks to undo harm between an offender and victim without involving the court system. It shows promise in keeping youth crime down. Scientists have also found that the full development of the part of the brain that controls judgment and impulse lags far behind other neurological development, with maturation not complete until around the 25th year. Court personnel are trying to incorporate this understanding into their work and services for youth. The court is also endeavoring to establish trauma-informed practices into their approach to clients in juvenile court. Racial inequities continue to plague our society, the court system, and the child welfare system. They have far-reaching, long-term effects for everyone in American society and must be recognized and overcome.

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10

Teenage Pregnancy and Parenting

By Lynne Kellner

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Describe how teen pregnancy and parenting have been viewed historically, tracing the changes in attitude from colonial days until now.
- Identify the risk and protective factors associated with early sexual activity and pregnancy.
- Describe the impact of early parenthood on the mother, the father, and the child.
- Identify components of effective interventions in helping adolescents delay sexual activity and parenthood.

CHAPTER OUTLINE

HISTORICAL PERSPECTIVES 233
Defining Teen Pregnancy 234
How Teen Pregnancy Came to Be Viewed as a Problem 234
Fluctuations in Teen Birth Rates 237
RISK AND PROTECTIVE FACTORS 241
Individual Factors and Childhood Experiences 241
Family Factors 244
How Teens Make Decisions about Fertility and Childrearing 246
IMPACT ON MOTHER, FATHER, AND CHILD 248
Medical Concerns 248
Education and Developmental Issues 250
Economic Instability 250
Family Structure and Dynamics 252
INTERVENTION PROGRAMS 254
Primary Prevention: Focusing on Sexual Antecedents 255
Primary Prevention: Nonsexual Antecedents 257

HISTORICAL PERSPECTIVES

Raising a child to adulthood has become increasingly complicated and expensive in our technologically advanced world. Children tend to remain at home longer as they complete their educations before entering an ever-more-competitive work world. Economic instability following the Great Recession of 2008 has made it increasingly hard for young adults to become self-supporting. While some delay parenting, others may believe it is the only way to achieve adult status when other opportunities are unavailable. Consider Shannon's situation as described below. What might be motivating her decisions?

Primary Prevention: Sexual and Nonsexual Antecedents 258
Secondary Prevention: Services for Teen Parents 259
Shaping the Future of Services 262
SUMMARY 263

Case Example Shannon

Shannon, a 16-year-old high school junior, and her 1-year-old son live with her 22-year-old boyfriend and her mother. Her mother looks after the baby while Shannon attends school. Immediately on returning home, Shannon assumes full responsibility for the baby because her mother and boyfriend both work evenings. Shannon arranged with her guidance counselor to enter a half-day job-training program while condensing her academics into the other half; however, she has not attended the program in 9 of the past 10 days. "Why would Shannon pass up this opportunity to improve her income potential?" the counselor asks in frustration.

No wonder Shannon's guidance counselor thinks that acquiring job skills would give Shannon the "best chance" at self-sufficiency. Shannon, however, is struggling with adolescent developmental issues compounded by early parenthood. She is finding it hard to balance her need for peer contact, with its frivolous concerns that are independent of her child and her responsibilities to her child, her mother, and her boyfriend.

When adolescent pregnancy emerged as a national social problem in the 1960s, attention focused on the following: the psychological and financial inability of teen parents to care for their children; the negative impact on adolescent development, including decreased career and economic options for parenting teens; the economic consequences for the country of supporting children of unwed mothers; and the absence of fathers in children's lives. This chapter will place adolescent pregnancy in historical context, analyze these concerns and assumptions, identify risk and protective factors, and highlight key intervention strategies.

Defining Teen Pregnancy

Children having children is a phrase popularly used to describe adolescent pregnancy. Although catchy, it simplifies a very complicated phenomenon. Determining when adolescence ends is no simple feat in today's society. Using traditional responsibilities of adulthood as guideposts—such as establishing a career, buying a home, and marrying and raising a family—many psychologists now extend adolescence into the mid-20s. When teen parents are viewed as children, intervention strategies appear patronizing. If the intention is to empower teens to assume responsible parenting, the "children having children" perspective is counterproductive. Luker (1996, 4) suggests that this perspective denies the teen mother "the status of full personhood, exempting her from the obligations of being a moral actor held accountable for the choices she makes."

For the purposes of this chapter, age groupings established by the Department of Health and Human Services (Ventura et al., 2014) will be used to distinguish between three sets of teenagers: **young teens** (ages 10–14), **middle teens** (ages 15–17), and **older teens** (ages 18–19).

How Teen Pregnancy Came to Be Viewed as a Problem

Teen pregnancy is construed differently today than when our country was first settled. Many have preconceptions of the early Americans as moralistic and repressive. Think of Nathaniel Hawthorne's *The Scarlet Letter*, in which Hester Prynne, bearing the minister's love-child, is publicly humiliated and sentenced to wear a scarlet *A* (for *adultery*) on her bosom. Harari and Vinovskis (1993) clarify that the colonists reserved condemnation for

adultery and actually tolerated premarital sexual activity as long as any offspring were legitimatized through marriage. Luker (1996) estimates that one-tenth of brides in colonial Massachusetts and as many as one-third in the Chesapeake Bay colony married pregnant (17). Colonists feared that younger "unfit" parents would not be able to provide for their children, who would then become a social and economic burden to the community. Many brides were pregnant at the time they married. Abortions, herbally induced, were considered an acceptable treatment for "blocked menstruation" as long as there was no quickening, or movement of the baby (Mays, 2004).

Both societal and technological changes accompanying the **Industrial Revolution** impacted childbearing patterns. As Americans moved from farms to factories, young men delayed marriage and began to focus on saving enough money to provide for a family rather than relying on the fruits of the land (Furstenberg, 2007). Medical advances lead to more reliable birth control; advances in rubber processing resulted in a new kind of condom, replacing those made from linen or animal intestines, and the newly developed IUD provided a long-term birth control method (Tone, 2002). Wealthier women had access to birth control, but poorer women did not. Consequently, childbearing rates among the poor remained high, and some in the upper classes feared that our country would be swamped with those of "low grade stock" (Males, 2010, 40). President Theodore Roosevelt referred to the declining rates of childbirth among white women as "race suicide" (Males, 2010, 40). The public emphasis on pregnancy prevention as desirable for the lower socioeconomic class still continues.

Whereas previous generations resolved the problem of out-of-wedlock pregnancies with "shotgun weddings," by the late nineteenth century, homes for unwed mothers provided shelter, medical care, and a moral education (Hulsey, 2004). As the number of young pregnant women living in group homes increased, researchers began to study the effects of illegitimacy. In 1919, the newly established Children's Bureau concluded that the mortality rate among babies born to unmarried mothers was three times higher than those born to married couples; many were concerned that teen mothers were "too young" physically to bear healthy babies (Lundberg and Lenroot, 1919). As the twentieth century began, teenage and premarital pregnancy became the domain of the professional social worker.

After World War II, many young men returned from the war and young women left their military-supporting jobs to marry and start families. **Post–World War II baby boom** teen birthrates peaked at 96.3 per 1,000 women in 1957 (Ventura et al., 2014, 1). In the 1950s, half of all teens who married were pregnant, but this did not pose a problem in the national consciousness because most were married.

Until the 1960s, marriage and childbearing remained tightly linked; for many couples, engaged or pre-engaged, getting pregnant simply meant moving up the wedding date (Furstenburg, 2007). However, the National Fertility Survey of 1965 revealed that 34 percent of poor women reported unwanted pregnancies, compared to 15 percent of more financially stable women (Campbell, 1968), and politicians argued that those least able to provide for families were having the most children. The rising rates of federal assistance, coupled with higher birthrates among unmarried poor women, created a climate in which teen mothers were blamed for taxing the national economy.

But as the 1960s rolled along, a number of societal factors contributed to Americans questioning traditional values. Attitudes toward sexuality changed after publication of the groundbreaking Kinsey reports on both men's (1948) and women's (1953) sexual practices, which revealed that Americans had been engaging in premarital sex for some time; as many people revisited their assumptions about sexual attitudes and images of a moralistic national past, the stigma of illegitimacy lessened (Furstenburg, 2007).

When the birth control pill was introduced in 1960, contraception became less intrusive. Concurrently, leaders in the women's movement affirmed women as sexual beings,

thus making it easier for teen women to say yes to sex or, perhaps more realistically, making it harder to say no to their partners. In 1973, ***Roe v. Wade*** legalized abortion and made terminating unwanted pregnancies safe and legal. Feeling that they had more options, many women found marriage less attractive than those of previous generations and became less willing to enter unsatisfying marriages simply because they were pregnant. As manufacturing jobs declined, men delayed marriage so that they could complete more education (Furstenburg, 2007). The confluence of more relaxed sexual attitude and delayed marriage helped set the stage for increased rates of teen sexual activity and pregnancy.

Through the 1960s, pregnant students were forced to withdraw from high school, but in the environment of increasing tolerance of teen sexuality, this too changed. In 1971, a pregnant honor student, frustrated by the lack of challenge of home tutoring, sued her Massachusetts school district on the grounds that her right to attend regular classes had been violated (*Ordway v. Hargraves*). The school argued that the school environment was too dangerous for a pregnant teen. This perspective was typical of policies that ostracized pregnant teens for fear that they would negatively influence peers. The court ruled that the school had discriminated and acted illegally by expelling a student due to pregnancy. This case drew national attention to the rights of young pregnant women and shifted the focus from a moralistic one to a practical one on educational equality (Kiester, 1972). In 1972, **Title IX** mandated that public schools educate pregnant teens (California Department of Education, 2010).

Starting in the 1960s, teen mothers received economic support, education, job training, and developmental opportunities for their young children through ventures such as Head Start (see Chapter 6). Such services were intended to help stop the "cycle of poverty." During the 1960s and 1970s, most children growing up in female-headed homes were children of divorced parents, but a growing acceptance of out-of-wedlock childbearing became the major cause in the 1980s. The number of babies born out of wedlock has steadily risen since the 1990s, with younger mothers less likely to marry. In 2010, 88 percent of teen mothers were unmarried, compared to 63 percent of mothers aged 20–24 years of age and 34 percent of mothers aged 25–30 years of age (Ng and Kaye, 2012).

During the 1980s, many argued that young mothers, and others receiving federal benefits, do so in disregard of middle-class values; some suggested that "cutting off" supports would force welfare recipients to tow the line. While popular opinion supports this belief, many social policy analysts do not. The real value of welfare benefits, given inflation, declined significantly from the 1960s to the 1980s, thus decreasing the incentive young mothers would have had for collecting benefits, or as many believe, having another child to get more money. While the European countries offer much more generous welfare benefits, they have lower rates of teen pregnancy. To argue that subsisting on welfare benefits encourages teens into early parenthood does not acknowledge the impact of the larger social context in which they weigh their options concerning the relative benefits of early parenthood in relation to perceived educational and occupational opportunities. Feeling unable to achieve middle-class goals, a teen may turn to achieving adult status by becoming a parent; this may not represent a *good* choice, but it is often an *understandable* one, given the lack of better options (Raley, 2008).

This concern culminated in the **Personal Responsibility and Work Opportunity Reconciliation Act of 1996**, commonly known as Welfare Reform, which targeted prevention of teen pregnancy as one way of reducing entitlement benefits. Consequently, mothers younger than 18 were required to live with a parent or under other adult supervision and must remain in school in order to receive benefits. Teen fathers are included in our society's increasing focus on personal responsibility. Minor fathers are subject to the same support obligations as older men and were held accountable for payments (Giffords and Garber, 2014). Recognizing the difficulty, many teen fathers have providing financial support to their children, the Welfare Reform Act allowed for states to hold grandparents responsible for child support under the following conditions: The grandparents had custody,

the parent(s) were minors and could prove that they could not support the child, and one parent could not be found (Izzi, 2014).

The National Campaign to Prevent Teen Pregnancy (2013) conservatively estimates that teen childbearing cost taxpayers $9.4 billion in 2010, mostly for publicly funded health care for the children, child welfare service, and costs later associated with lost tax revenues of their adult children as a result of lower educational levels and earnings. However, if teen pregnancy rates had stayed at the 1991 rates, taxpayers would have paid an additional $12 billion.

Fluctuations in Teen Birth Rates

Generally teen birth rates have fallen in this country over the last 60 years with a number of fluctuations along the way. In 2013, teen birth rates for 15- to 19-year-olds were about one-third of the high in 1957 (26.6 births per thousand women compared to 96.3 respectively). The high in 1957 was partly a function of the post–World War II baby boom generation. Teen birth rates began to drop afterward by about one-third until 1969–1970, when they increased again by 4 percent. This was a time of increased sexual freedom for many. The following year in 1971 they resumed declining until 1979–1980. A 5-year decline followed, but then they began to rise again by 23 percent from 1986 to 1991. Once again teen pregnancy rates began to drop by approximately one-third from 1991 to 2005, with a 2-year interruption from 2006 to 2007 before beginning to fall again in 2008. Mothers aged 15–19 gave birth to 274,641 babies in 2013, a 43 percent decrease from the 644,708 births in 1970 around the time of the sexual revolution. The number of babies born to the youngest mothers, aged 10–14, also fell to the lowest in nearly 60 years to 3,108 births in 2013 (Ventura et al., 2014). (See Table 10.1.)

Table 10.1 **Fluctuations in Birth Rates for Women 15–19 from 1957 to 2013**

Year	Birth Rate Per 1,000 Women Ages 15–17	Change from Previous Chronological Year
1957	96.3	+1.8
1968	65.6	−2.8
1969	65.5	Not significant
1970	68.3	+4.3
1978	51.5	−2.5
1979	52.3	+1.6
1980	53.0	+1.3
2005	39.7	−2.0
2006	41.1	+3.5
2007	41.5	+1.0
2008	40.2	−3.1
2013	26.6	−9.5

Source: Based on Ventura, S. J., Hamilton, B. E., and Mathews, T. J. (2014). "National and State Patterns of Teen Births in the United States, 1940–2013," *National Vital Statistics Reports, 63*(4). Hyattsville, MD: National Center for Health Statistics. © Cynthia Crosson-Tower.

Table 10.2 **Birth Rates (per 1,000 Women) by Race and Hispanic Origin of Mother, Ages 15–19**

Year	All Races and Origins	Non-Hispanic White	Non-Hispanic Black	American Indian or Alaska Native	Asian or Pacific Islander	Hispanic
2012	29.4	20.5	43.9	34.9	9.7	46.3
2007	41.5	27.2	62.0	49.3	14.8	75.3
1991	61.8	43.4	118.2	84.1	27.3	104.6

Source: Based on Ventura, S. J., Hamilton, B. E., and Mathews, T. J. (2014). "National and State Patterns of Teen Births in the United States, 1940–2013," *National Vital Statistics Reports, 63*(4). Hyattsville, MD: National Center for Health Statistics. © Cynthia Crosson-Tower.

Teen birth rates among ethnic groups vary; the most recent detailed data we have on ethnic identification of teen mothers is from 2012 using classification categories established by the Census Bureau. Asian or Pacific Islander teens have consistently had the lowest rates of teen pregnancy among 15- to 19-year-old women, while non-Hispanic black teens had the highest rate in 1991, and Hispanic women had the highest rates in both 2007 and 2012. While all groups have shown declines from both the high rates of 1991 and the more recent bump in rates in 2007, non-Hispanic blacks and Asian and Pacific Islanders had the steepest declines from 1991 to 2012 (63% and 64%, respectively) while all other groups also had declines ranging from 53 to 59 percent. During the more recent downward trend from 2007 to 2012, Hispanic teens had the steepest decrease of 39 percent, while all other groups had decreases between 25 and 34 percent. Nine states report declines of more than 50 percent among Hispanic teenagers. Given these changing rates among various groups, differences between most racial and Hispanic ethnicity groups have narrowed for young mothers aged 15–19 (Ventura et al., 2014, 4 & 17). (See Table 10.2.)

Despite falling teen birth rates, the United States has had one of the highest teen birth rate for women of any developed country; in 2013, only Bulgaria and Romania were among the 37 developed countries tracked that had teen birth rates higher than those in the United States (Ventura et al., 2014, 7). Teen pregnancy rates vary widely by geographic region; the southern and southwestern states consistently have the highest rates and the Northeast has the lowest rates. Birth rates for women 15–19 range from a low of 13.8 per 1,000 in New Hampshire to a high of 47.5 in New Mexico. Many states have had significant declines; twelve have seen a decrease of 40 percent or more in teen pregnancy from 2007 to 2012. Colorado and Delaware have had the sharpest declines of 46 percent.

Older teens have historically had higher birth rates than younger teens, and rates among all age groups have fallen. Table 10.3 shows the rates of births among young women for the key time periods we have been discussing.

The percentage change from 2007 to 2012 is highest among middle teens 15–17 (−35%) followed by the youngest teens (−33%) and then the oldest ones (−28%). However, over the longer period during which teen pregnancy has generally been decreasing, the youngest teens have had the steepest decline of 71 percent, compared to 63 percent among 15- to 17-year-olds and 45 percent among the oldest teens (Ventura et al.,

Table 10.3 **Birth Rates per 1,000 Women: Ages 10–14, 15–17, and 18–19**

Year	10–14 Years Old	15–17 Years Old	18–19 Years Old
1991	1.4	38.6	94.0
2007	0.6	21.7	71.7
2012	0.4	14.1	51.4

Source: Based on Ventura, S. J., Hamilton, B. E., and Mathews, T. J. (2014). "National and State Patterns of Teen Births in the United States, 1940–2013," *National Vital Statistics Reports, 63*(4). Hyattsville, MD: National Center for Health Statistics. © Cynthia Crosson-Tower.

2014, 17). Since the youngest mothers often suffer the most health and social complications, these declines are encouraging.

Given different rates of pregnancy, it appears that cultural factors impact how teens and their parents view premarital sexuality and pregnancy. Early studies on ethnicity suggested that Hispanic teens were less likely to use birth control than whites or African Americans (Marsiglio et al., 2006), but more recent studies indicate that differences in contraceptive use among race and Hispanic ethnicity groups have diminished (Martinez et al., 2011). Latinos are a diverse group and come from over 20 countries and from urban and rural environments with varying resources. Yet, there are some cultural beliefs that they generally share that impact pregnancy rates, including religious beliefs. **Acculturation** plays a role in subtle ways. Lack of integration into the dominant culture somewhat protects against teenage motherhood; teens who have spent more than 10 years outside the United States, have low levels of acculturation, and speak Spanish at home are significantly less likely to have sexual relations than their more-acculturated peers (Aparicio et al., 2014). The issue of acculturation and its impact on teen pregnancy and how to serve this population warrants further research.



Diversity and Difference in Practice

Behavior: *Apply and communicate understanding of the importance of diversity and difference in shaping life experiences in practice at the micro, mezzo, and macro levels.*

Critical Thinking Question: How might you use the information on variation among ethnic/racial groups and teen birth rates to decide how to intervene? Would this information inform the venues that might be more effective for various groups?

Although it is difficult to get definitive numbers of the age of fathers because it is not reported on all birth certificates, it is clear that in many cases the father of a child born to a teen mother is an adult. Seventy percent of females 17 and younger who get pregnant do so by adult males over age 20. Many teens have children with even older men; decades of marriage and birth records indicate that a quarter of the fathers of children born to teen mothers are 25 years of age or older. About a quarter of teen fathers have children with adult women (Males, 2010, 32–33). According to self-reports in 2002, 13 percent of sexually experienced teenage males have impregnated a partner, and about 4 percent are fathers (Marsiglio et al., 2006, 12).

Moore (2008) suggests multiple factors that may contribute to the various cycles in teen births, including changing social and economic environments, fluctuations in the composition of the adolescent population, and factors related directly to teen childbearing. Since teen pregnancy data is based on comparisons to the number of teens accounted for through the U.S. Census, it does not reflect the actual number of adolescents in the country, some of whom are here illegally; this underestimation of teens may artificially deflate the

teen pregnancy rates. Additionally, the higher birth rates of 2006–2007 may reflect a modest increase in immigrants from countries that practice early childbearing and value motherhood, such as Mexico, and some European and African nations (Aparicio et al., 2014). Another factor that may have contributed to the bumps in the first decade at the turn of the century was the movement toward **abstinence-only sex education** that often resulted in a decrease in teens learning accurate information about contraception (Moore, 2008).

Since teen's perceptions of the pros and cons of early parenthood reflect their assessments of the availability of other opportunities, the post-1991 declines may partially be a function of increased **Title IX funding** that allowed more girls to participate in sports, possibly providing structure and means of fulfillment that made teen parenting less attractive. Although well-intentioned, one negative consequence of the 2002 **No Child Left Behind Law** may have been that marginalized students, often cut off from supportive services or non-academic opportunities such as art, music, and gym, may have felt more discouraged at the prospect of graduating and dropped out (Moore, 2008).

Several national studies have found that the declining trend in teen pregnancy rates between 1995 and 2002 is primarily a function of two factors: access to more and better contraception (86%) and a delay in teens initiating sexual activity (14%). There was no significant delay in adolescents having sexual activity in the period of 2003–2010, but teen pregnancy and abortion rates generally declined again (Boonstra, 2014, 8).

While access to highly effective contraception clearly has contributed to declines in teen birth rates, social and cultural factors have as well. The following societal influences have been cited as contributing to lower teen pregnancy rates: changing norms toward later childbearing in general, the effectiveness of comprehensive sex education programs in the schools, the role of the media in showing the hardships of teen parenthood, and the availability of information via the Internet on contraception. Although studies have found that adult women postpone childbearing during uncertain economic times, there is little evidence that this is a factor among adolescents (Boonstra, 2014).

Summary of This Section

- Adolescent pregnancy was first viewed as a social problem in the 1960s due to concerns that teen parents could not adequately care for their children, fathers were absent, and the resulting economic strain on the country for supporting children and unwed mothers.
- Teen mothers are distinguished by age grouping: young teens (ages 10–14), middle teens (ages 15–17), and older teens (ages 18–19).
- The colonists tolerated premarital sexual activity as long as any offspring were legitimatized through marriage.
- Post–World War II "baby boom" teen birthrates peaked at 96.3 per 1,000 women in 1957, but most couples married and this was viewed as acceptable.
- Marriage and childbearing remained tightly linked until the 1960s when Americans began to question traditional values.
- Teen mothers received economic support, education, job training, and developmental opportunities for their young children beginning in the 1960s as an effort to stop the cycle of poverty.
- Politicians argued that those least able to provide for families were having the most children, and teen and unmarried mothers were blamed for taxing the national economy.
- In the 1980s, popular opinion shifted to believing that cutting young mothers off from economic supports would force them to join the work force.

- Teen birth rates have generally fallen over the last 60 years.
- Asian or Pacific Islanders have consistently had the lowest rates of teen pregnancy; non-Hispanic black and Hispanic women have had the highest.
- Cultural factors impact how teens and their parents view premarital sexuality and pregnancy.
- Many fathers of the child born to a teen mother are adults.
- Abstinence-only sex education often resulted in a decrease in teens learning accurate information about contraception.
- Decreases in teen birth rates today are a function of increased access to contraception and delayed sexual activity.

RISK AND PROTECTIVE FACTORS

Popular opinion holds that teen females become pregnant because they and their teenage boyfriends cannot control their sexual impulses or do not know enough to use contraception. The movie *Precious* provides an example of how commonly it is assumed that a pregnant teen has made a bad decision with a fellow teen. Only after her second child is born, a social worker discovers that Precious' two children were the product of rape by her father. While some teens do make bad decisions, we must also acknowledge the complexity of factors that may lead to teen parenthood. Adolescents decide whether or not to engage in sexual relations based on their understanding of what is in their best interest. They weigh the pleasures of sexuality against the possibility of an unintended pregnancy. In this section, we will examine a number of **risk factors** that increase the likelihood an adolescent will become a parent, as well as **protective factors** that decrease this risk. These include the interaction among individual and family factors as well as peer, community, and cultural/societal influences (Youth.gov., n.d.).

Individual Factors and Childhood Experiences

Schools are social environments that convey a sense of available opportunities to students and an understanding of their options in the larger social structure. Differential funding among school districts impacts their ability to fund academic and other programs, offer competitive salaries to teachers, provide extra help to struggling students, and continue to acquire resources. Those with limited academic programs and high teacher turnover or "burn-out" are less likely to inspire students to believe that they have many options in their future (Raley, 2008). Teens who drop out of school are more likely to become parents subsequent to leaving school; about 40 percent become pregnant or impregnate someone after dropping out (National Campaign, 2012, 1–2).

Behavior problems are a risk factor for early parenthood. **Antisocial behavior** is a risk factor for teenage paternity; those who are persistently aggressive in school are at highest risk. Two-thirds of 335 boys whose peers described them as aggressive in at least two different grades fathered children as teens (on average, at age 17), and those aggressive males who enjoyed peer approval were more likely to father children than those who were rejected by peers (Miller-Johnson et al., 2004).

On the other hand, increased school engagement and achievement serves as a protective factor against early parenthood for adolescents. Teens who stay in school, have high grades and standardized test scores, participate in class, complete their homework, feel connected there, participate in school organizations, and plan to attend college have sex



Intervention

Behavior: *Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in interventions with clients and constituencies.*

Critical Thinking Question: How might you use this information on teens and school experiences to intervene with high-risk teens as a school social worker?

later and postpone childrearing (Kirby and LePore, 2007; National Campaign, 2010). Teens with higher cognitive skills and greater internal control have less frequent sex, use condoms more regularly, and are less likely to become parents (Kirby and LePore, 2007). Perhaps they may be better able to evaluate the consequences of having sex and less likely to succumb to peer pressure.

Adverse childhood experiences (ACE) place teens at risk of early pregnancy. A study of over 9,000 teen women found that cumulative exposure to adversity in childhood progressively increased the odds of teen pregnancy. Participants were given an **ACE** (adverse childhood experiences) score from 0 to 8 based on the number of negative experiences they had had; those included emotional, physical, and/or sexual abuse; exposure to domestic violence; living in a household with a substance abusing, mentally ill or criminally involved parent; and having separated/divorced parents. The researchers found that the risk of teen pregnancy progressively increased from 8 percent for teens with an ACE score of 0–53 percent for those with an ACE score of 8 (Hillis et al., 2004). Using the same ACE scale, Anda and colleagues (2002) found that the odds of a teen male impregnating someone increased with cumulative exposure to adverse events.

Youth who have been exposed to previous trauma, particularly sexual victimization, are at increased odds of initiating sexual activity earlier and risk of early parenthood (Males, 2010). In the United States, female teens are at significant risk of sexual victimization. Two studies of pregnant and parenting teens found that about 6 out of 10 had been sexually assaulted, and that an overwhelming number of the assailants (46% in one study) were at least 10 years older than the victim (Males, 2010, 33). Forty-four percent (15% under age 12 and 29% of 13- to 18-year-olds) of female rape or sexual assault victims report that at the time of victimization that they are 18 or younger (RAIN, n.d.). Seven percent of women who had their first sexual encounter in their teen years reported that it was involuntary. As the age difference between the young girl and her older male partner increases, so do the rates of coercion (Abma et al., 2010, 9).

Case Example Maritza

Maritza's stepfather sexually abused her for 2 years starting when she was 9 years old. When Martiza's mother learned of the abuse, she had her husband leave immediately and brought Maritza to a counselor. Maritza responded well to treatment. As an adolescent, she did well in school and had a circle of friends she could trust. When she was 15, the leader of a church youth group sexually assaulted her younger brother, Pedro. This new family crisis revived old issues of trust for Maritza. Much to her mother's horror, Maritza began to put herself in vulnerable situations. For instance, when Juan, a neighbor in his early 20s, dropped by, she entered the living room to talk to him wearing only her underwear. Uncomfortable with the situation, Juan immediately left the house.

Maritza began making provocative comments to older boys on the streets. When her mother confronted her, Maritza said that she knew the boys and they wouldn't "do anything." Maritza's placing herself in risky situations seemed inconsistent with her good judgment of the last few years. Her therapist wondered if Maritza was "testing the waters," placing herself in risky situations in the hope that she would not be further victimized and therefore would be reassured that the world was safe. Unfortunately, the neighborhood boys began to think of her as "loose," and one night at a party she was raped.

Teens, particularly males, who have experienced more severe forms of abuse—such as rape or incest—are at increased risk of teen conception. Fatherhood may be a way for a boy molested by an adult male to assert his masculinity. The relative lack of family support that some boys receive may also contribute to maladaptive behaviors. Depending on the nature and severity of abuse, between 13 and 26 percent of females who were sexually abused become pregnant as teens, and between 22 and 61 percent of males impregnate someone. This is in comparison to 8–10 percent of non-abused adolescents becoming involved in an unplanned pregnancy (Saewyc et al., 2004).

Once victimized, teens often lack the skills to protect themselves. Those who have been victimized engage in voluntary sexual activity at a younger age, have unprotected sex more often, have more and older partners, and are more vulnerable to re-victimization than non-abused teens (Logan et al., 2007). Dating or intimate partner violence, which can be part of the power imbalance that emerges in these unequal relationships, increases a teen woman's chances of pregnancy by four to six times over that of peers in non-abusive relationships (Office of Adolescent Health, 2012).

For the young teen trying to escape a troubled home, an older partner may provide increased resources, independence, and mobility (Males, 2010). Younger mothers have a disproportionate amount of older partners; a teen mother under 15 is just as likely to have been impregnated by a man 25 or older as she is by a peer. Adult males father most of the babies born to adolescents mothers, and 20 percent of the fathers are at least 5 years their senior. Older partners increase the chance of a young woman becoming pregnant; 69 percent of teen females with partners 6 or more years older become pregnant compared to 17 percent of those with partners only 2 years older (Solomon-Fears, 2008).

One might ask why such young women have babies with such older men. Some girls may find older partner appealing because they offer an escape from impoverished or abusive homes; the men may offer increased financial support and separate living space. Older men appear to be more mature and independent. Expecting more maturity from the young woman, adult male partners may expect the female to take responsibility for birth control. However, the youngest teens are the least likely group to use long-acting birth control. In addition to the increased risk of getting pregnant from an older male, compared to a peer, a substantial number of younger teens report that they were forced to have sexual relations (Males, 2004).

Due to concerns about teen–adult relationships, The American Bar Association (ABA) conducted focus groups with teen mothers whose children had been fathered by adults; in most cases, the relationship when the females were about 14 and the males were in their 20s. Older men offered the young women more maturity than peers, security, money, and sometimes a home environment better than the ones the women came from. However, most of the men were controlling and turned emotionally abusive and left soon after the women gave birth. Some provided stable, caring relationships, but this was the exception. The ABA recommends that protection under statutory rape laws be extended to all females aged 10–15 when the male is 20 or older, even if the sex was "consensual," and that states prosecute more aggressively and remove the "mistake-of-age" clause that many perpetrators currently use as a defense (Elstein and Davis, 1997). Nevertheless, statutory rape laws have changed little over the last couple of decades.

About 20 percent of children who experience child maltreatment go into foster care This may account for the fact that young women in foster care are more than twice as likely to get pregnant at 17 or 18 compared to peers who remain at home (33% vs. 14%). Unfortunately, 46 percent of these teens also have a **repeat pregnancy** before age 19. There are a number of contributing factors, including that youth in foster care tend to have sex at an earlier age and interruptions in both school placement

and residence may result in both general educational deficits and missing school-based sex education and prevention programs. Additionally, some may start their own families as a way to compensate for the lack of connection with one's own family of origin (Boonstra, 2011).

Teen sexual activity is correlated with increased substance use, particularly alcohol; however, a closer look at the role of drinking is warranted. Being under the influence of alcohol and/or pot increases the chances that a teen will make poor decisions, including engage in early sexual activity, have multiple partners, and refrain from using condoms. However, many teen girls who use substances also choose older partners who may be legally able to obtain alcohol or are in better financial positions to afford other drugs. The substance use may not be a determinant in the early sexual activity, but rather one manifestation of risky behaviors that is reinforced by an older partner. The context of the dating relationship is significant; when high school females date young men who are also in high school, even if they are 3 years older, they are not at increased risk of sexual experimentation. However, if the male partner has either dropped out or already graduated, the young woman is increasingly likely to engage in sexual activity (Koon-Magnin, 2014). Apparently, when both partners are involved in age-appropriate school activities, it lessens the chances of sexual relations.

Family Factors

Many correlations exist between teenage pregnancy and parents' socioeconomic status and family dynamics.

Socioeconomic Disadvantage

Teen mothers tend to have limited financial resources; however, a closer look at the mother's pre-pregnancy socioeconomic status reveals that many experienced systemic disadvantage prior to their pregnancies. Adolescents who grow up below 200 percent of the poverty line are twice as likely to get pregnant or impregnate someone (Sloup et al., 2009). Like adolescent mothers, teen fathers often are disadvantaged; disproportionately they come from homes of low socioeconomic status (Mollborn and Lovegrove, 2011). One might find it counterintuitive that the poorest teens would choose to have families so young, but when teens do not anticipate greater opportunities, they are more likely to have children early. The culture of the neighborhood itself is a risk factor; youth who grow up in poor, segregated neighborhoods, marred by graffiti, abandoned vehicles, trash and alcohol containers, and cigarette butts have higher rates of teen pregnancy (Centers for Disease Control, 2015b). The external sense of hopelessness tends to negatively impact their aspirations.

Low parental educational level is a risk factor for teen pregnancy (Centers for Disease Control, 2015b). Conversely, teens from families with higher parental education levels and SES are more likely than teens of lower socioeconomic status to delay sexual intercourse and use contraception (Kirby and LePore, 2007). More highly educated parents have higher expectations for their children and foster greater internal control. Typically, their children expect to graduate from high school and will view early parenthood as problematic to that goal (Sloup et al., 2009). Families that do not view an unintended pregnancy as interfering with educational or financial opportunities are less likely to socialize their children to avoid early parenthood (Fernández-Villaverde et al., 2010). Almost half (47%) of Latino-American teens believe that early parenthood does not prevent them, only delays them, from obtaining adult educational and employment goals achieving them (Sabatiuk and Flores, 2009).

Family Function

Many teens experience changing, perhaps unstable, family living situations. Supervision often becomes more relaxed during times of change, perhaps due to limited parental time or to children's "playing parents off against each other," particularly when there is discord. Adolescents' behaviors often embody implicit family messages, and parents in flux often convey confusing messages. Parents dealing with marital or other issues may turn to alcohol to help them numb their pain. Parental substance abuse is associated with teens having sex more frequently and with more partners. Those struggling with their own alcohol or drug problems may not provide appropriate supervision, or they may model substance abusing behaviors that make teens more likely to engage in sex (Kirby and LePore, 2007). Adolescents who experience significant family disruption, such as child protective services investigations and out-of-home placements are more likely to initiate sex before age 16, and have lower rates of condom use and higher rates of teen births (Perper and Manlove, 2009) and have a mother who gave birth as a teen, belong to a gang, and exhibit aggression and other problem behaviors (Guttmacher Institute, 2002).

Teens that live with two parents are significantly less likely to engage in sexual relations. In a national study, 19 percent of female teens 15–19 who lived in two-parent homes (either biological or adoptive) reported having sex within the past 3 months compared to 31 percent in living with a stepparent and 35 percent in single-parent homes. Adolescent males followed a similar pattern: 20 percent in two-parent homes, 25 percent in stepparent families, and 34 percent living with a single parent had sex within the last 3 months (Abma et al., 2010, 7). Not surprisingly, higher rates of sexual activity among teens from single-parent homes result in higher teen birthrates. Teens who live with two parents, either biological or adoptive, are less likely to become parents; 39 percent of all teen parents stem from two-parent homes while teens that live with only one parent comprise 57 percent of this population (Sloup et al., 2009, 2). Teens whose mother had them as teenagers are at risk of early parenthood, the role of modeling appears to play a factor in teens making decisions about sexual initiation (Guttmacher Institute, 2002).

The quality of the parent–child relationship plays a role in preventing teen pregnancy. When parents are warm, supportive, and maintain close relationships with their offspring, the teens are more likely to delay sex and to use contraception if they do choose to be active (Boonstra, 2011). Generally, consistent parental supervision correlates with lower rates of teen pregnancy; however, overly strict supervision or intrusive parenting appears to have the opposite effect (Kirby and LePore, 2007). For teens rebelling against tyrannical parents, pregnancy may be a way to establish independence, assert adult identity, or spite parents. Having a mother whose roles extend beyond caretaking seems to be a protective factor; female teens whose mothers work outside the home are less likely to get pregnant than teens whose mothers do not (Zavodny, 2001).

Case Example Alicia

Alicia, age 14, lives with her 30-year-old mother, Sharon; four younger siblings; and her mother's partner (father of the youngest two children). Alicia has been intermittently running away from home for the last year and is failing eighth grade despite her above-average intelligence. Sharon often expresses intolerance at Alicia's normal adolescent frustrations. She feels, "After all, I never had to worry about going out or clothes or schoolwork. I had Alicia to worry about."

Alicia is sexually active with her 18-year-old boyfriend, Brent. They plan to marry when Alicia graduates from high school. One night, after another screaming argument with her mother, Alicia is grounded "for the rest of her life." Alicia and Brent had planned to go out. Atypically, instead of leaving, Alicia sits at the kitchen table with the three condoms she had stored away, blows each up like a balloon, draws faces on them, and shows them to her mother.

As Alicia "bumps up" against her mother developmentally, they are more and more angry at each other. Her mother has little patience for the "normal" crisis of adolescence; her own development was foreshortened when she had to care for a baby. Alicia has not experienced her mother as protective or nurturing, and many of her behavioral problems serve to draw her mother into a more involved role. Although she seldom admits it, Alicia would like her mother to take a more authoritative role and "be a mother."

What kind of expectations do you think Alicia has for herself? How might her teachers and other adults in her life help her?

How Teens Make Decisions about Fertility and Childrearing

In making decisions about whether to engage in sexual activity and/or use contraceptives, teens integrate parental expectations, peer influences, personal ambitions, and believes about their futures. Family values and cultural factors play a role as well. There has been a slow and steady decline in the number of teens having sex; the percentage of females 15–19 who had sexual intercourse at least once dropped from 51 percent in 1988 to 43 percent during 2006–2010, with a similar decrease in males from 60 to 42 percent (Martinez et al., 2011, 10). Older teens (18–19) are more than twice as likely to be **sexually active**, defined as having had sex within the last 3 months, than younger ones (Martinez et al., 2011, 13). While the majority of teens had their first sexual encounter with a "steady" partner (70% of females and 56% of males), 16 percent of females and 28 percent of males first had sex with someone they had just met or with "just of a friend" (Martinez et al., 2011, 12). Roughly a quarter of teens (25% of females and 21% of males) reported having only one sexual partner within the last year; however, this increased as they became more sexually experienced. Among teen women who continue to be sexually active and choose male partners, 35 percent only had one partner, 16 percent had two, 32 percent had three to five, and 17 percent had six or more. Among sexually experienced teen men who choose female partners, 30 percent had one, 15 percent had two, 33 percent had three to five partners, and 22 percent had six or more (Martinez et al., 2011, 14). Teens that have intercourse earlier are more likely to have multiple partners, thus increasing the risk of pregnancy (Martinez et al., 2011).

Sexually active teens often feel ambivalent about their choices. In a retrospective study in which young adults 18–24 reflected on their early sexual experiences, many (48% of females and 33% of males) recalled having had mixed feelings about first becoming sexually active. Younger females who had relations reported the most dissatisfaction (Martinez et al., 2011, 14). Therefore, it is not surprising that in a national representative survey, 65 percent of sexually active females and 57 percent of males aged 12–19 said that they wished they had waited until they were older before having intercourse (Albert, 2012, 5).

In a 2012 study, youths aged 12–19 cited the influences that most affected their decisions about sex as parents (38%), friends (22%), the media (9%), religious leaders (6%), siblings (6%), and educators (4%). The vast majority of both teens (87%) and parents (79%) believe that more open conversations among them would help teens to postpone sexual activity, and teens wish that their parents would be able to be more open when discussing relationship issues, contraceptives, and sex. Both teens (66%) and parents (57%) believe that the media has played a role in reducing teen pregnancy in the last 2 decades; shows like *16 and Pregnant* and *Teen Mom* show the negative consequences of early parenthood.

As noted above, more than half of teens are deciding not to be sexually active. Adolescents report a number of factors that influence their decisions about whether or not to become sexually active (see Table 10.4).

Table 10.4 Reasons Teens 15–19 Choose for Never Had Sex

Reason	Females	Males
Against Religion or Morals	41%	31%
Fear of Pregnancy	17.6%	12.6%
Fear of STD	7.6%	6.3%
Haven't Met "Right Person"	18.7%	29.4%
In Relationship, But Not the "Right Time"	5.6%	10.8%
Other	9.5%	9.9%

Source: Based on Martinez G., Copen C. E., and Abma J. C. (2011). "Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, 2006–2010," Atlanta, GA: National Survey of Family Growth. National Center for Health Statistics. *Vital Health Statistics 23*(31). © Cynthia Crosson-Tower.

Many teenagers report that they did not consciously decide to have sexual relations; it "just happened." Planning for intercourse implies that one is a willing partner, which goes against societal messages that "good girls" do not seek out sex. Effective contraceptive use requires a comfort with one's body. Younger adolescents have not had time to adjust to raging hormones and changing body images, and they are less likely to use contraception. At first intercourse, 78 percent of females and 85 percent of males reported using contraceptives. Younger females' use of birth control dropped to 64 percent when the young girl's partner was 4 or more years older than her (Martinez et al., 2011,15–16).

As they continued to be sexually active, teens tend to use birth control more consistently. While condoms are the preferred method for first intercourse (68%), young women who remain sexually active rely on a number of options, including: condom (52%), birth control pill (31%), both condom and pill or other hormonal method (20%), and other hormonal methods such as injectable, emergency contraception, the patch, or the ring (11%) (Martinez et al., 2011, 17). Teens relying on periodic abstinence, or the calendar method, rose dramatically from 11 percent in 2002 to 15 percent between 2006 and 2010 (Martinez et al., 2011, 15).

Teen males who have a male relative who is forced to pay child support or who perceive the likelihood that they will have to pay child support if they impregnate their partners are more likely to use contraception and limit the number of female partners (Huang, 2005). Over two-thirds of teens report that they would find parenthood a "real challenge" and would be "very upset" and were unsure how they would handle it (Albert, 2010, 22).

Although all states allow adolescents to obtain contraceptive services without parental consent, some argue that parents have the right to know and that teens can benefit from their advice. However, on a practical level, parental notification laws would most likely result in more teen pregnancies. While 59 percent of sexually active teen women say that they would stop obtaining some or all of their reproductive health services, including contraception and testing for diseases, 99 percent of them also say that they would continue to have sex (American Civil Liberties Union, 2015). Older teens, and those with more resources, may feel more comfortable interacting with health care providers to obtain prescription contraceptives. Despite increased use of contraception, 82 percent of teen pregnancies are unplanned (Boonstra, 2014). In 2010, we saw a continuation of the downward trend of teens choosing abortions; 14.7 percent choose to terminate their pregnancies, the lowest rate since the procedure was legalized (Kost and Henshaw, 2014, 4).

Both adults (93%) and teens (87%) supported messages of abstinence and contraception; they did not consider these two messages to be in conflict or believe that discussing contraception encourages teens to have sex (Albert, 2012, 12). Parents worry about the impact of peers' attitudes on teens. Teens are more likely to have sex if their close friends are older, are sexually active, use alcohol or drugs, or view early childbearing and sexual intercourse positively. They are more likely to use condoms or contraceptives when their peers, especially their romantic partners, favor doing so or use them (Kirby and LePore, 2007).

Summary of This Section

- Risk and protective factors include individual and family factors, and peer larger community, and cultural/societal influences.
- Doing well and feeling connected in school is a protective factor against early pregnancy; conversely teens that struggle in school, attend substandard schools, and/or drop out are more likely to become teen parents.
- Cumulative exposure to adverse childhood experiences such as emotional, physical, and/or sexual abuse; exposure to domestic violence; living in a household with a substance abusing, mentally ill or criminally involved parent; and having separated/divorced parents increases a teen's risk of early sexual activity and parenthood.
- Youth, particularly males, who have been sexually victimized are at increased odds of initiating early sexual activity.
- Adult males father most of the babies born to teen mothers; younger mothers have a disproportionate amount of older partners.
- Family/Community risk factors include growing up at less than 200 percent of the poverty line; foster care placement; single-parent household; parental substance abuse, mental illness or criminal involvement; parents with low educational attainment; and/or living in debilitated neighborhoods.
    - Teens who believe they can achieve middle-class goals tend to deny parenthood.
    - Warm, supportive parent–child relationships provide a protective factor.
    - Most teens choose to use effective contraception.

IMPACT ON MOTHER, FATHER, AND CHILD

This section will explore the impact teen pregnancy has on the child as well as the parents.

Medical Concerns

Because teens have more complications in pregnancy than older women, many argue that they are not physiologically ready to bear children. Adequate prenatal care allows the provider to educate the mother on lifestyle choices and their consequences for the baby, monitor health-compromising conditions, and prepare the expectant mother emotionally. Many teens delay or avoid prenatal care because they deny their pregnancies, fear or do not know of resources, or are unable to pay for services. In 2011, 22 percent of the youngest teen mothers and 10 percent of those 15- to 19-years-old, only received prenatal care beginning in the third trimester, in contrast to 4 percent of mothers in their 30s (Child Trends, 2013).

When teens receive early, frequent, and quality prenatal care, their babies tend to do well, with the exception of very young mothers under 15 whose young age appears to be a risk factor in itself (Center for Prevention and Early Intervention Policy, 2005). Additionally, poverty, lack of education, and poor health care decisions contribute to the poor outcomes of teen pregnancies.

Many young mothers do not make healthy choices; almost a quarter of pregnant adolescents gain excessive weight that can cause complications (Martin et al., 2007, 13). Pregnant teens have higher rates of smoking than older women (12% compared to 9%) with an alarmingly high rate of 27% among non-Hispanic White pregnant teens. Smoking increases the risk of low birth weight, preterm delivery, infant mortality, and compromised postnatal development, (Kaye, 2012, 2). Almost 1 in 10 (9.6%) of babies born to mothers aged 15–17 are of **low birth weight** (defined as less than 2,500 grams or 5.5 pounds), compared to 7.9 percent of those born to mothers over 20 (Ventura et al., 2014, 5). Low birth weight places an infant at increased risk of illness, infection, and death shortly after birth, as well as later delayed motor and social development and/or learning disabilities (Child Trends, 2016). Psychological stress also can have a negative impact. Pregnant teens who experience high levels of self-reported psychological problems and endocrine stress reactions, as evidenced in increased levels of cortisol production, are more likely to have babies of younger gestational age and of lower birth weighs (Spicer et al., 2013).

Some experts question whether the adverse outcomes of teen pregnancies can be attributable to environmental factors stemming from lower socioeconomic status and the delay in prenatal care. In an attempt to control for these factors, de Vienne et al. (2009) found that teens under age 16 had significantly higher rates of anemia, risk of prematurity, LBW babies, and fetal death. They found that young women who have not reached biological maturity, which usually happens when the woman stops growing about 2 years after menarche, have poorer prenatal outcomes than and those who have. Biologically immature expectant mothers and their babies are competing for the maternal iron supplies. They also are less able to mobilize the fat reserves late in pregnancy that help enhance fetal development, and may suffer from an immaturity of uterine and cervical blood supply, making them more vulnerable to subclinical infections, both of which increases the chances of preterm labor.

Gilbert et al. (2004) compared 300,000 births to Californian first-time mothers aged 11–15, 16–19, and 20–29 to determine if teen mothers suffer more birth complications than older women of the same ethnicity. Compared to older women, teens in all four racial groups (Asian, white, Hispanic, and African American) collectively were one-and-a-half to three times more likely to have **adverse birth outcomes**, including infant and neonatal death, prematurity, and low birth weight. However, they did not have higher rates of preeclampsia or eclampsia, as in previous studies. Like older Asian women, teen Asian mothers had the best overall outcomes, except for increased prematurity and low birth weight. African American teens had the worst outcomes, but these outcomes did not significantly differ from those of older African American women; perhaps lower socioeconomic status (SES) and limited access to health care accounts for their poor pregnancy outcomes. White teenagers had the best outcomes of all adolescents. However, compared to older white women, they were also at higher risk for negative outcomes. All teens except Asians were at increased risk of complications during delivery, mostly caused by urinary tract infections. Although younger teens had more complications, their babies were least likely to be delivered by **Cesarean section**, which may account for the higher rates of infant and neonatal death.

Although attention has focused on teenage mothers, babies born to teenage fathers have a 15 percent increased risk of premature birth, a 13 percent increased risk of low birth

weight, a 17 percent increased risk of being small for gestational age, and a 22 percent increased risk of death within the first month. Although it is not clear why the children of teen fathers are at higher risk, risky social behaviors, such as smoking and alcohol and drug use, are known to negatively impact the quality of sperm (Reinberg, 2008; Mollborn and Lovegrove, 2011).

Education and Developmental Issues

Do children of teen parents suffer developmentally? Educators site the fact that children of teen mothers are 50 percent more likely to repeat a grade as evidence that teen pregnancy is a risk factor to their children's academic achievement (National Conference of State Legislators, 2015a). The children score lower on measures of **school readiness** in math and reading, have lower standardized test scores as they continue in school, and are less likely to complete high school. Difficult family situations, poverty, and single parenthood may be compounding factors that also negatively impact the educational attainment of children of teen mothers (National Campaign, 2012). Teenage fatherhood has been found to have a negative impact on child development as well. Children born to teen fathers are more likely to have poor health than those of older fathers. By age 2, they are more likely than peers of older fathers to have cognitive delays and behavioral issues (Mollborn and Lovegrove, 2011).

The relationship between teen pregnancy and education is recursive; pre-existing academic hardships contribute to the likelihood that a teen will become a parent, and early parenthood increases the chances of not completing one's education. Thirty percent of adolescent girls who drop out of high school cite pregnancy or parenthood as the reason, with higher rates among Hispanics (40%). While 89 percent of young women who delay having their first child until at least age 20 obtain a high school diploma or GED, only 51 percent of mothers who give birth as adolescents do. Younger teen mothers are less likely to complete their educations; only 38 percent of mothers who gave birth by age 17 earned a high school diploma and only 19 percent obtained a GED (National Campaign, 2012, 1–2). Teen mothers are also less likely to complete higher education: Less than 2 percent of women who have babies as teens complete a 4-year college degree by age 30 (National Conference of State Legislators, 2015a).

Teen parenting has been associated with gender-specific social impacts on the offspring. Pogarsky et al. (2006) study of male children (73% African American, 15% white, and 17% Hispanic) found higher rates of externalizing behaviors, drug use, gang membership, and unemployment in early adulthood among sons of teen mothers compared to sons of older mothers. Perhaps these behaviors contribute to the fact that sons of teenage mothers are more likely to be incarcerated before age 40 than sons born to women aged 20 or 21 (2.2 times more likely for sons born to mothers 17 and younger, and 40% more likely for sons born to mothers aged 18 or 19). Daughters of teenage mothers are at an increased risk of having children early in life, even after academic factors and family background are taken into account. The daughters of mothers who gave birth at age 20 or 21 are 33 percent less likely to become pregnant as teenagers than the daughters of mothers who gave birth at age 18 or 19, and 60 percent less likely to become pregnant as teenagers than the daughters of mothers who gave birth at age 17 or younger (Hoffman, 2006, 16–18).

Economic Instability

Given the emphasis on education in the workforce, it is not surprising that a young mother's earning potential is impacted; in fact, women who had babies by age 17 earned about $84,000 less during the first 15 years of motherhood than those who waited until age 20 or 21 (Hoffman, 2006, 19–21). Although women who have children as teens have

life-courses similar to peers who wait until their 20s to start their families, they often suffer financially because they have difficultly completing their educations and typically do not find jobs that help them enter the middle-class (Furstenberg, 2007). Even older teens may have trouble balancing their multiple roles; young mothers attending community college are 65 percent less likely to graduate than peers who postpone childrearing until after graduation (National Conference of State Legislators, 2015a).

Teenage mothers rely on public assistance more than older mothers do, and this increases within the first few years of the child's life. Sixty-three percent of teen mothers with a child under 1 receive some kind of public assistance, mostly through Medicaid (55%), food stamps (one-third), and Temporary Assistance to Needy Families (TANF) (10%). However, the chances that a teen mother will receive public assistance increases over the first 3 years of the child's life; 40 percent go on to receive food stamps and 25 percent benefit from TANF (National Campaign, 2012).

While we cannot assume that the entire gap in income between teen mothers and those who wait to start their families is due to early pregnancy, teen motherhood statistically does have a negative impact on employment and one's future financial stability. Some young women from disadvantaged background may perceive, rightly or wrongly, that they have few options and not pursue opportunities that may be available. Nevertheless, controlling for external factors, it is clear that teen parenthood significantly impacts a young women's economic status. Forty-eight percent of all teen mothers aged 15–19 fall under the poverty line, but it is also significant that the rate of young mothers living in poverty increases as the child gets older. The chart below shows that the poverty rate increases 9 percent from the time the child is 1 till age 3. There are also differences among ethnic and racial groups that most likely reflect larger societal inequalities. One reason the poverty rate probably increases is because as teen mothers get older, they are more likely to live on their own and not have the benefit of their family's economic support. Only 34 percent of teen mothers living with their parents were under the poverty threshold (National Campaign, 2012). When the teen father does not live with the mother, it increases the chance the child will live in poverty threefold (Ng and Kaye, 2012, 5). (See Table 10.5.)

Early parenthood is also challenging for young fathers struggling for economic independence and identity formation. Paschal and colleagues (2010) interviewed 30 African American fathers, ages 14–19, about how they defined and performed their roles as fathers. Three major themes of engagement emerged: provider (53%), nurturer (27%), and autonomous behavior (20%). The providers defined a "good father" as one who provides financially or materially; most helped provide tangible goods, such as diapers and sporadic financial assistance, often with the assistance of their parents. Those romantically involved

Table 10.5 **Percentage of Teen Mothers, Ages 15–19, Living in Poverty by Child's Age**

Child's Age	Non-Hispanic White	Non-Hispanic Black	Hispanic	All Teen Mothers
Under 1 year	35%	39%	51%	41%
3-years-old	41%	48%	69%	50%
Any age	39%	48%	60%	48%

Source: Ng, A. S., and Kaye, K. (2012). *Why It Matters: Teen Childbearing, Education, and Economic Wellbeing*. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.

with the young mothers were most likely to assume this role. The nurturers believed that "helping out" or "being there" made them good fathers, and often did so with the help of their families. Older teen fathers were more likely to view themselves as nurturers and the younger fathers were more likely to view themselves autonomously, expressing their opposition to the idea of their fatherhood by deliberately detaching themselves from the role both conceptually and practically.

Family Structure and Dynamics

Very few teen mothers marry the baby's father before the birth: 88 percent remain single. This represents a sixfold increase in non-marital childrearing since the 1960s. Of those who do marry, 38 percent separate before the child reaches age 5. Teen mothers report less satisfaction in their relationships with their romantic partners than older women; they are more likely to argue over their relationship, family responsibilities, and money (Ng and Kaye, 2012, 1–2). When the parents are not married, issues of financial support often emerge. Child support from the baby's father can be one means to offset the economic difficulties of young mothers, but few actually receive such support despite increasing efforts to hold fathers responsible. More than 58 percent of teen mothers have no financial arrangement with the baby's father, and consequently receive no money from them. Although 29 percent of teen mothers do have a legally binding arrangement with the father, only 15 percent actually receive any money. Teen mothers who have informal arrangements have a higher likelihood of receiving some support for the child; of the 18 percent of young mothers with informal agreements with their current or previous partner, 14 percent actually received some assistance. Perhaps the fathers are viewing themselves as responsible when they agree to informal arrangements that the courts did not intervene in. Even when young mothers receive financial assistance from the child's father, it tends to be minimal, averaging less than $2,000 a year (National Campaign, 2012, 3). Given the difficulties teen fathers encounter in their own education and careers, it is not surprising that many may have difficulty contributing more financially. Young mothers involve fathers more in parenting if the father contributes financially (Wiemann et al., 2006).

Approximately 6.8 million children in the United States live with at least one grandparent or other relative (Child Welfare Information Gateway, 2013). Many of these households are **three-generational households** comprised of teen parent(s), the child, and the grandparent. Single mothers are the most likely to live with their parent(s) (45%), but married (9%) and cohabitating (17%) couples may also live with the older generation for a while after the baby is born. However, these arrangements are usually short-lived and often fraught with many transitions and tensions as the young families attempt to establish its independence (Pilkauskas, 2012). Grandparents can provide a safety net. Children born to teen mothers who live with grandparents are 80 percent less likely to live in poverty than those of teen mothers who live by themselves (University of Southern California, 2009). Teen parents who continue to live with their parents are more likely to complete high school than those who co-habituate; financial pressures to support a household negatively affect both teen fathers' and mothers' ability to complete secondary education (Mollborn, 2010).

Case Example Bruce

Bruce, age 17, is the father of 18-month-old Korinna and newborn Rickie. Last year Bruce dropped out of school to apprentice at his uncle's automotive repair shop. Having never had much patience, Bruce did not take directions well. Three months later his uncle asked him to leave.

When Bruce's girlfriend, Hannah, became pregnant the first time, her parents unsuccessfully tried to convince her to end the relationship. Hannah planned to place the baby for adoption. But once Korinna was born and her parents held their first grandchild, she and her family decided to raise the child. Bruce visited Hannah and the baby every day, but relations with Hannah's parents were strained. Bruce resented that Hannah's mother thought she knew more about the baby than he did. He boasted of the work that he could get, the income he could make to support Hannah and the baby, but he remained unemployed except for occasional work through Day-Temps. Hannah dreamed of sharing an apartment with Bruce and the baby.

On two occasions, to prove to Hannah's family that they were "worthy" parents, Bruce and Hannah took off with the baby for a few days. Hannah's parents were worried sick. The young couple had little money and did not say where they were going. Bruce and Hannah continued to want to spend time with their friends, who sometimes enjoyed the baby and sometimes felt constrained by her presence.

When Korinna was 9 months old, Hannah became pregnant again. She and Bruce decided to marry. Hannah's parents hoped that the engagement meant that the young couple was maturing. Bruce looked harder for work this time, but there were few jobs for those with his low level of skills and low tolerance of frustration. When Rickie was born, Bruce was proud to have fathered a son. He spoke of his intentions to "be there" for his son and provide for his family, but day by day he became less confident that he could do so. As it became harder to maintain that he could support his children, he began to have one-night stands.

The impact of a teen's emotional immaturity as a parent is harder to assess. Some teens welcome the challenge of parenthood; others feel overwhelmed and are impatient with their children. One consequence of parental frustration and lack of parenting skills is increased child abuse and neglect (see Chapter 7). Compared to mothers who give birth at age 20 or 21, mothers who give birth at age 18 or 19 are one-third more likely to have their children placed in foster care before they reach age 5, and mothers who give birth at age 17 or younger are more than twice as likely. Although children born to mothers 17 or younger suffer more chronic medical conditions, they are less likely to receive medical care and twice as likely to be reported for suspected child abuse or neglect than peers born to mothers aged 20 or 21 (Hoffman, 2006, 13–14). Mothers who wait until their 20s may have better parenting skills, in part of a result of exposure to educational opportunities (Furstenberg, 2007).

About 30–50 percent of children of teen mothers also have teen fathers (Mollborn and Lovegrove, 2011). Children whose young fathers remain involved in their lives benefit socially, emotionally, and academically (Lundahl et al., 2008). About half of teen fathers remain involved with their children, and half of those visit at least weekly. Father involvement is a protective factor for young children. The positive impact is greatest when the father lives with the child as opposed to just visiting the mother and child. Teen boys whose fathers reside with them initiate sex later themselves, making it less likely that they will impregnate someone and continue a cycle of early parenthood. Conversely, longitudinal studies have found that children of teen fathers who are unavailable are twice as likely to drop out of school, abuse drugs and alcohol, and end up in jail (Ng and Kaye, 2012, 5).

Whether adolescent fathers remain involved in their children's lives tends to be tied into their relationship with the child's mother. Those who were emotionally involved during the pregnancy and maintained a romantic relationship after the birth, were employed, and had male peers who were fathers tended to remain more involved (Fagan et al., 2003; Robbers, 2009; Paschal et al., 2011). Young fathers who had antagonistic relationships with the maternal grandmother tend to be less involved with their children (Bunting and McAuley, 2004).

Given previous socioeconomic disadvantages, teen fathers typically have about 2 years less education, averaging 11.4 years, than adult fathers; without completing high school, their ability to find adequate employment is compromised. One study found that their income averaged under $20,000 when their children were 9-months-old, and that it remained significantly lower than those of adult fathers when their children were 2 years of age. Despite their low incomes, teen fathers were surprisingly willing to help support their children in informal, irregular ways, such as buying diapers or presents for holidays (Mollborn and Lovegrove, 2011).

Although the added responsibilities of fatherhood can be enormous, many teen fathers also experience some positives experiences. Teen fathers who remained involved with their children reported a sense of attachment to their children greater than that of older fathers. There is no significant difference in the amount of time that teen fathers play and care for their children compared to slightly older adult fathers; however, this may indicate a low level of father involvement on the whole. However, teen fathers who lived with their children reported more negative attitudes toward parenting than older fathers, while those who did not live with the children actually perceived themselves as better fathers (Mollborn and Lovegrove, 2011). This paradox may stem from the amount of time resident versus nonresident fathers spent with their children. If a father only sees a child for a limited time, rather than throughout the week, he may only have some of the "good" experiences such as playing together rather than a larger continuum of caretaking experiences.

Summary of This Section

- Poverty, lack of education, and poor health care decisions contribute to the poor outcomes of teen pregnancies.
- Older teens who receive quality prenatal care tend to have healthy babies, but being under 15 appears to be a risk factor for compromised development.
- Babies born to teenage fathers have increased risk of perinatal and infant negative outcomes.
- Children of teen parents have poorer academic achievement and are less likely to complete high school than those of older parents.
- Teen parents have lower educational and economic stability than older parents.
- Nearly half of teen mothers live under the poverty line.
- Most teen mothers do not marry, and most receive little or no child support.
- Single mothers are likely to live with their families after the birth.
    - Child of teen mothers are at risk of involvement with the child welfare system.
    - Father involvement benefits the child socially, emotionally, and academically.

INTERVENTION PROGRAMS

Until recently, there was a great divide between those who advocated for "Abstinence-Only" programs and those who thought comprehensive programs providing accurate information on sex and contraception and decision making skills was the most effective means of preventing teen pregnancy. Abstinence-only education was integral to the Welfare Reform Act of 1996 and continued until 2009; each year $50 million of federal funds was allocated for educational programs promoting abstinence-only. However, the Obama

Administration's focus on **evidence-based practice** now requires teen pregnancy prevention programs to prove their effectiveness in changing behaviors based on scientifically sound research. Most Americans believe that teen pregnancy prevention efforts can promote abstinence and provide information for teens to make more informed choices on contraception (Solomon-Fears, 2015).

Primary Prevention: Focusing on Sexual Antecedents

Primary prevention programs, aimed at preventing sexual activity and pregnancy, vary in format, philosophy, and success rates (Kirby, 2007). Some of these programs focus on sexual antecedents, such as decisions about abstinence, sexual activity, and contraception. Twenty states and the District of Columbia mandate sex and HIV education in their public schools (National Conference of State Legislators, 2015b).

Abstinence Education, Revised

Early proponents of abstinence education often stressed that teens should learn to "just say no" and that teaching them about contraception gave them mixed messages. However, current abstinence education programs often take the stance that teaching abstinence and contraceptive information are complimentary, not competing strategies. Abstinence education has been found to be the most effective in helping the youngest teens delay or reduce their amount of sexual activity; they are less effective with older teens. Effective programs do not advocate waiting until marriage to have sex or portray sex in a negative light, and they provide only medically accurate information. Programs present abstinence as the best choice to avoid unwanted pregnancy and disease but some also provide accurate information on contraception in case participants choose to have sex (National Campaign, 2011).

While abstinence-only programs contributed to teens' intentions to remain abstinent, these intentions do not always translate into behavior (Kirby, 2007). One popular abstinence program, the **Silver Ring Thing**, offers a "concert-style show incorporating music, laser lights, fast-paced video, drama and comedy performances" geared to convincing middle- and high-school students that abstinence until marriage is "God's plan" (see www.silverringthing.com). Upon pledging, teens receive a silver ring, inscribed with a phrase from the Bible, that they are not to remove until their wedding nights. Teens who have had intercourse are offered a chance for "secondary virginity" if they vow to have no further intercourse until marriage. A study comparing pledgers to peers found that 82 percent of pledgers denied ever having taken the pledge 5 years later and that pledgers did not differ from non-pledging peers in rates of premarital sex, sexually transmitted disease, and initiated sex and had the same number of lifetime sexual partners. The pledgers, however, were less likely to report using birth control or condoms in the past year or any form of birth control the last time they had sex (Rosenbaum, 2009). Adolescents from conservative, religious backgrounds who are committed to their ideals are more likely to keep their pledges and delay sexual initiation; however, those who attend religious services without internalizing the teachings do not keep their pledges (Landor and Simons, 2014).

Teen Pregnancy Prevention Initiative

Under the Obama Administration, the CDC and the Office of Adolescent Health have funded both public and private entities to implement innovative **Community Initiatives** designed to reduce teen pregnancy, particularly among African American and Latino/Hispanic teen women 15–19 who have higher rates than other ethnicities. Programs must provide medically accurate information, include age-appropriate interventions, and be

evidence-based or innovative. Programs must also demonstrate a community-wide model that is tailored to the specific members of the community, include broad-based strategies to reach a majority of area youth, and provide intensive strategies for high-risk youth. The goals of the program are: (1) to decrease teen birth rates by 10 percent in targeted communities; (2) decrease teen pregnancy nationally by 10 percent; (3) increase the percentage of youth who abstain or delay sexual relations; and (4) increase the percentage of youth who use condoms and other birth control consistently (Solomon-Fears, 2015).

The Teen Health Project is an example of a broad-based intervention model that includes communication strategies and media campaigns tailored to its target audience (Centers for Disease Control, 2015a). The Project includes small group workshops on communicating with a potential partner, how to refuse sex, and condom negotiation. Teens participate in follow-up sessions, media projects, social events, talent and musical shows, festivals, and may join the Teen Health Project Leadership Council. Parents attend workshops on HIV/AIDS education. Follow-up found that program participants delayed sexual initiation and those who were already sexually active increased their condom use (Sikkema and Kelly, n.d.).

Educational Programs for Teens and Their Families

Sex education programs vary considerably in length and curriculum. Programs provide information and emphasize the building of skills and clarification of values (Kirby 2007). "Safer Choices" is a 2-year multi-component program for ninth and tenth graders that combines classroom curriculum and school-wide activities and attempts to change the school's normative culture by creating a School Health Promotion Council and a Safer Choices Peer Team. It promotes the message that unprotected sex, or intercourse before one feels ready is an *unsafe choice*, using protection against pregnancy and STDs is a *safer choice*, and abstinence is the *safest choice*. Activities for parents help them learn how to talk to their teens about the Safer Choices message. In a comparison of twenty participant sites, Safer Choices participants had fewer instances of unprotected sex, and reported increased knowledge of sexual information, greater self-efficacy to refuse sex and communicate with a partner, and more positive beliefs about condom use than control sites. The program had a positive impact on parent-child communication, but did not demonstrate that participants delayed sexual initiation, reduced the frequency of sex, or the number of sexual partners (Child Trends, 2016).

"Get Real" is a promising new comprehensive school-based sex education program developed by the Planned Parenthood League of Massachusetts. Students in grades six, seven, and eight receive nine lessons in addition to eight activities to complete at home with their parents each year. All ninth graders participate in another 8-11 lessons. Students from the 24 middle schools that implemented "Get Real" were significantly less likely to have sexual activity by the end of eighth grade compared to peers from other area schools (Goesling et al., 2015).

Programs Providing Contraceptive Access

Two types of programs provide access to contraceptive services: reproductive health clinics and **school-based or school-linked clinics**. Many worry that providing contraceptive services to teens increases their sexual activity, but studies have not confirmed this. When clinics, whether publicly funded such as Planned Parenthood or school-based, provide one-on-one counseling on abstinence and contraception, give clear messages about the inherent risks of sex, and provide contraceptives, teens consistently increase their use of protection. When California increased funding for low-cost family planning clinics, the number of teens acquiring contraceptives greatly increased (Kirby, 2007).

School-based clinics that also provide prenatal care may help pregnant teens remain in school (Barnet, 2004).

The Media

The media provides many instances of sexual content; about two-thirds of television shows, particularly those on the major networks, depict or strongly suggest scenes of sexual intercourse. Only about half of these are among couples with established relationships, and 10 percent are among couples that had just met. Nine percent of the programs depicting sexual scenes involve adolescents; while only 20 percent of these programs make reference to the risks of pregnancy or STD's or discuss the merits of waiting to have sex, this is higher than the norm of 10 percent for all sexually depicted scenes on TV (Teen health and the Media, n.d.).

On the other hand, the media has occasionally addressed teen sexuality in an informed, serious manner. The National Campaign to Prevent Teen and Unplanned Pregnancy (2010) funded a study to analyze the impact of the popular reality show, **16 and Pregnant**, which premiered in 2009. Each hour-long episode chronicles a teen's journey through her pregnancy and early parenthood, including the challenges of tumultuous relationships, lack of supports and financial resources, school and work stress, and the impact of gossip. Six out of ten teens have watched at least one episode; and 82 percent of those stated that the show helps teens better understand the challenges of early parenthood while only 15 percent felt it glamorized teen pregnancy. More than a third talked to a parent after watching the show (3).

Three-fourths of teen respondents stated that when a teen TV character becomes pregnant, they think more about the negative consequences of teen pregnancy (Albert, 2010, 6). When celebrities, such as Bristol Palin or Jamie Lynn-Spears, have children in their teens, parents have an opportunity to ask their children how they feel about the celebrity's decision and discuss the possible outcomes for mother and child.

Each May since 2002, the National Campaign to Prevent Teen and Unplanned Pregnancy has sponsored a National Day to Prevent Teen Pregnancy. Teens are invited to take a short online quiz, available in English or Spanish, that asks the how they would respond to a number of risky sexual situations (http://www.stayteen.org/quiz/). The extensive website of the National Campaign provides teens with a wealth of information and a chance to communicate on-line with other teens. Although a vast amount of Internet information is questionable at best, some solid websites provide information on these issues. Columbia University hosts a website called "Go Ask Alice!" (http://www.goaskalice.columbia.edu) where teens can access information on alcohol and drugs, various health issues, sexuality and sexual health, and relationships.

Primary Prevention: Nonsexual Antecedents

Programs focusing on nonsexual antecedents target risk factors, such as school failure and societal disadvantages, and help young people develop skills and confidence, and broaden their horizons.

Early Childhood Programs

Preschool programs such as **Head Start** (see Chapter 6) provide structured learning experiences to help young children overcome the disadvantages of poverty that are linked to teen pregnancy. Some programs intervene at younger ages. The Abecedarian Project, sponsored by the University of North Carolina, provides low-income families with full-time, high-quality care for their children from infancy to age 5. When compared to a

control group at ages 12, 15, and 21, the Abecedarian Project graduates had higher reading and math scores in the primary grades, had their first children later, completed more education, and were more likely to attend 4-year colleges. Young mothers who participated in the program achieved higher educational and employment status than those in the control group ("University of North Carolina," n.d.).

Youth Development Programs

Youth Development Programs involving national, state, and local organizations; schools; social service agencies; community-based groups; businesses; religious organizations; and tribes provide supportive, nurturing environments that make it less likely that teens will choose behaviors leading to teen pregnancy. Some programs are gender-specific. Girls, Inc. developed a series of age-related groups that progressively teach more skills and information. The first group for girls aged 9–11 and their parents helps them to foster communication around sexual issues. Groups for 12- to 14-year-olds provide decision making and assertiveness skills training and reproductive health information. These skills are reinforced in groups for 15- to 18-year-olds as well as helping them to define healthy relationships, recognize, and move beyond sex-role stereotypes, and to start to set some life goals (Girls Inc., 2015).

The Wise Guys program provides reproductive information and health care to male teens either in schools or through local health centers, sports leagues, or faith groups (see www.wiseguysnc.org). An evaluation of the program highlighted the importance of establishing a male-friendly environment and focusing on issues important to males (Troccoli and Whitehead, 2006). Because intervention efforts have traditionally focused on girls, it is important to create gender-neutral pamphlets on contraception; reflect male interests in waiting rooms and meeting rooms (e.g., with sports magazines and videos and posters of prominent men such as Barach Obama); and reach out to young men on their own turf, such as at sporting events or in the locker room. Programs that address other health needs, such as school or job physicals, can create a comfort zone in which teen men can discuss sexuality. Male staff and "male-only" hours can increase a program's friendliness, provide a forum for increasing academic and job skills, and provide a place to discuss relationship and sexuality issues. Effective intervention programs for males deliver messages about teen pregnancy that are authentic and present real-life stories. They are credible, not preachy, funny, age- and gender-specific, original, and positive.

The recent focus on service learning, in which community volunteer work is combined with a reflective component, has been found to have a positive impact on teen pregnancy. Several studies have found that service-learning programs that require extensive commitments keep teens busy after school and consequently reduce the teen conception rate, particularly during the academic year (Solomon-Fears, 2015).

Primary Prevention: Sexual and Nonsexual Antecedents

Comprehensive programs are based on two premises: (1) adolescents with hopes for the future delay parenthood and (2) intervening in more than one realm of the teen's life is more effective than intervening in only one.

In 1984, Dr. Michael Carrera started the Adolescent Pregnancy Prevention Program, sponsored by the Children's Aid Society, for girls ages 13–15 in Harlem, which was later extended to males. Currently, the program recruits youth between 10 and 12 years of age and works with them until the graduate high school. The program entails a job club, career guidance, academic assessment, tutoring, college admissions assistance, performing arts workshops, a family life and sex education curriculum, and sports instruction. Reproductive

health services and mental health counseling are available. Teens meet daily after school and on Saturdays. In the summer, they work while maintaining contact with the program (U.S. Department of Health and Human Services, n.d.). A 3-year evaluation across 12 sites in 7 states indicated that female participants had significantly lower rates of pregnancies and births; both genders scored higher on knowledge-based tests on health habits and sexual and contraceptive knowledge, as well as on the PSAT than a control group, and were more likely to have life and technical skills, hold bank accounts, and have skills necessary for employment (Child Trends, 2009). Kirby (2007) found that girls in the program delayed first sex, used contraceptives more, and had fewer pregnancies compared to peers who did not participate but that the program had no impact when implemented with boys.

Secondary Prevention: Services for Teen Parents

From 1991 to 2009, repeat teen births decreased by 23 percent (from 25% to 19% nationally) (Ventura et al., 2014, 5). Nevertheless, in 2010, nearly one in five births to mothers 15–19 was a repeat pregnancy: 86 percent of these were second births; 13 percent were third births, and 2 percent were fourth-sixth births. When teens have babies very close together, it does not give the mother time to heal and replenish her body; the babies are often born too small and have health complications (Centers for Disease Control, 2013). Teen mothers with multiple children tend to have the poorest socioeconomic outcomes of young parents. **Secondary prevention** targets successive unwanted pregnancies and provides supportive services to parenting teens and their children. School-based programs, vocational-skills training, life-skills training, health care, childcare, counseling, case management, and GED classes address the many needs of adolescent parents.

Parenting Programs

Programs for teen mothers and their children, sometimes called **teen-tot programs**, have three goals: (1) preventing repeat pregnancies while teen mothers complete their educations, (2) improving the health of mother and child, and (3) improving parenting skills. Studies on the effectiveness of parenting programs indicate mixed results; a review of four programs did not find increased care-giving skills compared to control groups, but participants were less likely to have repeat pregnancies (Akinbami et al., 2001).

The Boston Medical Center runs a comprehensive program for pregnant and parenting teens that provides a multitude of services; housing multiple services under one roof allows teens to meet most of their needs in one place. Mother, child, and father can all see the same physician in the Adolescent Center at the Medical Center. Services include family planning, prenatal visits and classes, parenting and nutrition classes, HIV/STD counseling and testing, and support groups. A nurse can make healthy baby/child home visits until the child is 3 years of age. Participants can also access mental health services. Intensive case management services are also available for parents and children who need additional referrals, such as early intervention services (Boston Medical Center, 2014).

Case Example A Teen's View Trinh

Darany and I were going out almost a year. I thought we were in love. So when he asked to make love, I said okay, except for trying to hide it from my parents. Then I got pregnant. He pulled out, so I didn't think it could happen, especially so soon. I told Darany, and he tried to avoid me. Always had something to do, somewhere to go. I told him we had to talk; finally we did. And he wanted me to have an abortion. But I couldn't. No. It's wrong. I couldn't do that to my family. I didn't plan to have Mony, but I really love him.

But it sure has changed things. I go to group [expressive arts group], and I have to leave early so I can get home for Mony. My mom helps watch him, but she has to go to bed early to get up for work. My dad works two jobs, so he has no time. Then I have to watch Mony and my three younger brothers and sisters. I used to hate school, used to say I hated school anyway. . . . But I sure miss it now. Funny thing is, now that I'm not really in school [she attends GED classes], I want to be there. I want to do good and get a job. Now that I'm around a baby all day, I want to be a pediatric nurse. But it's hard to find time to study. I'm tired at the end of the day. I'm glad I have the playgroup at the Y[MCA] to see other moms. Sometimes it's hard for them, too. But I do love Mony. I just wish Darany would come over more. Last Saturday I did my hair and had a new dress and waited and waited for him. I was so angry; he didn't call. He finally came, but it was too late to go out. . . . I have to be up at six with the baby.

When Trinh learned she was pregnant, she went to the school health counselor, who informed her that she would need to live with her mother or another adult relative in order to receive welfare benefits. Trinh had hoped to live with 19-year-old Darany, but he would not marry her. When Trinh gave birth, her mother was with her. They named the baby Mony, meaning "precious stone" in Cambodian. Darany came to the hospital the next day but did not visit for another month. Trinh's mother taught her how to care for an infant. The counselor helped her find a Saturday GED class while her mother cared for the baby. During the week, Trinh was so tired that it was hard for her to study. One day, desperately wanting to be around peers, she dropped by the Teen Center and was invited to join an expressive arts program. Delighted with the idea, she joined despite feeling self-conscious about being the only parent, and the only Cambodian, in the program.

Trinh's mother provides childcare and emotional support. Trinh longs for a commitment from Darany but knows that's a dream. Every few weeks he visits but doesn't show much interest in the baby. Although mandated to pay child support, Darany works "off the books" and gets around it. Fortunately, Trinh receives assistance through Women, Infants, and Children. As the baby sleeps through the night, Trinh is able to study for her GED. She plans to attend a nursing school at the community college.

Residential Programs

Second Chance Homes allow pregnant and parenting teen women, unable to live with their families due to maltreatment or other extenuating circumstances, to learn parenting skills, earn educational credentials, and develop skills to earn a livable wage. These programs vary considerably from short-term ones servicing young mothers only for a brief period after delivery to longer-term, more comprehensive programs providing parenting and job-finding skills services. Programs may be housed within group houses, a cluster of apartments, or a network of houses; some programs move young mothers from more structured, restrictive, rule-governed group homes to their own apartments as they progress. Regardless of format, all programs hope to counter the negative impacts of poverty, unhealthy relationships and unsafe living situations, educational barriers, and lack of support for the young parents within the context of a supportive, adult-supervised living arrangement.

Georgia, which had the third highest rate of repeat teen pregnancies in the country, developed a Second Chance Home network to provide housing and support to teen mothers. Two-thirds of the young women had been in the custody of child protective services at the time of intake. Data has been collected on key variables at time of intake, discharge, and 3, 12, and 24 months post discharge. The results are promising. Two years after discharge, 50 percent of participants had completed high school or a GED, compared to the national average of 38 percent of teen mothers. There was a steady increase toward more self-sufficiency, including securing an apartments and steady employment (raising from

5% at intake to 50% 2 years post discharge). Follow-up studies indicate that the participants benefited from the extensive parenting classes, particularly in terms of significant improvements in developing age-appropriate expectations for their children, showing empathy, and maintaining appropriate parent-child roles. This may account for the steady decrease in the number of children involved in protective services. Although there was a decrease in the number of mothers having custody of their children from intake to discharge, many cited that needing to focus on their education or employment had been a factor in releasing their children to others to care for temporarily. Over time, the percentage of mothers having custody rose from 56 percent at discharge to almost two-thirds 2 years later. Perhaps one of the most encouraging factors is that repeat pregnancies dropped to 4 percent, compared to the state rate of 25 percent.

Keeping Fathers Involved

The Obama Administration wants to send a message to fathers that they are important to their children, and has shifted emphasis away from promoting marriage, as established by the Clinton Administration and continued through the Bush Administration (Marsh, 2010). While the President's **Fatherhood Initiatives** do encourage marriage, they also acknowledged that families are created through many different circumstances and urge all parents to stay involved with their children. The Fatherhood Initiative attempts to meet the needs of fathers in various situations through three entities: a new Fatherhood, Marriage and Families Innovation Fund designed to expand on local fatherhood and family-strengthening programs; transitional jobs programs through the Department of Labor to help non-custodial parents develop job skills and find work; and newly-created "fathering reentry courts" through the Justice Department to assist fathers as they leave the criminal justice system in finding employment, allowing them to make child-support payments and reconnect with their families (Feldman, 2010). The President's website National Responsible Fatherhood Clearinghouse, www.fatherhood.gov, has much information for teen parents along with links to other resources and videos by teens.

The Fatherhood Initiative program supports a number of programs across multiple sites to help low-income fathers obtain skills to support their children financially and emotionally. Young fathers are more likely to engage in services when they are invited to participate as part of a program that serves the young mother, but in separate groups with male leaders to allow them to feel safe and willing to open up about their doubts, fears, and other feelings that they might not want to express in a co-ed group. Engaging both the father and mother in complementary group activities simultaneously helps the young father to maintain a good relationship with the child's mother. Allowing young fathers to identify their own needs and activities helps empower them; some may engage more with curriculum teaching parenting skills, while other may want to have a fathers nights out or engage in sports. Programs should be culturally relevant rather than "mainstream," and recognize important elements of the ethnic, religious, and socioeconomic composition of the group (Rosenberg and Wilcox, 2006).

One project for teen and disenfranchised fathers is the Men in Relationships Group (MIRG), an open-ended group led by mental health counselors that helps them learn how to interact with their children and gain job seeking skills. The fathers bring their children along to participate in play activities while they attend their groups. There is a Job Club for those who are unemployed or underemployed, which teaches job-seeking skills. Fathers who have progressed through the program may pair up with the professional staff to begin another MIRG group or complete a 5-day trainings in the MIRG model, leading to a certificate and the ability to lead MIRG groups (Administration of Children and Families, n. d.).

Initiatives under Responsible Fatherhood grants have shown promising results. In eight states, participants have increased their employment rates 8–33 percent and their incomes 25–250 percent. Consequently they have increased their child support compliance. Also, 27 percent of the fathers reported seeing their children more after the program (U.S. Department of Health and Human Services, 2005, 2). To build on these successes, the Office of Family Assistance (2010) has developed guidelines to help agencies and community organizations continue to develop and refine programs for fathers of all ages and backgrounds. Programs are expected to target the following goals: help to promote and sustain healthy co-parenting relationships; increase parenting skills and knowledge, economic stability, and involvement with child; and help to facilitate personal growth for the young man and connection to one's community. The guide offers examples of evaluation methodologies, outcome measures, and measurement tools (Hudgins et al., 2014).

Shaping the Future of Services

Substantial research over the last few decades has helped to identify key components of effective teen pregnancy prevention programs. In their review of over 400 studies, Kirby and LePore (2007) found that the risk factors most amenable to change include poor parent–child communication and peer-related factors such as peers' failure to use condoms and contraceptives and peers' permissive values about sex and early childbearing. It is essential that programs are cultural sensitive and target the needs and life experiences of the teens. Certain groups of adolescents may have significant needs that do not respond to the standard programs. For instance, the Fostering Connections and Increasing Adoption Act of 2008 helps foster care youth with transition planning as they age out of the system at age 18. Given the high pregnancy rates of this population, the Act stipulates that in addition to helping youth access housing, health insurance, education, mentors and employment, caseworkers should provide directly information on sexual health and services (Boonstra, 2011).

The National Campaign to Prevent Teen Pregnancy (2011) has identified the following elements as key in providing effective programs:

- Present abstaining from sex and/or using contraception as the right thing to do; don't just discuss pros and cons;
- Provide instruction over a sufficient period of time, not just a few weeks;
- Adequately train group leaders and ensure that they believe in the program;
- Actively engage youth and personalize their experiences;
- Address peer pressure;
- Teach communication skills; and
- Reflect the age, sexual experiences, and culture of participants in program.

Strategies to reduce teen pregnancy are varied; many focus on providing opportunities for teens and changing their attitudes about the future before they have children. Such interventions are broad-based and include educational, social, and vocational opportunities to help at-risk teens develop goals and hopes for their futures. Teens who believe that they have good things to hope for before they have children tend to delay beginning their families.

Summary of This Section

- Most people now view abstinence education and providing information on contraception as complimentary, not competing, strategies.
- The Obama Administration mandates that programs be evidence-based.
- Primary prevention programs aim to prevent sexual activity and pregnancy.

Interventions include sexual antecedents through abstinence education, community initiatives, educational programs, and clinics providing contraception; nonsexual antecedents such as early child and youth development programs; and comprehensive programs that target both sexual and nonsexual antecedents.

- Secondary prevention provides supportive services to parenting teens and their children and attempts to reduce repeat pregnancies. Programs include parenting education, residential programs and efforts through the Fatherhood Initiative to keep young fathers involved.
- Effective prevention programs emphasis abstinence; have sufficient instructional time; have trained, committed group leaders; actively engage youth and personalize their experiences; teach communication skills; and address peer pressure.

SUMMARY

- Teen pregnancy was generally tolerated in this country as long as the parents married before the child was born; rates of teen mothers reached a high during the post-war "Baby Boom." In the 1960s, adolescent pregnancy came under scrutiny; there were concerns that young parents could not take adequate care of their children, and that governmental assistance to unwed mothers was an economic strain for the country. Many services were provided to teen mothers and their children to help raise them out of poverty, but these were moderated in the succeeding decades because many believed that that teen pregnancy could be reduced if economic supports were withdrawn. Teen pregnancy rates vary by racial and ethnic identity of the mother; decreases in teen birth rates today are a function of increased access to contraception and delayed sexual activity.
- Risk and protective factors include individual and family factors, peer influences, and community influences. Doing well in school and feeling connected helps prevent teen pregnancy, while teens that struggle academically or attend substandard schools are at risk. Cumulative exposure to adverse childhood experiences such as child maltreatment, domestic violence, living with a substance abusing, mentally ill or criminally involved parent, and separated/divorced parents increases a teen's risk of early sexual activity and parenthood. Various kinds of impoverishment increase the risks: including poverty, living in foster care, low parental educational level, and unsafe neighborhoods. When teens believe they can achieve middle-class goals, they tend to delay parenthood.
- Poverty, lack of education, and poor health care decisions contribute to the poor outcomes of teen pregnancies. Teens younger than 15 have poorer health outcomes due to biological immaturity. Young fathers also have offspring with increased health problems. The children have poor academic outcomes, are at risk of dropping out, and becoming involved in the child welfare system. Teen parents have lower educational and economic stability than older parents; nearly half of teen mothers live under the poverty line and few benefit from child support. Father involvement benefits children socially, emotionally, and academically.

- Abstinence education and providing information on contraception are now viewed complimentary, not competing, strategies; programs applying for federal funding must prove that they are evidence-based. Primary prevention programs aim to prevent sexual activity and pregnancy by addressing sexual antecedents, nonsexual antecedents, and a combination of the two in comprehensive programs. Secondary prevention programs attempt to reduce repeat pregnancies and provide teen parents with skills to nurture and provide for their children. Effective programs emphasis abstinence; have sufficient instructional time; have trained, committed group leaders; actively engage youth and personalize their experiences; teach communication skills; and address peer pressure.



11

Children in Family Foster Care

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Describe the emergence, development, and today's function and purpose of foster care, including reasons why children enter it.
- Explain the role of foster parents, how they are recruited and trained, and the stresses and responsibilities of the role. Discuss the reactions, responsibilities, and stresses for the birth parents when their children are placed in and returned from foster care.
- Discuss the various feelings of children toward their placement and life in foster care, including their reactions to both birth and foster parents.
- Describe the role of the foster care social worker.
- Discuss the trends for the future of foster care.

Case Example Riki

Riki was 6 years old when her father abandoned the family. Even at that age, Riki knew that her father sold drugs and that he had to leave before the police found him. Her mother, an addict, was usually too strung out to care for her. Riki's younger sibling had died 3 years earlier. Child protective services (CPS) had not removed Riki only because the family had fled. Riki and her mother drifted from place to place until they found themselves in the home of a man her mother knew. Riki begged to go to school, and finally they agreed to send her. But the

CHAPTER OUTLINE

FAMILY FOSTER CARE: HISTORY AND TODAY'S FOSTER CARE SYSTEM 266

Historical Beginnings 266

Foster Care in Recent Years 267

The Nature of Foster Care Today 268

Types of Foster Homes 271

Reasons Children Enter Foster Care 272

PARENTS: FOSTER AND BIOLOGICAL 275

Foster Parents 275

Birth Parents with Children in Foster Care 281

CHILDREN IN FOSTER CARE 284

Feelings About Placement and Separation 284

Feelings About Birth Parents 285

Feelings About Foster Parents 286

Life in Foster Care 286

Leaving Foster Care 286

THE ROLE OF THE FOSTER CARE SOCIAL WORKER 289

THE FUTURE OF FOSTER CARE 292

Political Influences 292

Future Directions and Concerns 293

SUMMARY 295

school recognized that the child was ill-kempt and poorly fed. They became concerned that she was overtired and that she had lice. The school's report to CPS initiated an investigation and resulted in Riki's removal from her home. At age 6.5, Riki found herself in a new home—a foster home—with three new siblings and a mother and father who appeared to care about her. Although she missed her mother, it was kind of nice to be warm in her own bed instead of wondering where they would sleep or where the next meal would come from.

Child welfare advocates attest to the fact that the best environment for a child, especially a young one, who cannot be maintained in his or her own home is another family setting. Although some children cannot tolerate a family atmosphere once their own has failed them, many do well in family foster care.

FAMILY FOSTER CARE: HISTORY AND TODAY'S FOSTER CARE SYSTEM

To better understand foster care today, we need to look at the origins of the foster care system.

Historical Beginnings

In ancient times, it was expected that children would be part of a family. Children without a family became a problem to society. If relatives could not take them in, another solution had to be found. Indenture was a popular method of providing for children, but it was not always a solution, especially with very young children who were not old enough to work. Institutions such as almshouses were often the solution for poor children, much to the detriment of their health and safety.

In the early 1800s, **Charles Loring Brace** became concerned about the children abandoned in institutions and on the streets of New York. In 1853, he and a group of New York City clergymen founded the New York Children's Aid Society, designed to advocate for and solve the problem of dependent children. Brace initiated a program of transporting children from the city to farm families in the Midwest. His plan involved sending small groups of children—40 to 100 per trip—by train, accompanied by "agents" (nurses and social workers), to preselected spots in the rural Midwest. These children would be met at the train station by families interested in caring for them. Later, churches became involved and would preselect families before the trains arrived. This practice, called **placing out**, lasted well into the 1920s (Cook, 1995; Hacsi, 1995; O'Connor, 2004; Warren, 2004).

In his biography, Brace, O'Connor (2004) suggests that romanticized tales of the "orphan trains" must be set straight. At least 25 percent of the children whom the Children's Aid Society placed out (as opposed to placing in orphanages) had two living parents financially or emotionally unable to care for them. Further, not all of the children who were placed out rode the trains. Some were placed out in nearby states such as New York, Connecticut, and New Jersey. Parents were recruited by suggesting that these "orphaned children" would supplement the farm or household workforce, and there was little screening of applicants except that they were known to the local preacher. Finally, Brace and the Children's Aid Society rarely had any further contact with the children nor did they do any supervision of these placements. O'Connor also suggests that the incredible numbers of children said to have been on the orphan trains (the term "*orphan train*" seemingly was

used to romanticize what was known as the Emigration Movement) resulted from the fact that the Children's Aid Society bureaucracy never kept statistics on how and where children were placed. Despite the need to clarify some widely held beliefs about placing out, Brace's efforts marked a historical milestone for dependent children.

Other agencies besides Brace's adopted the practice of placing out. One woman, abandoned at the New York Foundling's Hospital in the early 1920s, recounts her experience on an orphan train:

> By the time I rode the train out to Nebraska, in 1923, you knew where you were going to. I was twenty-two months old and wore a sign with my birth name on it and the name of the family who expected me. Years earlier, my parents told me later, children used to be dropped off at stations and lined up for people to pick up which one they wanted.
>
> My Mother and Father told me that a priest had announced in church some months before that an orphan train was coming. If anyone wanted a child, they were to tell the priest. My folks had lost six of their own children and had a boy of nineteen. To them, a girl sounded ideal. We arrived all dressed in white. I later learned that the clothes were made of bed sheets. A nurse handed me to my new parents and that was that.

For some children, the experience was positive. Some were adopted; others remained in an early form of foster care. From 1853 to 1929, 31,081 children reportedly were placed in families through orphan trains (Thurston, 1930, 121). How many of these actually rode the trains to the Midwest is unclear (O'Connor, 2004).

Support for the concept of foster care strengthened in the 1890s when **Homer Folks**, also of New York City, extolled the virtues and importance of family life for children. **Charles Britwell** of the Children's Aid Society of Boston instituted supervised boarding homes (as opposed to orphan asylums). These homes were developed with the idea of rescuing "good" children from "bad" parents. Initially, any parents willing to foster children could do so. Not until the 1930s were foster parents assessed for their ability to care for children (Carp, 1998; Holody, 1998).

Early foster homes did not expect payment for the children they housed. Agencies advocating foster care argued that payment for foster care might cause foster homes to take children for money rather than out of goodwill. However, in the early 1900s the practice of paying foster parents evolved. The government did not become involved in regulating and administering the foster care system until the twentieth century (Hacsi, 1995).

Over the years, foster care became an increasingly acceptable method of caring for children whose parents were unable to do so. Voluntary placement by parents who recognized their inabilities or who sought a place for their children while they underwent treatment or looked for employment or housing became more widely practiced. Infants awaiting adoption were often placed in foster homes pending their placement.

Foster Care in Recent Years

After World War II, the complexion of foster care changed considerably. With the advent of more resources within the community, families who had placed their children while they recovered from illness, received treatments, or solved financial problems were less dependent on foster care. Increasingly, newborns were placed in adoptive homes directly from the hospital. With the advent of the **Aid to Families with Dependent Children (AFDC)** program, impoverished families who previously might have needed to place children in asylums or homes were able to maintain them at home. By the 1950s, most of the

children not residing in their own homes were in foster care rather than institutions. These figures increased until the late 1960s, when three times as many children in care were in foster homes than in earlier years. Subsequent amendments to the Social Security Act made more federal monies available to support foster care (Hacsi, 1995; Holody, 1998).

By the 1970s, the trend in child welfare became **permanency planning**. The move toward permanency planning was the result of several studies that found that children placed in foster care remained there, in virtual limbo, for years.

With the emphasis on permanency planning, the mandate of child welfare agencies was to find the best possible solution for children whether with their birth families or in foster care. Nonetheless, children often bounced back and forth between their birth parents and foster care while social workers attempted to work with the families aware of the research that brought attention to the effect that separation had on children. In addition, the Indian Child Welfare Act of 1978 and the Adoption Assistance and Child Welfare Act of 1980 emphasized the preservation of the child's biological family; *Family preservation* became the new phrase in child welfare. Now efforts were made to save the family unit with a variety of services and resources so that the children would not be subjected to the pain of separation. It soon became obvious that, with the advent of such problems as drug addiction, homelessness, and HIV/AIDS, it was not always possible to save the original family unit. By the 1990s, the numbers of children placed in foster care began to increase again.

The 1997 Adoption and Safe Families Act (ASFA) is credited with changing the philosophy of child welfare services from the focus of family reunification in almost all cases to emphasis on child safety and achievement of permanency planning within an expedited timeframe. ASFA set time limits on the time a child could remain in foster care, mandating that if reunification with parents could not be achieved, adoption should be the goal. A child who had been in foster care for 15 of the most recent 22 months could be released for adoption. These new mandates were a reaction to the complaint by child advocates that the best interests of children were not being served by lengthy placements in foster care (Lewis, 2011).

Today, the emphasis is on **family continuity**, or attempting to strengthen or preserve the family unit while recognizing that foster care may be a necessary alternative. Increasingly, there has also been an effort to assess the availability of kinship care, the placing of children with relatives of their birth parents. This practice may also serve to acknowledge and preserve important cultural connections for the children.

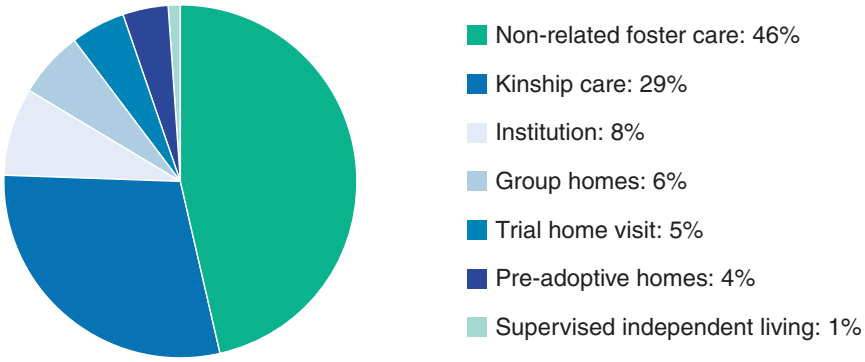
There is also increased recognition that children who entered the child welfare system and especially foster care have experienced some form of trauma in their young lives. Often they have been exposed repeatedly to several forms of violence resulting in **complex trauma**. The impact on children who have experienced six or more forms of abuse or violence is referred to as **polyvictimization**. Social workers and foster parents strive to understand the impact that trauma has had on children and how to insure that their experiences in foster care will not further traumatize them.

However, we must see foster care as only one option in the effort to protect the best interests of the children in our society.

The Nature of Foster Care Today

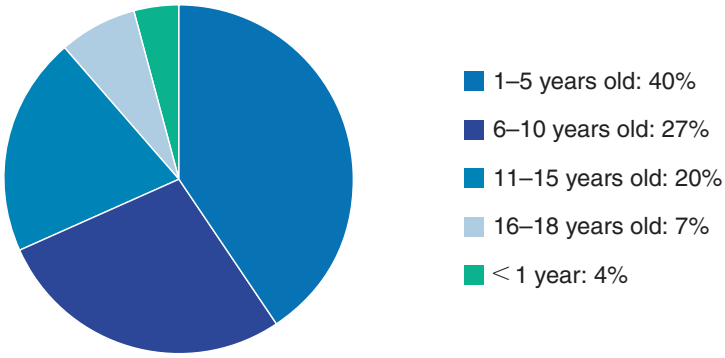
By September 30 of 2014, approximately 415,129 U.S. children were in foster care. About 264,746 have entered family foster homes during that calendar year. Of those in some type of substitute care during 2014, 46 percent were in non-related foster care, 29 percent in foster care with a relative (kinship care), 4 percent were in pre-adoptive homes, 5 percent were on a trial home visit, 6 percent were in group homes 8 percent were in

Figure 11.1 • Children in Substitute Care 2014: Types of Care



Source: Based on Adoption and Foster Care Analysis and Reporting System. (2014). "AFCARS Report No.22." © Cynthia Crosson-Tower.

Figure 11.2 • Children Placed in Foster Care in 2014: Ages Care



Source: Based on Adoption and Foster Care Analysis and Reporting System. (2014). "AFCARS Report No.22." © Cynthia Crosson-Tower.

institutions, and 1 percent were in supervised independent living (see Figure 11.1). Of the children placed in foster care, 4 percent of these were under 1 year, 40 percent were between 1 and 5 years old, 27 percent were 6–10on years old, 20 percent were 11–15 years old, and 7 percent were 16–18 years old (see Figure 11.2). The goals for these children broke down as follows (see Figure 11.3): reunification with parents (55% of the children), placement with other relatives (3%), adoption (25%), long-term foster care (4%), emancipation (5%), and guardianship (4%). For 5 percent of these children, no plan had as yet been identified. Although foster care is intended to be a temporary solution, 21 percent of these children were in foster placement for 2–4 years with 7 percent for over 5 years. This is actually a decrease from previous years (Adoption and Foster Care Analysis and Reporting System, 2014).

Ethnically, more white children (45%) reside in foster care than any other race. There are also 22 percent African American,

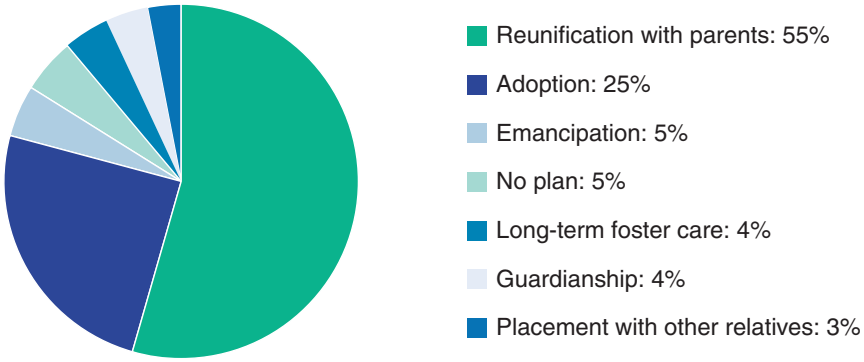


Policy Practice

Behavior: *Assess how social welfare and economic policies impact the delivery of and access to social services.*

Critical Thinking Question: Foster care is an important service to provide stability for dependent children. How has the service changed? Are children better served today? Research the statistics on how these percentages have changed. How might the economy have influenced the need for foster care placements?

Figure 11.3 • Goals for Children in Foster Care, 2014 Care



Source: Based on Adoption and Foster Care Analysis and Reporting System. (2014). "AFCARS Report No.22." © Cynthia Crosson-Tower.

21 percent Hispanic, 1 percent Asian, and 2 percent Native American children in care, while an additional 5 percent are of multiple races or race was not specified. Children enter foster care at various ages with the majority (17%) doing so at under a year of age and 46 percent under the age of 5 years (Adoption and Foster Care Analysis and Reporting System, 2014).

The intent of foster care is to offer children care within a family environment when their own homes are temporarily unable to do so. When their own extended family is not able to provide a home for them, foster care is the next option. Foster care is meant to provide the following:

- Temporary emergency care of a child
- Relief for a parent when he or she cannot manage stress
- Time for a parent to solve problems (e.g., housing, addiction, illness)
- A different home experience or protection for a child (in case of abuse, neglect, or extreme instability)
- Care until institutional treatment is available
- Care until release for adoption or adoption is approved

In 1991, the National Commission on Family Foster Care outlined that family foster care must fulfill five critical tasks, which still remain accurate.

Foster care is designed to:

1. Protect and nurture infants, children, and youth.
2. Ameliorate developmental delays and meeting social, emotional, and medical needs resulting from physical abuse, sexual abuse, neglect, maltreatment, exposure to alcohol and other drugs, and HIV infection.
3. Enhance positive self-esteem, family relationships, and cultural and ethnic identity.
4. Develop and implement a plan for permanence.
5. Educate and socialize children and youth toward successful transitions to young adult life, relationships, and responsibilities.

Added to these tasks, those who make up the child welfare team are dedicated to identifying and treating the trauma that these children have experienced (Klain et al., 2013; Casey, 2016).

Foster care may be voluntary or at the parent's request. The written agreement between the parent and the agency may be terminated at either's request. In most instances, however, foster care is mandated by parental abuse, neglect, or other type of inability to care for the child.

Types of Foster Homes

There are several types of non-relative foster homes, designated by their various functions: crisis or emergency foster homes, family boarding homes, small group homes, and specialized foster homes. Some states use homes interchangeably; others clearly define the role of the home as one particular service.

Crisis homes accept children at any time of the day or night and keep them for a limited time while other arrangements are made. For example, children who have been abandoned may be placed in a home temporarily while their parents are located. Or parents who must undergo short-term medical or rehabilitation treatment may require an emergency home for their children. In some situations, the risk of severe abuse necessitates that children be placed on a short-term basis until protective services workers can diffuse the situation. Foster parents who operate emergency homes may need specialized skills. Sometimes such homes' short respite care is used for diagnostic purposes; it is important that foster parents have crisis-intervention skills. However, not all foster parents are trained in these skills, and that may actually make their jobs more difficult. Like all foster homes, crisis homes are paid for the care of children. Sometimes the rate reflects their crisis status or the specialized training some foster parents have received. In other states, these foster parents are paid at the same rate as the caregivers at long-term boarding homes.

Family boarding homes take children for longer periods—months or even years. Foster parents are expected to work as part of the therapeutic team overseeing the needs of the children in their care. They are usually paid for this work according to the numbers and ages of the children in their care. The rate differs from state to state. In addition, children usually receive a clothing allowance and some kind of medical benefits such as Medicaid. A *small group home* is a family that takes small groups of children, often siblings or adolescents. The home may be administered like a boarding home or a specialized foster home.

An emerging foster care concept is the **specialized foster home**. Such homes are set up to deal with particular populations of children or particular individuals. For example, some foster parents have skills in dealing with adolescents, sexually abused children, or HIV-positive children and take only such children. The number of children in the home usually depends on the need and the particular population. Theoretically, specialized foster parents are better trained, receive more support, and are better paid than the average foster parent. The term "*specialized*" can also refer to foster parents whom the placement agency has screened and approved for one or more specific children. For example, if an adolescent runs away to a friend's home, the agency involved in the case might screen the friend's parents as potential foster parents for the runaway. Or a teacher who befriends a child who must be placed outside of his or her home might request approval as a special foster home.

Kinship care, another type of fostering arrangement, reflects the increasing awareness that placing children with extended family members can minimize the trauma of placement. Kinship care is care of children by a relative, close family friend, godparent, or tribe or clan member when the children's parents are unable to provide care (Hegar and Scannapieco, 1999). Popular in the African American community for centuries, this practice has now become an option for other cultures as well. The U.S. Children's Bureau reports that approximately 120,334 children were in kin foster homes in 2014 and

increase over previous years (Adoption and Foster Care Analysis and Reporting System, 2015; Denby, 2015).

The purpose of kinship homes differs slightly from that of traditional foster homes. Although most foster homes provide substitute care, kinship placements also allow for some degree of family preservation when the children are placed with relatives (Child Welfare Information Gateway, 2010). A recent study found that children placed in kinship care have fewer behavioral problems than those in traditional foster homes (Rubin et al., 2008), but a British study reported that kin caregivers also persisted with more challenging children and youth (Farmer, 2009).

Although kinship care is increasingly popular, some child advocates are concerned about the quality of care given by untrained caregivers. In response to these concerns, the Child Welfare League Kinship Care Policy and Practice Committee has recommended that foster homes be assessed with attention to:

1. The nature and quality of the relationship between the child and the relative
2. The kinship parent's ability and desire to protect the child from further abuse and maltreatment
3. The safety of the kinship home and the ability of the kin to provide a nurturing environment for the child
4. The kinship family's willingness to accept the child into the home
5. The kinship parent's ability to meet the child's developmental needs
6. The nature and quality of the relationship between the birth parent and the relative, including the birth parent's preference about placement of the child with kin
7. Any family dynamics in the kinship home related to the child's abuse or neglect
8. The presence of alcohol or other drug involvement in the kinship home

Source: Kinship Care: A Natural Bridge : a Report (1994). © CWLA. Reproduced with permission of the Child Welfare League of America (www.cwla.org).

Increasingly, there is a move toward licensing kinship homes, raising the question of whether the same standards should be applied to these homes as to other types of foster homes (see Hegar and Scannapieco, 1999; Denby, 2015).

Foster homes are funded in a variety of ways. Most are state or county funded, either directly or through contracts. Most state or county protective services agencies maintain a number of foster homes that they study, approve, pay, and supervise. In other instances, privately funded agencies approve foster homes that they agree to let state agencies use for a contracted fee.



Assessment

Behavior: *Collect and organize data, and apply critical thinking to interpret information from clients and constituencies.*

Critical Thinking Question: Kinship care has become a viable alternative for children. How would you assess the advisability of placing children with relatives? Can you find any first person accounts (Check YouTube) that give you insight into whether kinship care is in the best interests of children? What is your opinion about the use of kinship care? On what do you base your opinion?

Reasons Children Enter Foster Care

Today, most children who enter foster care have parents unable to care for them for some reason. However, at one time it was not unusual for children to be placed when their parents died. Today, more effort would be expended to help such children find relatives who could assume their care.

Many children enter care because they are abused or neglected. Chapter 7 discusses in depth how children are placed in foster homes as a result of abuse and neglect. Usually foster care serves to protect them from continued abuse. In some instances, they will return to their parents; in others they will be released and placed for

adoption. Children who enter care as a result of maltreatment often exhibit behavior that is reactive to their abuse and resulting trauma. Today, foster parents are trained to recognize, and help with, a variety of reactions and disturbances as part of the emphasis on trauma-informed care. Sometimes the nature and degree of traumatic assaults cannot be pinpointed, but it becomes obvious that the child's home is dysfunctional, as in the following case:

> *My mother, my brothers and I moved around a lot when I was little often moving from project to project. I got used to hearing gunfire at night—and sometimes during the day too. My mother used to tell us to come right home. She'd count her children at night just to make sure we were all there. The gangs tried to get my brothers—who were a lot older than me—to join, but my mother put a stop to that. But then some gang members vandalized our apartment and we moved again. One day coming home from school I was beat up by a drug dealer who wanted me to sell some drugs at school. When I refused and tried to run, he caught me and beat me good. I think he might have raped me too but some guys came along and he ran. Mom freaked and moved us again. By the time I was fifteen I was desperate for a place to call my own—a place I could stay for more than a few weeks or months. I had a boyfriend and was an honor student in school. I didn't want to change schools again either. But then we had a bunch more moves, sometimes six times a month, my school work began to suffer. If my school records were anywhere, they were in the mail. I wanted to run away. I thought of suicide. I finally attempted it and the school called Protective Services. They knew I was really unhappy with all the moves. The pressure had gotten to my mother and she had started using drugs and entertaining a lot of different men. They were also using and sometimes they beat her up. When I told CPS this, they put me in a foster home. It was really better. I loved my Mom but I knew that she was messed up by the life we had led. Now I had stability and I got to finish school.*

Increasingly, families are being seen with histories of domestic violence. When a parent is being battered, the children often suffer as well. While agencies first attempt to work with the family to stop the violence, doing so is often impossible. If the battered parent will not leave, the children are sometimes removed and placed in foster care to protect them.

Substance abuse destroys many families today. Children of substance-abusing parents may come into care voluntarily or through court mandate. Some parents recognize their need for drug rehabilitation and request voluntary foster care while in a program, or children may be addicted to drugs and automatically taken into care as a result. For many other families, substance abuse results in the maltreatment of children. Child welfare systems reported a 50–80 percent increase in the number of substance-abusing (mostly drug-addicted) parents on social workers' caseloads over the last several decades. Many of these children have ended up in foster homes.

Physical and mental illness are often factors in the families of children who enter foster care. Parents who find themselves facing operations and who have no other resources may request foster care.

Case Example Doreen

Doreen discovered that she had uterine cancer, but the prognosis was good if she could be operated on immediately. She had no family in the area and no friends able to care for her daughter. She requested that her daughter be placed in foster care while she had her operation and got back on her feet.

Such a request would be considered carefully. Being placed in the home of strangers could compound a young child's trauma in the face of a parent's illness. If children are placed too early or too often, they may fail to attach to their caregivers (Kagan, 2004; Levy and Orlans, 2014). Because one of a child's most profound fears is abandonment, and separation can have a profound effect on children, all avenues other than placement must be explored. Social workers will often search out relatives who might act as kinship foster homes, but this is not always an option. In Doreen's case, foster care with non-relatives was the only alternative, but sensitive preparation of the child enabled the plan to work.

Throughout the years, mental illness has had a significant impact on the need to place children in foster homes than physical illness. Although mentally ill parents still need placement for their children during periods of acute crisis, there have been changes in the provision of long-term mental health services that have impacted how long children remain in care. Prior to the 1970s, the chronically mentally ill were treated in institutionalized settings. Today, with the implementation of community-based treatment whereby people live in the community and are seen on an outpatient basis with counseling and support, more mentally ill parents care for their own children.

Today, some children are given up for foster care or adoption due to their own physical or emotional problems. Increasingly, HIV-positive children are entering foster care. Their parents, usually with AIDS themselves, are either unable to care for them or feel that the children would have a better chance in placement. Coping with children with particular disabilities, such as cerebral palsy, developmental delay, brain damage, attention deficit disorder, or autism, may be beyond the skills of some parents. As a result, these children may be placed in foster care.

Incarcerated single fathers or mothers may also have a right to have their children in foster care. Usually, other relatives are sought who can assume the responsibility of caring for the children; however, if no one is available, foster care may be the answer.

Over the years, children have sometimes been placed in foster care due to their parents' inability to provide adequate housing. Fortunately, this practice is now discouraged because several studies found that, under subsidized housing, the monthly rental assistance for a family may be only slightly more than the cost to place one child in foster care. In addition, it is better for children to remain with their own families whenever possible. For this reason, social service agencies now make a concerted effort to find housing for intact families rather than placing children in foster care (see Chapter 9).

Finally, foster care may be an interim arrangement while a child awaits an adoptive home or placement in a residential setting. Parents wanting to give up their children for adoption may need time to decide if this is the right course, or an agency may need time to find the appropriate home. By the same token, children who are slated to be placed in a community residence may find that there are no beds open at a given time, or that the agency placing them needs time to find the appropriate setting. In such situations, a child may be placed in foster care for days, weeks, or even months.

Summary of This Section

- Foster care emerged as method of placing children whose parents could not care for them in homes rather than in almshouses or orphanages. The "placing out" initiative of Charles Loring Brace is often seen as one of the first efforts to address children's needs for homes. Children were transported by "orphan trains" to the Midwest for placement. Initially, fostering homes were not paid but expected children to work for their keep. Only later was a payment system instituted.

- Since World War II, various pieces of legislation have addressed and influenced foster care. In the 1970s, permanency planning—or the effort to place children in permanent care situations as soon as possible—shaped the foster care system, while at the same time family preservation efforts suggested that children should remain home whenever possible. The 1997 Adoption and Safe Families Act set limits on the time allowed to attempt reunification and attempted to speed up the time when a permanent home was sought for children.
- Currently, there is increased emphasis on trauma-informed care, recognizing the need to address the trauma that has been a part of the lives of most foster children and not intensifying that trauma by multiple moves or unsafe conditions.
- In 2014, approximately 415,129 children in the United States were in foster care, both in family boarding homes and in kinship placements. Of these, most were white followed by African American, Hispanic Native American, and Asian.
- Foster care is designed to be a temporary home setting where children can be protected, nurtured, educated, and socialized. During their stay in foster care, it is assumed that efforts will be made to develop a permanent plan for their care as well as addressing their treatment needs.
- The various types of foster homes can be characterized as crisis home for emergency short-term placement; family boarding homes, for longer placements, specialized foster homes designed to meet the needs of specialized populations, and kinship care where children are place with relatives, or godparents.
- Children enter foster care due to abuse and neglect, abandonment, or parental incapacity (e.g., substance abuse or mental illness). Although at one time, children may have been placed in foster care because their parents did not have adequate housing, this is no longer a regular practice.

PARENTS: FOSTER AND BIOLOGICAL

The relationship between biological parents and foster parents can be challenging; both may have concerns for the child in foster care and doing what is best for the child may require careful case management on the part of the child welfare agency. Understanding the roles that both foster parents and birth parents play in the life of a child is crucial to providing for the child's best interests.

Foster Parents

Foster parenting is not the relatively uncomplicated task that it once was. Today, foster parents are expected to be part of the therapeutic team involved in children's lives. Foster parenting requires new responsibilities and brings many stressors. Agencies differ in their recruitment, training, and involvement of foster parents, but some standards are found throughout the field.

Recruitment

Foster parents are recruited to their jobs in a variety of ways, including public service announcements (PSAs), newspaper ads, television spots, and personal contacts. Which means are most effective is much debated.

Some agencies now use the media to recruit foster parents. One problem with media recruitment is that many of the resulting applicants may lack the necessary qualities

to become foster parents. One recruiter remarked, "The media often appeals to the softhearted, and a soft heart doesn't help one through the real world of foster parenting. Foster parents must mix caring for kids with realistic expectations of kids who are often reacting to tough lives. They must also refine their parenting skills beyond those expected of most parents." Increasingly PSAs are outlining the types of children for which homes are needed, presenting a more realistic picture to those who might consider becoming foster parents.

Some agencies use trained foster parents to recruit others. Existing foster parents can be the best source of recruitment efforts. These recruiters begin in their own neighborhoods. Agency social workers help each recruiter develop a plan tailored to his or her environment. They provide support, coordination, and supervision. As an additional incentive, foster parent recruiters may be paid for each family they recruit. Agencies using recruiters encourage them to evaluate agency policy. For example, if applicants drop out of the process of being studied because of some restrictive agency policy, the recruiters are asked to report it. The agency will then try to remedy this situation. Throughout the process of foster parent application and selection, agency social workers closely follow these recruiters.

A foster care specialist for the Bureau for Children, commented, "In the long haul, the most effective recruitment is foster parents who are satisfied with agency services. This is often apart from any specific recruitment effort: Word of mouth reports tend to be viewed as most credible."

Why do people want to become foster parents? Reasons vary from empathy with unhappy children and a desire to provide a community service, to wanting to continue to parent or wanting a playmate for their own children. Increasingly, agencies are encouraging potential foster parents to assess the expectations that motivate them to become foster parents and determine how realistic they are.

Experts suggest that successful foster parents sincerely like children, have a strong sense of themselves and their own abilities, and are able to tolerate a variety of behaviors from children that some other homes might find intolerable (Gerstenzang, 2007; Guishard-Pine et al., 2007; Marcellus, 2010).

The shortage of foster homes, particularly for specific ethnic groups, children with attachment disorders and other specific problems necessitates that agencies look more closely at recruiting foster homes from the children's own families (i.e., kinship care) or informal networks. Formerly, there was some resistance to extensive use of kinship care for several reasons. First, if birth parents abused or neglected a child, their relatives might behave in similar ways (although what drives one individual to abuse may not affect his or her kin in the same manner). Second, children's relatives might be difficult to locate, thus requiring more social worker energy for recruitment (although using relatives can be more beneficial for the child). Third, parents considered for a particular child are less likely to see themselves as working for an agency; they are less aware of child welfare policies and may be less interested in cooperating with agencies in the interests of the child. Although these characteristics make the home a more natural environment for the child, they may present difficulties for social workers who expect total cooperation from foster parents.

However, kinship care has significant advantages. Placement with known relatives reduces the trauma to children. On average, a child stays 6.5 months in an unrelated foster home but 10.5 months in a kinship home. Certainly, homes studied for specific children have a greater commitment to those children, perhaps lessening the feelings of isolation described by many former foster children. These homes might also maintain closer ties to the children's birth parents (Hegar and Scannapieco, 1999; Farmer, 2009, Denby, 2015).

From the perspectives of both the kin caregivers and the agency, kinship care has advantages and disadvantages. Kin who foster-parent through an agency lose some

autonomy; they must comply with state regulations governing sleeping arrangements, discipline methods, and other family matters. The financial benefits they receive may not compensate for their loss of privacy, the need to attend trainings, and the need to accept home visits from social work staff. Agencies interested in giving children the advantages that kinship care can provide must exercise more ingenuity. Not only must the child's informal networks be explored for potential homes, but the potential foster parents must also be studied, trained, and supervised with the understanding that they may provide a foster home for only one child rather than the many children taken by professional foster homes. Yet the result—the child's well-being—seems worth the effort. In this time of scarcity of foster homes, this approach is also a way of increasing foster care resources.

Homestudy and Training

Once recruited, potential foster parents undergo a lengthy process of screening, selection, and training known as a **homestudy**. At one time, a homestudy was an individual affair between the foster parents and the social worker, known as a **homefinder** or **family resource specialist**. Now, however, most agencies favor a group approach. The current emphasis is on foster parents as part of a team that strives to ensure that the child is provided with the best plan possible. *A Blueprint for Fostering Infants, Children, and Youths in the Nineties* was the Child Welfare League of America's effort to outline the new role of foster parents as team members (National Commission on Family Foster Care, 1991). With this new emphasis came revised training for potential foster parents. This training is based on a variety of models and has been updated over the years.

Numerous states have adopted the Model Approach to Partnerships in Parenting (MAPP) (based on information gained from a study done on foster parent training by Nova University), which combines screening with intensive training for future foster parents. One Massachusetts family resource worker described their MAPP program: "Our training is completed in ten sessions. We explain to our group participants at the onset that foster parents need three things: certain information, attitudes, and skills that will enable them to be good at their job. Some people develop the attitudes and skills as they go through life and bring them to the group. Other people will learn them through the ten weeks of the group process. We, as facilitators, reserve the right to discuss with the applicants at the end of training whether we feel that they have the information, attitudes, and skills that our agency has found are needed by foster parents."

Critics suggest that home studies have traditionally been conducted in a manner that suggests subjectivity on the part of the homefinder. As a result, some now favor the Structured Analysis Family Evaluation (SAFE). SAFE is a standardized home study method that gives practice guidelines, questionnaires for information gathering, a psychosocial inventory, a standardized reporting procedure, and a matching inventory. Although there are some definite advantages to such a standardized approach, such as more professional practice, a more equitable way to conduct home studies, and more guidelines for inexperienced staff, a recent study found that more experienced home assessment workers, do not want to lose the personal approach that have been the signature of home studies in the past (Crea et al., 2009).

Whatever model an agency uses, through a combination of providing information, role-play, exercises, and discussion, it encourages applicants to explore their attitudes toward discipline, birth parents, loss and separation, how their own children might react to sharing their parents, the behaviors exhibited by children in foster care, and a variety of other topics relevant to parenting a foster child successfully. There is much more emphasis today on helping foster parents to anticipate and respond to a variety of behavioral and emotional problems. Foster parents are helped to recognize that children who come into

foster care have experienced trauma—one piece of which is the separation from their parents. Potential foster parents are helped to understand the nature of trauma and what can be done as part of therapeutic intervention.

Participants in foster parent training also discuss feelings about their own upbringing and how their past, or realizations about their past, helps or hinders them in their roles as parents. The social workers visit the families in their homes to determine how their thinking has evolved (see also Dickerson and Allen, 2006; Rosenwald and Riley, 2010).

Not all applicants who begin the training finish. Some learn that foster parenting is not what they had hoped for. Others drop out for other reasons: "I dropped out of the homestudy because I learned that I had a great deal of emotional housecleaning to do before I could be comfortable parenting someone else's kids. When I applied to be a foster parent, I imagined saving poor little kids from abusing parents. Now I realize that part of a foster parent's job is to work with those same parents, and I am not sure I could do that."

In addition to being studied, trained, and selected, foster parents must be licensed. Many states include the licensing process as a part of the homestudy. Other states have an independent process. Basically, a license means that the family and their home have passed specific requirements, such as fire safety, health safety, and cleanliness. Potential foster parents are expected to have a physical exam and to undergo a criminal records check. It is possible for a family to meet licensing criteria but not be approved by a homefinder because of their emotional instability or lack of readiness. The reverse is also possible.

Although the preceding is the typical plan for recruiting, screening, and training foster parents, agencies recognize the need for flexibility, given the cultural diversity of children in foster care and of the families who apply to take them in as foster children. It is important to train workers to understand ethnic and cultural variations so that they do not fit families into a particular stereotype.

Once foster parents have been approved to take children, their file is kept until a child needs a home such as the one they offer. The amount of matching done between child needs and foster parent characteristics differs from state to state, but studies show that the more these factors are taken into consideration, the more successful the placement. Given the shortage of foster homes, however, foster parents are often asked to take children who do not fit the age range or type of child they feel equipped to handle. This may not be beneficial for the child or the foster parents.

Placement and Follow-Up

When a child needs a particular type of foster home, the foster family is approached about taking him or her. The placement process can take as much as a week but usually is very quick. "When I go into court on a particular abuse case," one social worker said, "I know that I may need to place the child immediately after the hearing. I line up a home that will be ready to take the child. It doesn't give the foster family much time to prepare, but that is the way the system works."

Once children are in foster placement, an agency social worker visits them regularly to provide support and monitor the placement (Iwaniec, 2006; Marcellus, 2010). Foster families provide ongoing care and may also be responsible for such extras as transportation to medical appointments, therapy visits, or even visits with the child's parents. If parents are allowed to visit in the foster home, the foster parents may also supervise these arrangements. Further, foster families are included in periodic case conferences to assess the progress of the child and the family. For these services, they are paid a small foster care allowance and often a sum for clothing for the children in their care (see DeVooght et al., 2013).

Although the foster mother usually shoulders most of the responsibility for caregiving and dealing with the social service agency, the role of the foster father should not be underestimated. The support he provides his wife can make a real difference to the success of the care. If foster children are truly to be part of the family, their involvement with the foster father is as important as their involvement with the mother.

The inclusion of foster parents on the therapeutic team is a continually evolving concept. At one time, foster parents were seen as mere caregivers, but they are now expected to be part of the child's treatment. More recently, foster parents have received training in the effects of trauma so that they may be more effective in their roles on the treatment team. Some agencies, such as the Casey Foundation, use highly trained foster parents for intense therapeutic services. Other agencies provide ongoing training and even special certification for foster parents. Certified foster parents receive higher rates of payment for their services and describe feeling more competent and able to handle the problems presented by their charges.

Stresses of Being a Foster Parent

Foster parenting comes with many stressors. First and foremost, foster care is designed to be temporary. Thus, foster parents are asked to love children in their care but then let them go. How well they have been able to handle the losses in their own lives may determine how successful they are at letting go and preparing their foster children for return to their birth parents' home or adoptive placement (see Gerstenzang, 2007; Marcellus, 2010, Rosenwald and Riley, 2010).

Foster parents also are asked to handle a variety of behaviors exhibited by the children who enter their care. These children may be withdrawn, be destructive, abuse others, set fires, or act out in a variety of ways. Often children with early trauma suffer from some degree of attachment disorder. Foster parents are expected to consider the underlying causes as opposed to just reacting to the behavior. In the crunch of everyday activities, this is not always easy. It is also not unusual for children whose early relationships have been problematic or traumatically terminated to have experienced disrupted attachment. These children may have difficulty forming new relationships.



Diversity and Difference in Practice

Behavior: *Apply and communicate understanding of the importance of diversity and difference in shaping life experiences in practice at the micro, mezzo, and macro levels.*

Critical Thinking Question: Should foster parents be of the same racial or cultural backgrounds as their foster children? What are the advantages and disadvantages of this arrangement? What obligation might foster parents have to children of different cultures living in their homes?

It may be a challenge for foster parents to provide foster care while considering the needs of their own family members. The foster parents' own children may not always understand the needs of the foster children (Wozniak, 2001; Gerstenzang, 2007; Marcellus, 2010). Or they may mimic behaviors that their parents do not appreciate. Foster couples find that they need to pay careful attention to their own relationships lest the stresses of having foster children alienate family members from one another. Dedicated foster parents tell us that none of these tasks is easy and that they must be constantly aware of the dynamics of their own families.

It is also not easy to have one's parenting techniques under constant scrutiny. Providing care for someone else's child under agency supervision may make people feel that they are constantly under observation. In addition, each social worker has his or her own method of supervision, and foster parents sometimes feel that they cannot please everyone. More experienced foster parents learn to develop a personal style that helps them weather the turnover of social work staff.

In addition to feeling scrutinized by the agency, foster parents may feel that they are being criticized by the birth parents. But the birth parents' feelings, too, must be

understood. As one foster mother commented, "It must not be an easy thing to have your children taken away from you. It's like a judgment that says you weren't a good enough parent. So, if you see someone else taking care of your children, it is just human nature to want to find fault with them. I try to understand how hurt these parents must feel, and it helps when I feel criticized by them."

Visits by **birth parents** may not always be easy on foster parents. Not only can foster parents feel criticized, but they also may have to deal with birth parents who abuse alcohol or drugs or who may be mentally ill. Sometimes a visit by a birth parent sends the foster child into crisis. Foster mothers often describe the conflict felt by foster children about separation from their parents and the reactions exhibited by children after each visit. Once again, foster parents are expected to understand these problems and deal effectively with birth parents (Wozniak, 2001; Gerstenzang, 2007; Marcellus, 2010).

Foster Parents as Part of the Team

With the number of profoundly disturbed children entering foster care, more and more is expected of foster parents. Most states require foster parents to seek out or participate in ongoing training. Foster parents are often asked to monitor and record the behavior of the children in their care. They are asked to participate in foster care reviews not only as advocates for their foster children but also as professionals with vital pieces of information to contribute to an overall assessment of the children.

It is not unusual for foster parents to be asked to help birth parents by providing role models, aiding them in understanding their children, or discussing parenting skills such as behavior management, discipline, and the management of challenging health care issues.

Case Example Demetrius

Demetrius was a 5-year-old child whose medical problems necessitated that he has a colostomy. The bag that collected his urine had to be changed regularly and the medical incision cleaned properly. Although well-meaning, Demetrius's mother failed to complete these procedures properly. In fact, she was overwhelmed by the magnitude of his care. Feeling unable to cope after a drinking binge, she left her child with a neighbor and disappeared. After a week, she missed him and felt very guilty for having abandoned him. She called the neighbor, who told her that she had had no idea how to meet the child's medical needs. The neighbor had taken Demetrius to the hospital and explained that his mother had abandoned him. The hospital had called CPS, and Demetrius had been placed in a foster home with a foster mother who was a nurse.

After talking with the boy's mother, CPS became convinced that she could care for her child if educated to do so. Thus, for the next 3 months, the mother visited the foster home and received intensive training from the foster mother on how to care for Demetrius.

In this situation, the foster mother's skill provided the needed therapeutic intervention that allowed Demetrius to eventually return home.

As foster parents become more involved as members of the therapeutic team, there is more pressure on agencies to discard the attitude that these parents are merely children's caregivers. There is also an increased emphasis on more intensive training opportunities.

Kinship Foster Parents

Kinship foster parents have their own set of struggles within the foster care system. Although some agencies provide the same training for kinship parents as they do for

unrelated foster parents, other agencies see these family members in a different category and do not provide adequate training. Increasingly though, agencies recognize not only how important kinship homes can be in serving the needs of children but also that these parents may need additional support, training, and help in order to accomplish their roles. While at one time, it fell to the foster care worker to support and train kinship homes, more agencies are now arranging more formalized training for these parents (Child Welfare Information Gateway, 2010, 2012).

For the relative or godparent who takes in children, the foster care system and the child welfare agency may seem frightening and overwhelming. They may feel the divided loyalties between the children's parents—their relatives—and the foster care agency. They may also harbor anger and a variety of other emotions toward their family members for their inability to care for or treatment of the children. Fortunately there is increased sensitivity to the needs of kinship homes, and efforts to meet these needs are increasing (Child Information Gateway, 2010, 2012).

Birth Parents with Children in Foster Care

The characteristics of parents whose children are in foster care are discussed in various chapters of this book. When we are caught up in protecting children from maltreatment and improper care, it is not always easy to recognize the impact that placement has on the birth parents.

Attitudes and Reactions

Our society communicates the message that anyone can parent. Most people expect to have children. There are no directions provided for the important role of parenting; unless individuals have had role models in their own parents, they may have no concept of what parenting is about. This lack of knowledge can remain a carefully hidden secret until society, in the form of CPS, intervenes and removes the children because they are being inadequately parented. In other cases, parents are forced to place their children because life circumstances interfere with their ability to parent. Imagine your resentment, no matter how aware you may be of your inabilities, if your children require the care of someone else, often a stranger. Parents often go through a variety of feelings. The first may be shock.

Although there are those people who may protest that it should be obvious to some parents why they lost their children, this fact does not diminish the feelings. "When my kids were taken away," one parent recalls, "I just couldn't believe it. I knew I had been drinking a lot, and I know I left them alone overnight, but I still loved them. It's just that no one ever told me that it would be so tough to take care of kids! As I sat in that apartment after they were gone, I just stared at the walls. I kept thinking I heard them. No, it wasn't them—just the unbearable silence. I hated myself then. I hated the drinking and drugging. I hated everything. But I missed my kids!"

When parents come out of the shock, they may feel resentful and angry. These feelings often mask feelings of failure because the parents have not been able to do what other parents do—care for their children. This may lead to feelings of inadequacy that



Intervention

Behavior: *Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in interventions with clients and constituencies.*

Critical Thinking Question: Working with birth parents whose children must be placed in foster care can be difficult and sometimes heart-wrenching. What might she or he be feeling? How do you see yourself working with a birth parent who is not really able to care for his or her child but desperately wants the child returned to him or her?

can manifest in a variety of ways (Plumer, 1992; Grant, 2004; Iwaniec, 2006; Alpert and Britner, 2009; Lewis, 2011). Some parents eat more, drink or drug more, or act out in other ways.

There may also be cultural reasons for their reactions. For example, in some cultures the birth parents become extremely hostile and threatening. In others they protest with silence.

Case Example Poppi

Poppi was a 34-year-old African American mother whose children were removed after she neglected them. Although she sincerely loved her children, her drinking had interfered with her caring for them. When they were removed, she was very angry and depressed. The social workers told her that there were numerous things she had to do to have them returned. Feeling that she could never please "them nigger-hatin' child stealers," Poppi refused to respond to phone calls or attempts on the part of CPS workers to visit her. Unfortunately, the workers interpreted Poppi's behavior as indicative of lack of interest in her children.

Many birth parents get stuck in the anger stage. It is easier to be angry than to acknowledge the hurt. Unfortunately, some social workers react to the angry behavior rather than recognize the feeling beneath it. Parental rights may actually be terminated if the parents cannot move beyond the anger stage and the desire to strike out long enough to cooperate with the agency. It is often forgotten that people who lose their children due to their inability to effectively parent have usually faced failure, betrayal, and disappointment throughout their lives. The coping patterns they have developed may not seem appropriate, but for some the anger or withdrawal has enabled them to survive.

Parents who give up their anger often go into despair. They become depressed and unmotivated. Nothing seems worth doing. Some may also feel relief that there are no children at home to force them to do daily tasks. Some parents reach out to social workers or foster parents. But many, from troubled backgrounds themselves, cannot trust others to this degree and turn inward. Again, social service personnel often interpret their lack of energy as lack of caring.

Due to feelings of inadequacy, some parents search for ways in which the present caregivers also are inadequate. Birth parents who visit their children in foster homes may look for ways to criticize foster parents. It may be difficult for the foster parent to remain sympathetic about the loss the birth parents have experienced. However, for the child's sake it is important that relations remain harmonious.

Certainly, some birth parents are able to adjust to their children's placement in foster care and can work in cooperation with the agency involved to secure their children's return.

Rights and Responsibilities of Birth Parents

Birth parents are encouraged to visit their children while the children are in foster care, especially if the plan is family reunification. Traditionally, parental visits have taken place in the foster home, but they may also be arranged at the agency. Some parents say it is very difficult to see their children briefly and then leave them again. As one parent put it:

> You see your child in a home situation where everything is apparently orderly and calm, and, quite often, materially superior to anything you are going to be able to offer them, and you wonder why the hell you are bothering to rock the boat . . . maybe it would be better to leave your child there. It would be a lot less upsetting for everyone involved if you just drop out of the picture (McAdams, 1972, 18).

But therapeutically it may be better for children to maintain contact with their birth parents than to cut all ties. Studies also show that children do better in foster care and are less likely to be damaged by separation if they are able to maintain contact with their birth parents.

Birth parents should be considered an integral part of the foster care team for several reasons. First, their involvement with the foster home helps the child adjust. Second, foster parent involvement may be therapeutic to the birth parents. By seeing the foster parents model parenting skills, they may recognize what their children need. Finally, if the children return home, their having maintained contact with their birth parents may smooth the return.

Certainly, not all birth parents end up being reunited with their children, nor should all continue to be involved with their children. However, birth parents who are encouraged to stay involved with their children, although still held accountable, tend to make more progress toward reorganizing their lives and having their children returned.

Parental involvement refers to contact of parents with their children in foster care, whether the contact is minimal or involves participating in goal setting, attending conferences and reviews concerning their children, and visiting and even caring for the children at the foster home or during extended home visits (Alpert and Britner, 2009).

Birth parents have certain rights while their children are in foster care. Unless the court terminates parental rights, parents have a right to see the treatment plan (an outline of what is expected from them and what the agency will provide to them) and to attend all court hearings concerning their children. Whether parents exercise these rights depends on several factors, not the least of which is whether the agency has informed them of their rights. Even if that is the case, parents are not always able to act on their rights. Some are so angry that they refuse to cooperate, and others feel that nothing they do will make any difference.

When Children Return Home

Removing one individual from a family constellation shifts the balance of that family. Because a family is a system and all systems seek homeostasis, the family may rebalance itself without the missing member(s). Thus, when a child returns to a birth family (referred to as **reunification**), the transition may not always be smooth, no matter how much it was anticipated by parents or children. Children will test limits. They expect old patterns to continue and are confused when they do not. Parents who have worked hard on their own issues may find that the added stress of the child's return brings up those issues again.

Careful reunification planning and implementation often make the difference between a child's being able to reintegrate into the home and his or her returning to foster care.

Summary of This Section

- The role of foster parent can be a difficult and complex one. Foster parents are recruited through a variety of methods but the most effective way to attract people who understand the commitment necessary is through existing foster parents. These applicants are then screened through a lengthily serious of discussions called a homestudy that looks at their backgrounds, their understanding of the complex issues facing children, and their attitudes toward child rearing. This also serves to train the foster parents for their roles but some agencies also provide additional training once a foster parent has been approved.
- Once approved, a foster home awaits a social worker's call that a child or children are in need of what that home can offer. The wait is usually not long as the need for foster homes is constant. Following placement of a child, the foster care worker

visits the home on a regular basis to supervise as well as meeting the needs of the child and the foster parents. The foster parents are considered to be a part of the therapeutic team.

- The stresses of being a foster parent are myriad. Children bring their own behavioral and psychological issues often as a result of the traumas that they have experienced. Foster parents must continue to meet the needs of their own families while they often feel scrutinized by the agency. Contact with birth parents can also create tension as not only do many birth parents feel critical of those who are caring for their children, but children feel torn in their own loyalties between two parents. Kinship homes and parents have their own set of stressors, including their own conflicted feelings about the child's birth parents.
- Having one's children placed in foster care is not easy for many birth parents either. They often feel that they have failed their children and may compensate through anger at the system or the substitute parents who symbolize their failure.

  Although it can be beneficial for birth parents to be involved in their children's lives, this may also be difficult on a variety of levels. Although many birth parents would like to regain custody of their children, this reunification has its own set of stressors

CHILDREN IN FOSTER CARE

Foster care is not always an easy experience for children. Not only have they been separated from the only parents they may have known, but they may also not know what is expected of them in this new home. Even children placed with relative in kinship care may have difficulties in adjusting.

Feelings About Placement and Separation

When children are placed in foster care, they may not understand what is happening to them. For children, separation evokes many different feelings. For most, there are feelings of sadness. No matter what experiences they have had there, most children want to be at home. They may also feel lonely and abandoned. They may feel that they are unlovable. If their parents "didn't want them," they may wonder if anyone ever will. Feeling that they are somehow to blame for being taken from their parents, children often feel guilty. They wonder how they could have been so bad that their parents wanted to "get rid of them." Even if children are removed because of abuse or neglect, they may feel that their parents wanted them sent away (Kagan, 2004; Guishard-Pine et al., 2007; Lee and Whiting, 2008, Lewis, 2011).

Case Example Nicole

Nicole was 5 years old when she entered foster care. At age 12, she was still in a foster home, although she had been in seven foster homes since she first entered care. Her mother had visited only at first. When Nicole talked about her life, she expressed resentment toward her parents for "dumping her." In reality, she had been removed from her mother's care due to severe neglect. Like some other foster children, Nicole showed hostility. She was very angry and spat out her words as she described how she felt about her mother.

Being without their birth family causes some children to feel fear. They wonder who will care for them and where they will live. And some children feel shame—shame at being a foster child; shame at having parents who, seemingly unlike other parents, cannot take care of their children. Like their birth parents, foster children often pass through different feelings: shock, outrage, despair, and detachment (Plumer, 1992; Harrison, 2004; Guishard-Pine et al., 2007; Lee and Whiting, 2008).

Being with one's own parents seems like such a fundamental part of childhood that foster children begin to wonder why they are different from other children. When it is too threatening to blame their parents, children internalize the guilt. As one teen put it, "I used to lie in bed in my foster home and think about every lousy thing I had ever done when I was with my parents. It never occurred to me that the fact that both of my parents were drug addicts could have been the cause of my placement. I was convinced that if I had been good enough, they would have kept me." This feeling of being different and unworthy causes foster children to devalue themselves. Each child expresses these feelings of inferiority differently. Some children become withdrawn, compliant, and even self-abusive or suicidal; others act out in anger. A few are able to question the injustice of their having been forced to leave home because of their parents' problems. Even if the child is able to recognize the injustice, a good explanation is not always provided to them.

In addition to the hurt and anger, some children may feel sadness. A former foster child described this sadness: "I think I did a lot of crying that people never knew about. I suppose I was scared. I never let my mother see me cry when she visited. I always felt that I had to be strong for her. I knew that she hadn't wanted us taken away, but she just couldn't kick her problems long enough to take care of her kids. I cried alone in bed at night and just wished sometimes that the world would end."

Children may be separated from their siblings as well as their parents. The overwhelming desire of many children taken into care with their siblings is to protect their younger siblings.

It is not unusual for older siblings to care for younger ones in dysfunctional families. Separation from each other may increase the impact of separation on both siblings. The caregiving role has given the older child a sense of purpose and a feeling of some control. Separation robs the older child of not just the home but of the responsible role he or she may have needed. Separation of siblings may also make the younger child feel more vulnerable and alone. Certainly there are exceptions; however, for the most part, when siblings can be placed together, doing so will ease their transitions.

Feelings About Birth Parents

The ability of foster children to attach to their new caregivers is affected by their previous experiences with their birth parents, how they separated from their parents, and their contact and relationship with their parents while they are in foster care (Kagan, 2004; Guishard-Pine et al., 2007; Alpert and Britner, 2009; Levy and Orlans, 2014). Although it might seem that less contact with birth parents would help the child adjust, that is not the case. In addition, an attempt by foster parents or agency personnel to discredit birth parents—however well-meaning the attempt—makes placement more difficult for the child. When foster parents convey disapproval of birth parents, they set up conflicting loyalties for the child. One former foster child explained, "My parents were part of me. I guess I knew that they would never get me back, but I needed closure, I guess. At first they visited and then they didn't, but it helped me to adjust. My foster parents were great about the visits. That was good because no matter what my parents had done to me, I cared about them. If anyone had knocked them, I would have felt that they were knocking me."

Some children, hurt by abuse at the hands of their birth parents, are angry and do not want contact. Although this is usually respected, the child may confront this issue in later life.

Feelings About Foster Parents

The feelings that foster children have about their foster parents vary. Some are so hampered by their previous experiences at home that they are unable to trust and bond with others. They may see foster parents as threatening or as having the potential to let them down. Some learn from their foster families how to trust again. For young children, foster care may represent the first consistent care they have experienced.

Certainly, the chemistry that affects any relationship is important in the bond, or lack thereof, between foster parents and foster children. Children who have lived in many foster homes recount that some "felt right" and some did not. Today, foster parents are trained to understand what their charges are experiencing, in the hope that the relationship can be as strong as possible.

Life in Foster Care

What is it like for a child who is residing in a home that was totally strange to him or her at placement? A former foster child recounted, "Every family has different rules—not just the spoken ones like when to come in at night or who takes out the trash. It's the unspoken rules that are hardest. For example, it may not seem like a big deal, but everyone sets the table somewhat differently. That shouldn't matter, but when you're new in the home and you're asked to set the table and you do it wrong, it can seem monumental. Like you have failed when you are really trying to fit in and please these people. It may sound silly, but when you don't have a home you can really call your own, it is important to fit in."

It is not only family rules, routines, and relationships that may be difficult for a foster child. There continues to be a stigma attached to being **in care**, and foster children can feel it profoundly. "I began to think of myself as the bag girl," recounted one foster child who had moved from home to home. "Whenever I moved, all my belongings were stuffed into a plastic bag." In a sensitive response to the alienation felt by most foster children, in 1999 North Carolina teen Aubyn Burnside began a program called "Suitcases for Kids"; she asked that suitcases and duffel bags be donated to local foster care agencies for the use of foster children in moving from home to home (www.suitcasesforkids.org). In school, too, such children often feel like "foster kids" and feel alienated from their classmates. They may also recognize that foster care is designed to be a temporary arrangement and wonder when they will be asked to move again. It is small wonder that permanency planning is considered an important move in the provision of services to children (Plumer, 1992; Harrison, 2004; Iwaniec, 2006).

Leaving Foster Care

Until not too long ago, the emancipation of youths from foster care was informal. The Title IV-E Foster Care and Subsidized Adoption Program, created by the Adoption Assistance and Child Welfare Act of 1980 (PL 96-272), mandated that states provide transitional living programs for foster children 16 years and older who were **aging out** of the foster care system. In 1999, the **Foster Care Independence Act** was passed; it doubled the funds previously available under Title IV-E. These funds increased from $1,000 to $10,000, the amount that foster children are allowed to have in savings or other assets while being eligible for foster care. Further, the legislation enabled states to provide funds for room and

board and to extend Medicaid coverage for medical/mental health services to youths who are 18 to 21, have left foster care, and are living on their own. Training was also provided to help foster parents, group care staff, and social workers to transition these youths into independent living (Child Welfare League of America, 1999). Child welfare advocates applauded such steps to improve the future of foster children.

Children leave foster care for a variety of reasons. In some cases, their parents are able to alter their lives and welcome their children home. Some foster children who are unable to adjust to a foster home move to institutions designed to cope with behavior that the foster home could not handle. Other children (fewer in number in recent years) "age out" of foster care by turning 18. There may be provisions for continuing the support of a child if he or she seeks more education or has a physical or mental disability, but for others 18 is the cutoff age. After this, the foster parents and the child can choose if and how the relationship will continue.

When most of us think of living on our own, we rarely consider all the implications of independence. Our complex society mandates that we have specific skills and resources (such as the ability to obtain housing and set up housekeeping, hold a job or some means of support, maintain relationships, etc.). Usually, children are prepared for independence by their parents, who then maintain ties with them to help them along the way. How many young adults have not called their parents for extra money; for advice on budgeting, career choices, or moves; or for child care? Many people's first apartment is furnished with excess or cast-off furniture, eating utensils, and dishes from the family household. Foster children do not have such assistance, nor have they been able to watch parents balance the checkbook or make everyday decisions. The responsibility for their emancipation education rests with their legal "parents": the state or county agency. Thus, programs have been set up to enable foster children to develop the skills they need to leave care.

Youths leaving care need not only practical information but also help in addressing their personal needs. Abuse may have been part of their experience prior to or during foster care, resulting in scars. Their years in foster care may have failed to address these issues and possibly exacerbated them. When a youth faces **emancipation**, these issues of emotional conflict do not disappear. A full assessment should be done of the psychological, emotional, and health-related needs of each foster child about to leave care. Once these needs are identified, they can be more adequately addressed (Shirk and Stangler, 2004; Pew Commission on Children in Foster Care, 2007; Bruskas, 2008; Jones, 2014).

Although preparation for leaving care is usually considered orientation to independent living, foster youths need a whole range of services. Some may require that independent living skills be taught throughout the placement.

In addition to teaching skills to emancipating youth, or in many cases a vehicle for doing so, programs for mentoring youth after they leave foster care have become popular. Mentoring involves the matching of youth with a caring adult who provides support, guidance, and companionship for a young person who may not have other support systems. Such formalized programs have increased in number over the last decade or so. Spencer et al. (2010) point out that despite high hopes, these programs have not been as successful as anticipated. In fact, studies have shown that youths leaving foster care may experience—despite being involved with mentoring programs—higher levels of homelessness, substance abuse, incarceration, unemployment, and greater rates of poor physical and mental health. These authors suggest that it may be the influence of frequent moves and instability, as well as early experiences that brought them into care may impede their ability to benefit from the mentoring relationship. What they do suggest from their analysis of mentoring programs is the longer the duration and the more consistent the mentoring relationship, as well as the depth of the emotional connection between young person and

mentor, the better the outcome. In addition to formal mentoring programs, some youths also develop natural mentors among those who take an interest in them.

A recent study interviewed youth who had left foster care 6 months before to assess their perspective on the training they had been given to prepare them for emancipation from the child welfare system. These youths were involved with independent living services (ILS) designed to enable them to leave foster care and live as independent adults. These programs differ from state to state, agency to agency not only as to the tasks that are taught but also in the manner in which youth are taught them. While some programs used formal classroom or group settings, others employed the skills of foster parents. Some of the tasks included in many of the programs are money management, employment skills, interpersonal skills, mental health education, and housing information (Jones, 2014).

The study participants were asked if they felt prepared for leaving foster care after their ILS, how satisfied they were with these services, how could they have been better prepared, and what were their educational and employment plans in the next 5 years. Ninety-five young people participated in the study—60 percent of which were females and 47 percent were African Americans, followed by 24 percent white and 20 percent Hispanic with the remaining 3 percent from other racial backgrounds. About 58 percent were 18 at the interview while 31 percent were 19. The remainder were divided between the ages of 17 and 20. About 25 percent reported that they attended school or worked (Jones, 2014).

Most of the youth in the study reported that they were somewhat prepared for independent living. About 60 percent said that they were satisfied with the ILS that they had received, which leaves a significant percentage who were not satisfied. While many felt that they could do basic activities (e.g., meal preparation), many were having problems with money management and other self-care issues. Some complained that they had not developed good study skills or work habits while in foster care, which made it difficult for them to go on to higher education or pursue some jobs. Many wished there were aftercare services that they could access (Jones, 2014).

Although much has improved over the years by way of preparing foster youth for emancipation, there is obviously additional work to do in this area.

Summary of This Section

- Being in the foster care system can be difficult for children of all ages. Although life might not have been optimal at home, separation from one's parents has its own trauma. Children experience sadness, hurt, anger, and guilt at separation often wondering if it is their fault. They may feel shame and worry that being a foster child makes them different or abnormal. Above all children feel that they have little control over their lives.
- Children in foster care have conflicting feelings about birth parents. Despite what may seem obvious to adults, children often wonder why they cannot be home with their parents. They feel hurt, abandoned, and often wonder if they are loved.
- Children's feelings toward foster parents can also be conflicted. Some children have been so traumatized that they are unable to bond to any parent. They also have difficulty trusting. Often foster parents must work hard to gain their trust.
- Living in foster care makes children feel different in a world where kids want to fit in with their peers. Older children might recognize the needs for them to be somewhere other than their birth parent's home, but they might still feel resentment.
- When children leave foster care, they are often unprepared for what they will face. As a result, a variety of programs have surfaced that prepare youth for this

emancipation. They are taught a variety of skills that they will need for the future. A recent study found that these programs were somewhat successful although youth felt that they could have used more preparation around going to school and getting jobs.

THE ROLE OF THE FOSTER CARE SOCIAL WORKER

Hubbell (1981) when describing the role of the foster care social worker, suggested that intelligence, fairness, good judgment, empathy, and determination were required. The role requires that one be responsible for the care and safety of foster children while dealing with often angry and bewildered birth parents, anxious foster children, and a variety of demands and irritations from foster parents. This is compounded by a myriad of documentation requirements now mostly accomplished by computer. Despite the increase in technology, the job has not changed substantially.

The foster care social worker enters the child's life during a troubled, volatile period and must assess the situation with understanding and expertise. Often, this worker makes the recommendation that leads to the decision to place a child in foster care. It may be that the foster care worker follows the child through foster care until either the child returns home or is placed for adoption or the worker leaves the unit or the agency. The latter often happens first. Every day, a social worker may witness pain and loss. And every day, the decision that the worker must make alone or in conjunction with his or her supervisor must be covered by an immense paper trail of forms or computer records to document that decision. It is not surprising that workers can feel overwhelmed.

What exactly does a foster care worker's job entail? Two or three types of workers are involved in foster care. The first, usually referred to as a "homefinder" or "family resource specialist," recruits and assesses foster parents (see the previous section on homestudy). Often, homefinders keep in touch with approved parents until they receive children. Sometimes, these workers perform a supportive role to ensure some degree of continuity for the foster parents. The average day for a homefinder might be filled with group meetings with foster parents, home visits, case recording, or supportive counseling with foster parents. Group meetings necessitate much preparation, supervision, and consultation, which also take time.

The foster care caseworker is responsible for case management. Some agencies use their protective services workers to monitor the homes in which they place children. Other agencies use protective services workers to do intake and the placement of children and then transfer the case to a foster care worker for ongoing case management (see Chapter 7). While larger agencies use a variety of workers in various roles, smaller agencies might require a social worker to follow a case from start to finish. Both these models of service have advantages. Although fewer workers may provide more consistency and continuity of services, having multiple workers allows for specialization and fresher, more objective viewpoints.

Caseworkers work with birth parents, foster parents, and foster children. One particularly difficult task is helping children sort out their feelings about the people in their lives. No matter what they have suffered in their natural homes, children have feelings for their parents. The social worker must be skilled in discerning children's feelings and not be judgmental about their ambivalence. Children must know that their parents' problems predated them. They must also be helped to deal with their disappointments when their

hopes of being with their parents are not realized. One social worker stated, "It used to kill me every time we arranged for Jody's mother to visit her. The foster mother would get Jody all ready. I would prepare her emotionally for the visit, and then we'd wait—and wait. Most of the time the mother never came. But we never knew because sometimes she would come full of smiles and gifts and promises. But when she didn't come, I could feel Jody's pain. It hurt her so much that it hurt me, too. So we'd talk about the hurt. No matter how angry I was at her mother, right then I had to remember that Jody loved her and that she was an important part of Jody's life."

Children may also feel torn by divided loyalties—loyalty to the birth parents they love and loyalty to the foster parents with whom they live. It is the worker's role to accept that confusion and help children recognize that there is room for both in their lives.

Leaving a foster home or moving from one home to another can be a traumatic event for which children must be prepared. Not only must the foster care worker logistically arrange for any move, but the children, foster parents, and often birth parents must also be prepared. Each individual must be helped to deal with the impending loss and guided through the grieving process following it. Counseling children becomes more intense around the time of the move, and a social worker involved in several moves at one time can be constantly on call. If the children go to another foster home, the adjustment must be carefully monitored. If they return to their birth parents, supervision may be necessary to ensure that the reunification succeeds. And, of course, every move must be documented by reams of paperwork. Forms authorize the payment of foster parents. Forms keep track of the children through the system. Forms open and close cases. As one social worker put it, "I felt as though I couldn't even breathe unless I did it in triplicate!"

Another important aspect of the role of the foster care worker, which often gets overlooked, is the need to do grief counseling both for birth parents but also for foster parents. Some birth parents are able to admit how difficult it is to lose their children to foster care. Some feel that they have failed as parents, while others blame everyone else for the fact that their children have been taken away. It can be a challenging role to help these parents process their anger, grief, and sadness. As one veteran social worker explained: "As a parent myself, I can really feel the pain that some of these birth parents endure. They love their children and they want to parent them but they cannot get beyond their frailties, be it addiction, mental illness or just being ill prepared and unable to parent. But it still hurts. And it hurts to watch the scenes play out and know that there is little that you can do to help them."

Transitions can also be difficult for foster parents. Losing children to whom one has become attached—to return home, to another foster home, or to an adoptive home—is not easy. In the past, agencies have not always recognized the need for foster parents to process their grief. Yet, an inability to grieve makes for difficulty with the next child and can hasten burnout for foster parents. Social workers now realize that it is important to do visits following children's departure, to help foster parents adjust.

Although not always easy, the job of the foster care case manager can have many rewards. Watching children gain stability and direction for their lives can be energizing. Seeing a child return home because of the effective casework done by the agency gives the worker a sense of accomplishment.

Yvonne Barry Cataldi, a professor in the field of human services, shares her experience of being in foster care:

> I was a young adult, approximately twenty-six years old, when I read my file and learned that I had been placed in foster care when I was three years old. This was quite a surprise to me. I remembered being in elementary school and being in foster

care but nothing younger than that. Unfortunately, I also have no memory of a lot of the experience. I think that many foster children who have been in more than one placement lose pieces of their memories. We often don't know things like what illnesses we had, what schools we went to, whether we were with our siblings or not. We wondered what had really happened to our parents. And little questions made us think. When did we lose the first tooth? Did anyone save it? Did we ever take music lessons or play sports? Were we good at some things? I have no answers to those questions. Most children have the oral tradition of their families to fill in gaps. I did not. I didn't even remember the names of the foster families who had sheltered me. Sometimes I recall faces, but I don't know if those faces had any significance in my life. Most of the time I felt like a "yoyo," repeatedly having to leave home and then come back.

I remember not wanting to go home sometimes and at other times wanting to return to my parents. These feelings often had more to do with the foster family I was with than my parents. When I was with the family who washed my sister's mouth out with soap, I wanted to return home. Often we were expected to be playmates for the foster parents' children even if we didn't like them. We had to adapt to the different ways people did things. I was told that I should feel "at home" when I didn't even know where the bathroom or the kitchen was. Sometimes it wasn't clear to me where I was expected to sleep. It certainly didn't feel like home, and by the time it did, I was returned to my parents once again. No one ever asked me what I wanted. It just happened.

I do recall that the placements I was fondest of were the ones in which I was placed with other foster children, like in group foster homes. I finally felt like I fit in. There were others in the same boat, and I felt that I fared well. The toughest placement was when I was separated from my sister because neither home had two beds available. I felt a tremendous loss being away from her. I was 13 and she was 12, and that was the last time we would ever be together. She died of cancer when she was eighteen years old.

I finally did have a set of foster parents in a group home who are still in my life today. Their acceptance and compassion and understanding gave me a view of what family life really could be. I regarded their son as my "brother." When my mother was again discharged from the hospital, a worker finally asked me if I wanted to return. I said no. I liked where I was.

Even though we did not always live in the same home, my sister and I did have an opportunity to talk about how unstable living with our mother was. When we finally had an opportunity to make some choices about where we lived, we were able to benefit from placement. It allowed us to begin to develop the skills we needed in order to become responsible, productive adults. I know that living with my family was not good for me, but parts of my experience in foster care had negatives, too. Once I had some choice, my view of foster care changed, and I believe that I felt more positive about it.

Summary of This Section

- The role of the foster care social worker requires intelligence, fairness, good judgment, empathy, and determination. This worker is not only responsible for the lives of children but also expected to be skillful in working with both birth parents and foster parents.

- Social workers in foster care may become homefinders responsible for recruiting, screening, and training potential foster parents or placement workers (also referred to as case management) who place and supervise children in foster homes, including coordinating service with birth parents. Some agencies separate these roles, while in other agencies a worker may assume a variety of different duties.
    - Ongoing foster care workers become responsible for helping children; birth parents and foster parents work out the myriad feelings and conflicts they have and work together in the best interests of the children. They must prepare children and parents for transitions from place to place and do grief counseling with both birth and foster parents.

THE FUTURE OF FOSTER CARE

Future trends in the provision of foster care services are influenced largely by the political climate in which those services will be provided.

Political Influences

Policies related to foster care are based primarily on several laws. Passed in 1974, the Child Abuse Prevention and Treatment Act (PL 93-247) changed the provision of services for children who were abused or neglected, influencing how alternative home care was provided for them. This was amended in 2010 to provide more services (see http://www.childwelfare.gov/systemwide/laws_policies/federal/index.cfm?event=federalLegislation.viewLegis&id=142). The Indian Child Welfare Act (PL 95-608) of 1978 mandated that greater attention be given to the placement of Native American children within their own tribe, and only placing them in a foster home of another culture when there was no other alternative. The Adoption Assistance and Child Welfare Act (PL 96-272) of 1980 and the Adoption and Safe Families Act of 1997 emphasized the need to consider permanency planning for all children who come to the attention of the social service system.

The Multiethnic Placement Act of 1994 was amended in 1996 to further promote permanency planning. The amendments loosened the original act's requirements with regard to same-race placements and prohibited racially based placement decisions. Finally, the Independent Living Initiative of 1986 (PL 99-272) and the Foster Care Independence Act of 1999 amended Title IV-E of the Social Security Act in such a way that youths leaving foster care would receive increased attention and support. With each of these laws came significant changes in the way foster care was provided.

In 2008, the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351) amended parts of the Social Security Act, improving outcomes for children in foster care, incentives for adoption, and other provisions (for more information, see http://www.childwelfare.gov/systemwide/laws_policies/federal/index.cfm?event=federalLegislation.viewLegis&id=121).

There is still considerable political debate about the termination of parental rights when abuse or neglect is an issue (see Chapter 7). Some states have streamlined court procedures to free children for permanent placements in a more timely manner. Others have mandated time frames that allow parents only a certain amount of time to rearrange their lives and resume the care of their children. Critics say that change for many of these parents is a long-term goal and the expectation that it can be accomplished in a short period is unrealistic. Others, including many former foster children, argue that the only way for

children to lead healthy lives is to separate them earlier from dysfunctional families and place them in permanent, consistent environments.

Future Directions and Concerns

There has been much scrutiny of the efficacy of the foster care system over the last several decades. From this, several themes have emerged that are worth noting.

Permanency Planning and Family Preservation

At one time, the only apparent options for permanency for a child were family reunification or adoption. Today, alternatives are considered. For example, there is now extensive exploration of the child's extended family as a potential placement alternative. Kinship care, is a viable plan for children whose parents cannot care for them but who can find a home with relatives, godparents, or close family friends. This trend may have gained strength from minority families who are connected with their own culture and extended families and who, in the past, have solved childcare problems within their own familial circle. However, as increased stressors are placed on these families and they begin to look to the dominant culture to solve more of their problems, formalized kinship agreements may become more effective.

The nature of adoption also has changed. In contrast to the closed adoptions of the past, adoptions may now be arranged according to the child's needs. Open adoption, in which the child maintains contact with the birth parents and/or foster parents, provides children with more consistency while still offering permanence. Subsidized adoptions by adoptive or foster parents help fund stable homes for children whose medical or emotional needs, and the financial obligation inherent in meeting these needs, may have formerly precluded their ability to be adopted.

Finally, permanent foster homes or guardianship arrangements make it possible for many children to have more consistency in their lives. Such arrangements might not have been sanctioned in the past, but today there is greater emphasis on children's needs.

Training and Professionalization of Foster Parents

For some time, foster parents have been seen as members of the child's therapeutic team. However, some agencies have merely paid lip service to this concept. As foster parents have developed more of a voice on their own behalf—through such organizations as the National Foster Parent Association—and handling the problems of children entering care has required more skill, foster parents have become more involved in training and areas of therapeutic intervention. Some agencies actually see foster parents as agency employees and treat them as such, but each agency and organization defines the concept of foster parent professionalization differently.

Attention to Special Populations in Foster Care

Over the years, the type of children placed in foster care has changed. As drug addiction becomes more prevalent (see Chapter 4), more children will be placed into care because of their parents' inability to overcome their addiction sufficiently to care for them. Many of these children will be born addicted to substances themselves, and many will live with the aftereffects of their parents' addiction to alcohol or drugs. In addition, an increasing number of children are born to HIV-positive mothers and may be HIV-positive themselves in years to come. The care of children of all of these types requires special knowledge and skills. Currently, most agencies have instituted training for foster parents and staff to help them handle these issues. Agencies will increasingly be called on to find creative solutions

to the provision of services to such children. Not only education, but other support services, such as grief counseling for foster parents who have an AIDS baby die while in their care, are vital to meeting these needs.

The number of fostered youths known to be gay or lesbian also is growing. Increasingly, foster parents and foster care workers need training to understand the complex issues and feelings faced by gay and lesbian youths. A few west-coast agencies provide homes specifically for gay and lesbian young people (Ricketts, 1991; Leve et al., 2009). Although this gives the foster children support and validates their feelings, it does not always insulate them from the prejudice of the larger society. As more youths feel comfortable in identifying themselves as homosexual, agencies will be pressed to respond more to their needs.

More Complex Demands of Foster Care Provision

No longer a relatively simple service provided for dependent children, foster care now demands attention to myriad cultural, community, and family-based issues. The skill of the social worker dealing with foster children must be more finely honed. In addition to being a case manager, counselor, and broker, the worker must be cognizant of the impact of trauma on children and an advocate for both foster children and their caregivers. Their knowledge must be more specialized. For example, it must include knowledge of cultural variations, HIV, trauma, and drug issues. Foster parents, too, cannot be merely caregivers but must be able to deal with the complexity of the children who come into their care. Not only must they have skills that help them to address the behavioral problems that many foster children exhibit, but they also must be educated about the trauma that may be the etiology of these problems. Increased attention is also being given to how to build resiliency in the children who are served (Leve et al., 2009; Braxton and Krajewski-Jaime, 2011).

Managed-care regulations also affect the provision of foster care. Funding is dependent on meeting specific criteria; those providing care must be able to meet children's needs while remaining within the guidelines set down by outside funding sources. This is not always easy.

Inherent in the changes in the provision of foster care is the necessity to ensure that the care given to dependent children is of high quality. It will be increasingly necessary to consider the child's best interests. It is not enough to give children shelter, food, a place to call home—albeit temporarily—and often a respite from abuse and neglect. Children need a feeling of safety, a sense of belonging, and attention to the development of positive self-concepts. Ultimately, children need to be helped to heal in ways that will foster wholeness (Braxton and Krajewski-Jaime, 2011). Although such assistance as protecting children from maltreatment in care, ensuring effective services for reunification, and terminating parental rights when necessary will provide a more therapeutic environment for foster children, there is a need to look at the finer points of what helps an individual grow and become a contributing member of society.

Increased Attention to Aging Out

Although foster care is designed to be a short-term childcare solution, more and more youths are turning 18 while still in care and "aging out" of the system. An estimated 23,090 youth aged out of care in 2013 (AFCARS, 2014). Although there have been advances in preparing young people for emancipation from foster care, more attention to this is needed. More attention must be given to preparing these youths for employment or schooling and for being on their own. Such questions as where they will live, how they

will support themselves, how they will obtain health services, and how they might access higher education must be addressed. Although some programs are in place, these must be expanded and intensified (Jones, 2014).

For many children, family foster care is a necessity. Although some people feel that a return to the concept of orphanages would better serve children, research indicates that a family environment, if healthy and sensitive to a child's needs, benefits dependent children more than an institutional environment. Our challenge as practitioners is to create the healthy environments that can most effectively help children become functioning adults.

Summary of This Section

- Several pieces of legislation have influenced the provision of foster care including the Child Abuse Prevention and Treatment Act (PL 93-247), The Indian Child Welfare Act (PL 95-608), the Adoption Assistance and Child Welfare Act (PL 96-272), the Adoption and Safe Families Act of 1997, the Multiethnic Placement Act of 1994, the Independent Living Initiative of 1986 (PL 99-272), the Foster Care Independence Act of 1999, and the Fostering Connections to Success and Increasing Adoptions Act (PL 110-351).
- Over the last few decades, there has been an emphasis on permanency planning for children care while at the same time, there has been increased emphasis on preserving families.
- There is increased recognition of the need to make training available for foster parents so that they are able to address the complex needs of the children in foster care today.
- Foster care in the future must take into consideration the needs of special populations (e.g., children who are HIV-positive, LGBT youths) and address the therapeutic needs of today's foster children.
- Services for youth who are aging out of foster care continue to evolve. Research indicates that increased attention should be given to preparing youth for higher education and in employment skills.

SUMMARY

- Foster care had its beginnings in response to reformers who felt that children should be in a home setting rather than in almshouses with their parents or orphanages. One of the early efforts to secure home was Charles Loring Brace's placing out or sending children on "orphan trains" to homes in the Midwest. Early foster homes were not paid but often expected that the children would help on the farms or around the house. Foster care evolved over the years, often reformed by various legislation. In 2014, there were approximately 415,129 children in the foster care system, some in non-related family foster homes and others in kinship care with relatives. Foster homes may be used for emergency situations or for longer term placement. Some are equipped to address the needs of special populations. Children enter foster care due to parental incapacity, death, or abandonment.
- Foster parents are recruited, screened, and trained by specific agencies to provide homes for children who need substitute care. The most effective

recruitment is through other foster parents who can attest to the realities of the role. During training, foster parents learn what is expected of their role, including helping them to address the trauma that most children in foster care have endured. Once children are place in a foster home, the case is supervised by a foster care worker who works with the foster parents to meet the children's needs. Children bring with them a variety of behavioral and emotional issues that must be addressed in foster care. In addition, foster parents must also work with the birth parents in the children's lives. These birth parents have their own set of issues, often feeling guilt, resentment, anger, or sadness over the fact that their children are in foster care. Some foster homes today are kinship homes or relatives or godparents who care for specific children. Although keeping children with people who they may know can be a distinct benefit, there can also be conflicts that social agencies must address.

- Children come to foster care with conflicting feelings that are often played out during their placements. Separation from birth parents, no matter how dysfunctional the home, can be difficult for children. Then they are asked to adjust to a new family who they may never have met before placement. Children have a variety of feeling about both their birth parents and often the foster parents. They may also feel that being in foster care makes them different from their peers and these feelings may also reflect in their behaviors. Over the last few decades, there has been more emphasis on preparing youth to age out of foster care, but some critics believe that even more can be done in the area of educational and employment skills.
- The role of foster care social worker has a myriad of challenges. Some workers—referred to as homefinders or family resource workers—recruit, screen, and train foster parents, while other workers (placement workers or case managers) are responsible for placing foster children and supervising the homes. Some agencies combine these roles. These workers must work with foster parents, the children in care, and often the birth parents, all in the best interests of the children.
- Foster care has changed over the ears partly in response to various piece of legislation designed to improve child welfare services. Emphasis for the future will be on continued attention to finding children a permanent home as soon as possible, helping them in the process of aging out of foster care, addressing the special populations of children in care, and attending to the needs of foster children especially in the area of addressing trauma.



12

The Adoption of Children

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Describe how adoption had changed throughout history from ancient times until today, explaining how it is currently defined.
- Discuss some of the issues inherent in adoption today.
- Discuss the roles and some of the feelings experienced by those in the adoption triad: birth parents, children, and adoptive parents.
- Explain the adoption process, including how adoptive parents are screened and prepared through the placement and follow-up, and also explain the role of the adoption worker.
- Discuss why an adopted child might search for birth parents and what this might entail.

Adoption has long been a method of providing children with legal and emotional security. Through adoption, children find permanency and parents can nurture or increase their families. Adoptive parents provide substitute, societally sanctioned, long-term care when birth parents have been unable to fulfill their roles. Through adoption a new family is created—hopefully, one that can meet the needs of everyone involved. Yet, adoption is not an event but a lifelong process.

CHAPTER OUTLINE

THE EVOLUTION OF ADOPTION 298
Definitions and Assumptions 300
ISSUES AND CHANGES IN ADOPTION TODAY 304
Decreased Number of Adoptable Children 304
Changes in Types of Children Available for Adoption 305
Controversy over Agency-Assisted Versus Independent Adoptions 306
Access to Information and Openness in Adoption 308
Transracial Adoption: Domestic and International 310
Adoption Disruptions and the Need for Follow-Up 313
ADOPTIVE PARTICIPANTS 315
Birth Parents 315
Children Available for Adoption 318
Adoptive Applicants 321
THE ADOPTIVE PROCESS 324
The Homestudy 325
Placement and Legalization 326
Postlegalization Services 327
Adoption Disruption 329
The Role of the Adoption Worker 330

THE SEARCH AND LIFELONG SERVICES 331
Supporters of the Search 331
Who Searches 332
Search Outcome 332
Sealed Records 333
Consent Contracts 333
Lifelong Services 333
SUMMARY 334

THE EVOLUTION OF ADOPTION

Adoption has not always been designed to meet the needs of *all* participants. Originally the practice was a method of meeting the needs of adoptive parents. Reasons for adopting children have included desires to continue the family line or trade (especially through male heirs), provide for ancestor worship, ensure additional workers, maintain family wealth, provide a solution to out-of-wedlock pregnancies, and provide homes for homeless children.

Perhaps one of the best-known adoption stories is that of Moses, whom Pharaoh's daughter found in the bulrushes. Being childless and knowing that Moses was a Hebrew child whose future was in jeopardy, she adopted him as her own son, thereby ensuring his survival and (she thought) his future. Documentation supporting adoption can be found as early as 2285 BC in the Babylonian Code of Hammurabi (Carp, 1998, 2005).

Early Rome, Greece, and Egypt had formal adoption requirements. The primary motivation was to ensure male heirs. Female children were ineligible for placement, and only men could adopt. A judicial hearing sealed the transaction (Howe, 1983). India and China used adoption as a formal method of providing male heirs. For Hindu men, a male child met the demands of religious ceremonials. Chinese families expected an heir to provide for the parents in their old age. In other early cultures, the adoption of children was more informally arranged.

European countries developed adoption practices based primarily on Roman law. In France, the Napoleonic Code most closely resembled Roman practices. England, a country with traditions based on blood lineage, found it more difficult to espouse adoption. A family that wanted to adopt required a special act of Parliament. Only then could the adoptee be considered a legal heir. It was not until 1926 that England passed a statute that made adoption a viable option for any family (Smith and Miroff, 1987; Carp, 1998, 2005).

Much legislation in the early United States was based on English common law. Because adoption was unknown in England, the new states were forced to devise their own standards; each did so in its own way. There is some controversy regarding which state enacted the first statute. Whether we believe sources that cite this forerunner as Mississippi in 1846, Texas in 1850 (Cole and Donley, 1990), or Massachusetts in 1851 (Carp, 1998, 2005; Herman, 2008), the Massachusetts statute was the closest to current philosophies in that it provided for the "best interests of the child." The four components of the law that have remained to the present require that

- There be written consent by the child's biological parent;
- Both the adoptive mother and father join in the petition;
- A judge must decree that the adoption is "fit and proper";
- There be legal and complete severance of the relationship between biological parents and the child (Kadushin and Martin, 1988).

By 1929, all U.S. states had enacted some type of adoption legislation. Prior to this time, state legislatures adopted legislation as individual cases came to their attention. As more procedures became formalized, standardization of adoption practice seemed imminent. Yet, in the late nineteenth century, states still interpreted their laws differently. For example, all that federal law required was legal transfer of the child from the biological to the adoptive parents and a judge's pronouncement that all was "fit and proper." This did not protect children from abusive adoptive situations. Some states began to look more closely

at adoptive applicants. Finally, in 1891, Michigan instituted a requirement that the judge investigate the adoptive home before finalizing the adoption. Later, agencies took over this task. A 1917 Minnesota law requiring detailed investigation by a social agency was copied in numerous other states by the late 1930s (Carp, 2005).

Where were the children while politicians and lawmakers were debating their fate? During the nineteenth and early twentieth centuries, most homeless children resided in orphanages. Some had been placed there by their unwed mothers or poor parents; others had been orphaned by death; and some had parents whose substance abuse, poverty, or other problems prevented them from parenting. Some were destined to grow up in orphanages; others (perhaps the younger and more appealing) would find themselves placed with adoptive parents.

"Orphan trains" (mentioned in Chapter 11) were also responsible for some adoptions. Although Charles Loring Brace's initial idea appeared to be to provide permanency for homeless children of all ages, some of the children sent to families in the Midwest eventually were legally adopted. By 1859, nearly 5,000 children had been placed "out West" (in both foster care and adoption), and 24,000 had found homes nationwide (Brace, 1872).

Finally, in the early twentieth century, more emphasis was being placed on the "best interests of the child." In 1917, Minnesota was the first state to mandate the sealing of birth records (Jasper, 2008). Agencies began to assess adoptive couples more rigorously. In 1938, the Child Welfare League of America (CWLA) published the first set of standards for adoption practice. But adoption did not become a popular form of substitute care until the end of World War II, when homeless children were more visibly plentiful. The upsurge in the demand for children caused agencies to further reassess and redesign their policies.

By the 1950s, the demand for healthy white infants outweighed their availability. African American and mixed-race infants were available, but usually only African American couples were considered as adoptive parents for such children. The numbers of African American couples seeking to adopt from agencies was small, so agencies began to look at other types of adoptive arrangements: interracial and international (Simon and Altstein, 2000).

In order to find suitable homes for all children, in 1958 Ohio developed an **adoption resource exchange** that pooled statewide resources in search of homes. Other states followed. In 1967, CWLA established the Adoption Resource Exchange of North America (Pecora et al., 2000).

The 1960s and 1970s saw a significant shift in the adoption picture. Agencies recognized that children who had once been considered unadoptable might also be placed. "Special needs" adoptions—defined as those involving older, African American, or disabled children—began to be seen as possibilities. For the first time, single parents were considered for "hard-to-place" children. Agencies began assessing couples in groups rather than just individually.

But as the adoption picture became more complex, more controversies arose. In 1972, the National Association of Black Social Workers (NABSW) asserted that **transracial placement** was "a threat to the preservation of the black family" (Pecora et al., 2000). They asked why more was not being done to place these children within the African American community. Agencies were criticized by the NABSW for using white middle-class standards in their recruitment and assessment of minority adoptive applicants.

At the same time, researchers and reformers of the childcare system found that children—many of whom were legally free for adoption (or could be after minimal work with their families)—were living in temporary foster care when they could have been given the permanency of adoption (Gruber, 1973). Foster families who were providing good, stimulating environments for children questioned why they could not

adopt them. Although adoption by foster parents had been discouraged in the past, in 1973 CWLA recognized the acceptability of this practice if the child's needs would be best served.

Amid the controversy over the placement of African American children in white homes, the Native American community began to question outside placement of its children. Largely in response to the fact that 25–35 percent of Native American children were being placed in substitute care (foster care and adoption), the Indian Child Welfare Act of 1978 (PL 95-608) was passed. This legislation mandated that Native American children be kept within their community whenever possible, to maintain their connections with their tribes (Hollingsworth, 1998; Cohen, 2000).

The numerous debates and controversies made it clear to child welfare advocates that more standardization of adoption practice was necessary. The 1980 passage of PL 96-272 was a milestone in substitute care history. This law mandated state adoption programs and provided federal matching monies for subsidized adoption. Adoption subsidy meant that families who were interested in adopting children with special needs, but were financially unable to do so, would be provided with funds to supplement the child's care. These payments could not exceed the amount that would be given to a foster family for the same child. To guide states in developing their own laws to govern subsidy payments, the federal government published the Model Act for the Adoption of Children with Special Needs (Kadushin and Martin, 1988).

PL 96-272, the Federal Adoption Assistance and Child Welfare Act of 1980, urged agencies to prioritize "permanency planning" for every child. Agencies were encouraged to first strengthen the child's biological family. If this was not possible, agencies should place the child in an immediate long-term or permanent nurturing situation with caring adults—usually an adoptive home. In 1997, the Adoption and Safe Families Act provided more impetus to the move to provide children with permanent homes as quickly as was feasible. Although the intent of these laws was to benefit children, agencies argue that they do not always have the funds or resources to adhere to them.

Today, adoption agencies provide services for older children and children with special needs in greater numbers than infants.

Definitions and Assumptions

The purpose of adoption is to provide a permanent home for a child whose biological parents are unable or unwilling to provide that home. Today we assume that, although the needs of the adoptive family are important, the adoption is primarily to provide a home for a child.

Adoption is a legally sanctioned arrangement. CWLA describes this legal agreement as "the method provided by law to establish the legal relationship of parent and child between persons who are not related by birth" (Child Welfare League of America, 1978, 11). It is in this legality that adoption differs from foster care. Whereas foster care is seen as a temporary living arrangement, adoption substitutes adoptive parents for biological parents, giving them all the rights and privileges of biological parents.

Adoption is based on several assumptions or values:

1. A child has a right to grow up in the safe, nurturing environment of a family.
2. If the child's biological family cannot meet his or her needs, the child has the right to a substitute family.
3. Adoption is the preferred type of substitute care because it provides legal sanction and permanency of the relationship.

4. Children should be placed for adoption as early as possible in order to provide maximum consistency.
5. Adoption is expected to be a lifelong experience for all the participants.
6. Adopted children are entitled to information about their birth, their biological family, their genetic information, placements, and particulars of their adoption (Herman, 2008).

Adoptions may be divided into two types: related and unrelated. In **related adoptions**, the child has a pre-existing blood tie to some member of his or her adoptive family. For example, a stepfather might adopt his wife's child, or a couple might adopt the child of their unmarried son or daughter. Or, in more recently recognized **kinship adoptions**, relatives of the birth parents may opt to care for and adopt a child. Another recognized form of related adoption is surrogate mothering. The term **surrogate mothering**, coined by Michigan attorney Noel Keane, refers to the agreement between a couple and a surrogate mother. The mother agrees, for a fee, to be artificially inseminated with the adoptive father's sperm, to carry the baby, and then to relinquish the child to the sperm donor and his wife. Usually this couple then legally adopts the child (Shanley, 2002; Markens, 2007). Although this practice seems relatively new, it has been practiced since ancient times. Surrogate mothering appeared to be gaining momentum until two legal landmarks brought the practice under scrutiny. In 1988, Michigan, concerned that surrogate mothers might use this practice as a lucrative business, passed a law that limits the amount of money surrogates can receive. Further, the controversy and court battle over "Baby M" may have changed sentiments. Baby M's biological mother, Mary Beth Whitehead-Gould, was impregnated by the sperm of William Stern and agreed that, once the child was born, she would relinquish him or her to the Sterns. However, after the birth, Whitehead-Gould decided that she wanted to keep the child. The result was the ***Stern v. Whitehead-Gould***, which received much media coverage and gave rise to 70 bills, in 27 state legislatures, seeking to ban, regulate, or undertake research on surrogate parenting (Carp, 1998; Ehrensaft, 2005).

Unrelated adoptions usually come to mind when the word "adoption" arises. In this type of adoption, the child has no blood relation to the adoptive family. Most such adoptions are agency-sponsored; the agency counsels and contracts with the biological parents or the court to place the child, recruits and assesses the adoptive couple, places the child, and provides follow-up until or after the adoption is legalized.

In 2014, approximately 415,129 children were in foster care, but only 107,198 were waiting for adoption (Children's Bureau, 2015). Not all children who are slated for adoption have been released legally. For this reason, agencies sometimes sponsor **legal-risk adoptions**. In these arrangements, the agency has already petitioned the court to terminate the biological parents' rights. The expectation is that the court will agree to termination and the child will be legally free for adoption. In the meantime, instead of placing the child in yet another foster home, the agency places the child with the family that hopes to legally adopt him or her. Because the courts usually take considerable time to process the termination of parental rights, this arrangement seems to be in the child's best interests. However, a problem arises when the biological parents contest the termination of their rights. In addition, adoptive couples often feel insecure until they know the child is legally free.

Another type of adoption that is fairly recent is special-needs adoption. Children who might be difficult to place are placed with families who have been assessed especially for them.

Case Example Walter

Walter was a 2-year-old boy with Down syndrome. When it became necessary to move him from the foster home where he had been from birth, the agency decided to place him in an adoptive home. The Brandts had had their children when they were young; now these children were grown and married. Mrs. Brandt, a teacher, and Mr. Brandt, a nurse, felt they could give love and a home to a special kind of child. The agency studied them for a special-needs child and eventually placed Walter with them. The match was a good one. Until Walter's death 10 years later, the family provided consistency and love.

Children with disabilities and older children are being placed with increasing frequency. Sometimes the placement of special-needs children requires **subsidized adoption** (discussed earlier). Parents interested in adopting a child whose care necessitates costs beyond those usually expected in raising a child receive a subsidy to defer the extra expense. Thus, children who require expensive medication, medical procedures, or therapeutic services can still benefit from an adoptive home.

Single-parent adoptions, which gained popularity in the 1960s and 1970s, are still in vogue today. In fact, 29 percent of the adoptions in 2014 were by single parents—26 percent by single women and 3 percent by single men (Children's Bureau, 2015). The assumption is that although most children should have the opportunity for a two-parent home, some children are better suited to a single-parent family. For example, if a child has been severely abused by most of the men in her life, she is likely to be distrustful of men and unable to bond with them. Therefore, the agency would seek a placement for this child with a mother in a fatherless home. Often, teenagers do better in a one-parent family than a two-parent one. Some children require a parent's undivided attention, leaving this person little energy with which to maintain a healthy marital relationship.

When children of one race are placed with parents of another, the adoption is referred to as transracial or interracial. Adoptive parents involved in these placements are guided in aiding children to understand and accept their own racial backgrounds. Most often, children of African American or mixed parentage are adopted by white families, although this practice continues to be controversial (see Simon and Roorda, 2000; Rothman, 2005; Quiroz, 2007). At one time, Native American children also were placed in the homes of white parents. The Indian Child Welfare Act of 1978 reserved the right of determining where a Native American child would be placed, with the hope of placing him or her in a family of the tribe in which the biological parent was registered. If this is not possible, Tribal governments at least try to place Native American children within their own culture before considering other alternatives.

International adoptions are those in which children are brought from other countries and placed with adoptive couples in the United States. **The Holt Agency**, founded in 1956 by Harry and Bertha Holt of Eugene, Oregon, to aid children of the Korean War, is responsible for most international adoptions. Originally the agency brought over Korean War "orphans" whose mothers were the Korean wives, lovers, prostitutes, or rape victims of U.S. servicemen. Later, Vietnamese children joined the ranks of children needing permanent homes (Holt International, 2016).

According to a recent study out of the Donaldson Adoption Institute, the nature of international, now termed intercountry adoption (ICA), has changed considerably. At the peak on ICAs in 2004, there were approximately 23,000 adoptions from abroad while more recently this figure has dropped to approximately 9,000. This fact is due not only to changing international relations but also to the fact that the cost of such an adoption can now be as much as $50,000 (Pinderhughes et al., 2013).

Independent adoption (also known as targeted or designated adoption) is the placement of children with parents unrelated to them without going through an agency. Gibbs (2000) refers to such adoption as parent-identified (as opposed to agency-assisted). Generally, independent adoptions fall into three categories:

- **Direct placement**, in which the biological mother gives the child to someone she knows.
- **Intermediate placement**, which is not for profit and in which an intermediary, usually well-intentioned, arranges for the birth mother to give her child to a couple or single individual. No money is exchanged, except that the adoptive parent or parents pay the birth mother's medical expenses. The birth mother may or may not know the adoptive parties. Such adoption is often referred to as **gray market adoption**.
- **Intermediate placement for profit**, in which the adopting parties pay an intermediary to arrange for the birth mother to give them her baby. This is often seen as "selling" babies and is referred to as **black market adoption**. Such placements are illegal in most states (Schwartz, 2006; Downs et al., 2008).

Even when adoptions are arranged independently, an agency may become involved. In many states, adoption cannot be legalized until an agency undertakes an adoptive homestudy.

Summary of This Section

- Adoption originated as an arrangement for the benefit of the adoptive parents, whether for an heir, or for help with labor.
- By the 1800s there were laws promoting standards for adoption. It was required that there be written consent from the birth parents, that both adoptive parents would join in a petition to adopt, that a judge must deem the arrangement "fit and proper" and that the relationship between the birth parents and the child be severed. By 1929 all states had some type of adoption legislation although these differed in their requirements.
- One early effort to secure home for dependent children were the orphan trains that transported children from New York to the Midwest to be adopted or fostered by families.
- By the twentieth century, more emphasis began to be placed on the "best interests of the child" and what he or she needed in an adoptive home.
- Ohio was the first state (in 1958) to develop an adoption resource exchange that pooled the resources of agencies across the state, or nation to find appropriate homes for children and children for waiting adoptive parents.
- While initially it was predominantly healthy white infants who were placed for adoption, the 1960s and 1970s saw more attention given to children who had special needs. In addition, transracial adoptions came into vogue creating controversy in African American and Native American circles.
- The Federal Adoption Assistance and Child Welfare Act of 1980, urged agencies to prioritize "permanency planning" for every child while at the same time social agencies sought to put resources into strengthening birth family homes.
- Adoption is defined as a legal arrangement that establishes relationship between a child and unrelated adults, although children can also be adopted by relatives. Adoption is favored as an arrangement for children in that it is permanent, and gives the child stability to grow and develop.

- There are a variety of types of adoptions, including unrelated adoptions (by those not blood relatives of the child), legal-risk adoptions when a child is placed in an adoptive home with the assumption that he or she will soon be released for adoption by the birth parents or through the courts, single-parent adoption (by one single adult), kinship adoptions when a child is adopted by a relative, and independent adoptions when the birth parent or a third party places a child rather than an adoption agency. Adoption may also be international where a child from outside the United States is places with parents who reside in the United States.

ISSUES AND CHANGES IN ADOPTION TODAY

The nature and world of adoption has changed markedly over the last few decades especially related to the number and type of children available for adoption. There also continues to be controversy over agency-sponsored adoptions versus independently arranged adoptions. The access to information in adoption cases and openness in adoption has also changed as have transracial adoptions, both domestic and International. Child advocates also express concern over adoption disruption and the need for follow up.

Decreased Number of Adoptable Children

In the early 1980s, there were an estimated 104,088 adoptions in the United States (National Committee for Adoption, 1989). Of these, 52,931 (about 51%) were adoptions of children by family members (related adoptions). These family members may have been stepfathers, grandparents, uncles and aunts, or other concerned relatives. Unrelated adoptions (placements of children with families unrelated and usually unknown to them) totaled 51,157 (about 49%). Adoption reached an all-time high in 1970 with 175,000 adoptions. The adoption rate has fallen since 1970. According to the Children's Bureau (2015), an estimated 50,644 children were adopted in 2014. The highest percentage of these children (14%) were around 2 years of age, but a significant percent (29%) were between 3 and 5 years. Only 2 percent were under a year old with the mean age of all children adopted in 2014 as 6.2 years (Children's Bureau, 2015).

What accounts for the decline in adoption rates since 1970, especially among children under a year? Researchers attribute it to several factors. First, increased acceptance of abortion, the availability of birth control, and the laws regarding abortion and birth control have influenced the numbers of children being born. Second, although teen pregnancy has gained attention in recent years, more teens are keeping their babies. Increased societal acceptance of single parenthood may be playing a role. At one time a pregnant adolescent was forced to leave school; this is no longer the case. Also, birth fathers are expected to be more involved in the adoption and decision making process. A father's protestations over a mother's decision to place her child for adoption may cause a teen to keep her baby, either out of concern for the father or because fighting him with regard to her adoption decision would be too complex or overwhelming.

For teens the adoption story does not end when their child is an infant. Often, teenage parents release their children at a later time, when they find their care too great a task. Unfortunately, by this time the children often have been abused or neglected or have developed other problems.

African American teen mothers often do not place their children for adoption for cultural reasons. A high percentage of children born to these teens live in their mother's family of origin (often in a kinship placement). Hispanic and Asian women, too, may place their babies with extended family members (Herman, 2008).

Changes in Types of Children Available for Adoption

At one time, healthy white infants were the most adopted and adoptable children. Today, few such children are available for adoption. According to the Children's Bureau (2015), 19 percent of the children adopted through public agencies in 2014 were African American; 22 percent were Hispanic, and only 48 percent were white. None were Asian. Native Americans comprised 1 percent with 9 percent designated as multiple race or race unknown. Of these children, 2 percent were under 1 year old, 55 percent were 1–5 years old, 27 percent were 6–10 years old, 14 percent were 11–15 years old, and 3 percent were 16–18 years old. Older and minority children are most in need of homes, but not all applicants are able to parent such children.

Today, many children do not become available for adoption until they are older, perhaps because of greater emphasis on family preservation or increased services for unwed parents There are additional difficulties that confront adoptive parents of older children often because these children suffer residual effects of abuse and neglect. Many are attachment disordered and have difficulty forming relationships (see also Levy and Orlans, 2014). A significant number, old enough at the time of separation to remember their parents, never properly complete their grieving process. Many of the children who are adopted beyond infancy have experienced some type of trauma. All of these factors can lead to additional behavioral or psychiatric difficulties and the need for more intense services for the child and the adoptive family. In addition, many children—both old and young—available for adoption have some type of mental or physical special need.

Some couples' hesitation in adopting older or special-needs children may be related to their inability to accept their infertility. Studies indicate a correlation between a couple's comfort level with their infertility and their willingness to adopt. Infertility is as much of a loss as a death in the family for some couples, yet they have never been helped to grieve. For them adoption may be an unhealthy substitute (Helwig and Ruthven, 1990). These couples want to parent an infant to whom they have given birth. As couples marry later and delay child bearing, their fertility may decrease.

Case Example Margie

Margie, a white, 43-year-old social worker, and her husband finally concluded that the only recourse for their infertility was adoption. They approached several agencies about adopting an infant; as they had expected, they were told that the wait could be 5–8 years. "They offered us special-needs children, but I wasn't ready for that," Margie admitted. "I work with abuse and neglect all day long and have for years. I've seen children maimed and their emotional growth retarded. After working with it all day long, I just couldn't cope with it at home."

Some couples believe that they are able to cope with special-needs children, but after the adoption goes through, they find the situation more difficult than they imagined. One such parent says, "People must really know what they're getting into—the doctors' visits, the bills, the attitudes of other people." Agencies are now beginning to better prepare adoptive parents for special-needs children.

Increasingly, the possibility of adoption for teens is being explored. At one time, teens who had been in foster care for years were expected to remain there until they aged out of the system and lived independently. But this does not give these young people a sense of belonging to a family. Advocates for teen adoption argue that it is never too late to join a family. If all parties recognize the issues involved and the adoption agencies provide ongoing postplacement support, adoption of teens can be successful.

Controversy over Agency-Assisted Versus Independent Adoptions

Each year, numerous couples and single adults seek to adopt children without going through a public or private agency. Whether an intermediary is involved or the mother places with the couple, there are numerous risks to all parties. Why, then, do people seek out independent adoptions?

Currently, agencies are telling couples either that they are not taking applications for healthy infants and young children or that the waiting period will be 5–8 years. Frustrated over what they consider an unreasonable waiting period, some of those seeking to adopt look for alternatives. The Uniform Adoption Act was proposed in 1994 to ensure that all adoptive applicants be required to participate in an agency-sponsored homestudy. With support from only a handful of agencies, the act was never passed.

Today, the Internet facilitates connections between waiting parents and those surrendering babies. Several websites provide profiles of interested parents along with appeals to mothers who are seeking to place their children for adoption. Roby and White (2010) contend that there must be more regulation in Internet-based adoption activities, which can be opportunities for fraud and exploitation. Despite the promise of a shorter waiting period when couples are in contact with birth parents either independently or through an intermediary, there are concerns about non-agency-sponsored adoptions.

Rights of the Child

Independent placements do not protect the child's right to the best possible home. Because the only eligibility criterion is that the couple can provide the necessary fee, there is no guarantee that they will be suitable parents. Granted, undergoing an agency homestudy does not guarantee that the parents will be ideal, but agencies put their years of experience into their decision to approve or not approve an adoptive couple.

Today, agency homestudies not only assess the applicant's readiness to parent through adoption but they also provide valuable information and education for potential adoptive parents. The intensity of today's homestudies also helps parents sort out their feelings about whether adoption is, in fact, for them. After participating in the homestudy, some applicants realize that adoption does not suit their particular needs. The time involved in the study and in waiting for the child, which every potential adoptive parent hates to consider, can actually contribute to the adoption's success. One adoptive mother recounts:

> Sam and I knew when we were married at age twenty-two that I'd never be able to conceive. So shortly after we were married, we approached agencies to adopt. What an eye opener! We had no idea it could take so long—up to six years, they told us. We tried to find an independent adoption. We found a doctor who would arrange it for us. He knew a teenager who was due in two months. A week before the baby

was due, I panicked. Suddenly I realized it was too soon. We hadn't even been married a year. We'd had no time to gel as a couple, so I backed out. Sam was really angry. It actually drove us to counseling. Then we reapplied to the adoption agency. They had us complete a ten-week homestudy with four other couples. At those meetings we looked at a lot of stuff I'd never considered—like how we would discipline. Sam and I totally disagreed. More negotiations followed. We learned a lot about our differences as well as our similarities. After a series of home visits, we were approved. Then came the waiting. It seemed an eternity. But three years to the date that we applied, they called us about a baby girl. After I took the call, I just sat there and thought, "Yes, now I'm ready."



Ethical and Professional Behavior

Behavior: *Use reflection and self-regulation to manage personal values and maintain professionalism in practice situations.*

Critical Thinking Question: A friend comes to you saying that she wants to adopt an infant. She has heard that agencies like the one in which you are employed has a waiting list of up to 8 years for a healthy infant. She wonders if there is any way around that waiting period. If not, she asks your advice about looking for an independent adoption. How would you respond to her request for advice?

No Follow-Up Services

In addition to receiving no education about adoption, parents who adopt independently receive no follow-up services. There is no supportive social worker to answer their questions, suggest resources, or provide referrals. Increasingly, researchers are citing agency follow-up as one of the most significant contributions to a successful adoption experience.

No Assurance of Confidentiality

Couples who adopt independently have little or no assurance that particulars about the adoption will be kept confidential. Neither intermediaries nor natural parents are necessarily bound to keep what is told to them confidential. In addition, biological parents may be given the name and address of adoptive parents and may in some cases feel justified in seeking them out. One couple recounts:

> We adopted through an attorney. He told us the mother didn't want to have any contact with us. She didn't want our name and didn't want us to have hers. But a year later I was at the laundromat and overheard two women talking. One said, in conversation, "My niece had a baby a year ago and gave it to a foster couple over on Chestnut. I told her she should go look them up." That was us! I whisked my son out of there quickly and went home. I was petrified. Would the mother come? Would she want Aaron back? I was also extremely angry with the attorney who had arranged the adoption. He would have been the only one who could have told. Who else had he told?

Biological parents may agree to, or seek out, independent arrangements because they are reluctant to face the red tape and perceived impersonal treatment involved when dealing with an agency. They may also feel that they have more control over the people with whom their child will be placed. Yet, their right to confidentiality may be unprotected. Even though there is more openness in agency-sponsored adoptions today, adoptive parents have the agency to mediate if need be. On the other hand, when adoptions are done independent of agencies, the third party who arranges the adoption may feel no obligation once the adoption is completed nor might this individual be trained to deal with psychological issues.

This biological mother who gave up her child through her doctor recounts her experiences:

> [The doctor] must have given the couple my name and address. I hadn't wanted that. The couple paid some of my medical bills and they felt I owed them.

> They'd call up around holidays and tell me that the baby needed this or that. Hey, I was working two jobs just to get by. They sent some pictures, which was a nice thing to do, but it made it hurt more. I just wanted to forget. I'd done what I thought was best. Then I got involved with someone and before I could tell him about the baby, they did. He answered the phone one day when he was at my apartment, and they told him my daughter needed something. I was really angry and hurt.

Insufficient Information About the Child

Experience has taught agencies that place children for adoption that honesty ensures the best placements. When adoptive couples are told as much as possible about a child they are offered, they are more likely to be comfortable with their choice. Agencies give couples the right to refuse a particular child if that child does not seem right for them. In contrast, in an independent placement couples are often told little about the child. In addition, they may fear that if they refuse a child offered to them, another will not be available.

Legal Aspects of Adoption Are Not as Clear-Cut

Agencies that place children for adoption either ensure that these children are legally free or inform the adoptive parents that this is a "legal-risk" adoption—that is, the biological parents have not yet legally surrendered the child or the court has not yet terminated their parental rights. In independent adoptions, the situation is not always as clear-cut. If a biological mother places her child in an adoptive home, she may have never legally surrendered her rights. If a couple is not aware of the necessary legal procedures, they may not realize this. Thus, at any point the child's mother could reclaim her child. If an intermediary is involved, there still is no guarantee that the adoption is free of legal risk.

No Counseling for Biological Mother or Adoptive Couple

Agencies recognize that the decision to place one's child for adoption is not made lightly. Birth mothers often require counseling to sort out their feelings and feel comfortable with their decision. Mothers who place their own children independently or through a third party and not an agency usually have not had professional help with their decisions. This lack of professional support often leaves the mother in conflict and makes it more difficult for her to get on with her life. Adoptive couples also may need support and counseling. The adjustments that come with new parenthood can be great. When an agency is not involved, this help is not readily available. Recognizing that independent adoption is not agency-sanctioned, couples may also be reluctant to seek out counseling from an agency.

No Protection in Adoption Disruption

When an agency places a child and, for whatever reasons, the placement is not successful, the agency will find another home for the child and provide counseling for the child and adoptive parents. Without agency involvement, the disrupted adoption becomes more problematic. Where does the child go if he or she cannot remain with the adoptive couple? Who will help the child and the parents cope with the loss and feelings of failure? Currently, most states discourage or prohibit independent adoptions. However, in many instances the penalties for violations are minimal.

Access to Information and Openness in Adoption

At one time, adoption was carried out under a veil of secrecy, yet numerous changes have taken place over the last decade. Confidentiality with regard to the past is no longer the norm. **Openness** refers to the amount of contact between the parties involved, especially the birth and adoptive parents. There is a continuum of openness from the closed, confidential arrangements of the past to totally free interaction between birth parents and the adoptive family (Grotevant and McRoy, 1998; Hicks, 2007). There had been little research to guide agencies in deciding where their policies will fall along the openness continuum. In the late 1990s, to gain more insight, Grotevant and McRoy (1998) assessed the feelings and experiences, with regard to adoption openness, of 720 participants recruited from 35 adoption agencies throughout the United States. The sample included 190 adoptive mothers, 190 adoptive fathers, 171 adoptive children (ages 4–12 at the time of the interview), and 169 birth mothers. The researchers concluded that many fears about openness were unfounded. Children did not have a more difficult time with divided loyalties, fully disclosed adoptions did not involve confusion about parenting rights and responsibilities, and birth mothers who were allowed contact with the child and adoptive family were able to resolve their feelings of loss more effectively than those who were not. Contact between parties allowed each individual to better understand the implications of adoption. The authors suggested, however, that the degree of openness be decided case by case and that agencies strive to act in the best interests of the parties involved.

Despite the secretive beginnings in the adoption process, the last few decades have been characterized with more openness in adoption giving rise to three types of adoptions. One source suggests that only about 5 percent of infant adoptions are **closed adoptions** meaning that all information is kept confidential, and there is no contact between the birth parents and the adoptive parents. Now 95 percent of adoption agencies are receptive to open adoptions and 55 percent of adoptions are now completely open or **fully disclosed**. Between these two poles are **mediated adoptions** where the adoption agency facilitates limited and usually not direct contact between the parties. These contacts may take the form of pictures or letters (Siegel and Smith, 2012).

The practice of more openness in adoption came about as a result of a growing recognition that secrecy had a negative impact on all parties. Secrecy often breeds fantasies that can be much more negative than the reality. Now, most of those who are involved in more open adoptions report that they are more satisfied with the whole process. For the birth parents, some degree of openness helps them with their grief, guilt, regret, and worry and enhances their peace of mind over their children's futures. And adoptive parents collectively report more satisfaction when there is openness in adoptions (Grotevant, 2007; Beckett et al., 2008; Crea and Barth, 2009; Grotevant et al., 2011; Siegel and Smith, 2012; Rampage et al., 2012). To ease the process and flow of information, Siegel and Smith (2012) suggest that as part of their homestudy, adoptive parents should be trained in what might be expected from open adoption, how to forge positive relationship if they choose to do so, what tensions might arise, and how these might be dealt with.

Perhaps openness in adoption and access to more information than once was the norm has the most impact on adopted children. Having access to information about and sometimes contact with birth parents and/or foster parents helps the child—become adult—to feel more continuity in his or her history. As adolescents, openness helps the adopted child with exploring his or her identity—a natural part of this developmental phase. In this period when belonging is such a crucial piece of identity, adolescents find meaning through knowing why their birth parents gave them up for adoption.

Over the years, therapists have reported that adopted children often questioned why their parents gave them up. Some were told, "Your biological mother [parents] loved you and wanted the best for you, so she [they] gave you up." This explanation does not necessarily quell the child's conflicts over being abandoned and rejected. Adoptees who struggle with these feelings may have felt distrust and confusion.

Any loss creates a need to grieve. Even an individual who was placed as an infant recognizes that another mother, some shadowy figure of his or her thoughts, bore and then gave away him or her. In past decades, adopted children were never given the opportunity to grieve this loss, however insubstantial it may seem to others. The result was often a profound sadness. When other losses occur in later life, they could be especially difficult to bear because they serve as reminders of the initial separation from birth parents. The individual may provoke rejection from others as confirmation that he or she is still unlovable (Simon and Roorda, 2000; Lifton, 2009; Rosenberg, 2010).

When children have access to information about their birth parents whether first hand or through an agency's willingness to share more than was typical in the past, it helps to dispel myths about birth parents. These shadowy figures begin to have real stories and faces that help the child to understand more fully what he or she meant to them.

Identity issues translate into a variety of behaviors and attitudes. In addition, past experiences may result in problem behaviors for their adoptive parents. Having some information about children's backgrounds can help adoptive parents to deal realistically with what is going on in their children's lives.

Transracial Adoption: Domestic and International

Transracial adoptions have existed in a variety of forms over the years. Children have been placed within the United States with parents of different races—referred to as **domestic transracial adoption**, while other children have been found in other countries and brought to the United States for adoption—referred to as international or ICAs.

Domestic Transracial Adoption

Perhaps one of the earliest forms of domestic transracial adoption was the Indian Adoption Project in 1958 and 1967 that sponsored the removal of Native American children from their families on reservations and placed them with white families in an effort to help the children to assimilate into white society. Despite the fact that the program was a collaboration between the Bureau of Indian Affairs and the Child Welfare League of America (CWLA), it met with resistance from both Native and other advocate groups (Lee, 2003).

Efforts to place African American children with white parents, due to the lack of African American couple's applying for adoption, was also surrounded by controversy. The NABSW, for example, called the practice racial and cultural suicide and in 1972 insisted that this practice come to an end. Although the practice did not end, it was decreased from 2,574 in 1971 to 1,400 by 1987. Since this time, there are no accurate and reliable estimates on how many children are places transracially in the United States (Lee, 2003; Samuels, 2009; Rampage et al., 2012; Jacobson et al., 2012).

Today, there continue to be mixed feelings about placing children across racial boundaries. Proponents argue that love and sensitivity to cultural variations is all that is needed, while critics contend that the fragile nature of race relations in the United States today does not bode well for children who are being brought up by those of a different race (Simon and Alstein, 2000; Lee, 2003; Donaldson Adoption Institute, 2015a).

To understand how race in general impacts adopted children, Barn (2013) sought to understand how African American/biracial (domestic) as well as some Asian and South American (international) children being adopted by white couples were socialized and taught about their identity. In a study, the attitudes of 15 white adoptive mothers—who the author believed are the primary transmitters of culture—were assessed as they sought to socialize their children. Barn identified three attitudinal positions: humanitarianism, ambivalence(ism), and transculturalism. The mothers who fell into the humanitarianism category believed that love would win out and de-emphasized race and culture. These mothers believed that culture was not something that came with the children but rather was instilled in them through family life. The researcher did acknowledge that many of these mothers adopted in the 1980s and 1990s when this attitude was more prevalent than now.

Mothers in the ambivalence (ism) category had similar views about the de-emphasis of race and culture but their attitudes seemed to stem more from their own uncertainty and indecision about the children's racial background. Several expressed that they had requested light-skinned Black children. Although these families expressed the need to expose the children to their cultural heritage, the reality was that the mothers reported that few if any of their own networks were of the same ethnic background as the child. In retrospect, these mothers expressed regret that that they had "never quite found time" to expose their children to ethnic variety (Barn, 2013).

The mothers who represented transculturalism were very much aware of and receptive to the need to help their children understand and embrace their cultural heritage. These women were concerned about the plight of their children had they not been adopted and made efforts to live in multicultural areas and/or racially diverse communities where the children could find like role models. While Barn admits that his sample was small, this may be reflective of families who adopt transracially (Barn, 2013).

It is not always easy to determine the current trend in transracial adoption as some studies group together families who adoption children domestically and those who enter into international adoptions (see Jacobson et al., 2012). Some authors report that the majority of transracial adoption are not white families adopting African American or biracial children as once was the case but rather families adopting other races, often internationally. One indicator of the number of children of any race being adopted in the United States is the Children's Bureau (2015) report of children placed with the involvement of public agencies within the United States. As mentioned above, the majority of these children were white (48%) with only 19 percent African American and 22 percent Hispanic (any race), but there is no indication as to the race of the adoptive couple.

International or Intercountry Adoptions

International—now more often referred to as ICAs— is not a new concept. After World War II, the adoption of foreign-born children gained popularity as children orphaned by war became available, most from German and Greece. Perhaps the awareness of service members who saw first-hand the need for homes for children whose parents had been killed encouraged the movement toward bringing these children to the United States for adoption. However, this need was short-lived as European countries began to rebuild and care for their own. After the Korean War, however the need to bring children to the United States once again became apparent—this time from Korea (Simon and Alstein, 2000; Brumble and Kampfe, 2011).

In the 1950s, Bertha and Henry Holt succeeded in having the international law (the Refugee Relief Law) changed to accommodate their adoption of eight Korean orphans. They also created an agency that revolutionized the nature of international adoptions. In 1956, Henry Holt built a small orphanage in Korea and was soon joined by his wife Bertha

and their youngest biological daughter and their eight adopted Korean children; here the family created the largest international adoption agency in the world (Brumble and Kampfe, 2011; Holt International, 2016). Over the years, U.S. parents continued to adopt through ICA, some for humanitarian reasons and others because very young children were not as available in the United States.

But ICA did not always protect the needs of the children involved. In 1993, the **Hague Convention on the Protection of Children and Cooperation in Respect of Intercountry Adoption** outlined specific safeguards to protect children and all involved. These required that the best interests and the rights of the children be served, that safeguards be put in place to prevent the abduction or sale of children, that families of origin be protected, and that specific policies surround the placement of children from other countries (Rampage et al., 2012; Pinderhughes et al., 2013). While these guidelines have continued to inform the practice of ICA, some critics argue that there is not enough enforcement of them (Rotabi and Gibbons, 2012).

Over the years, there have been distinct changes in the nature and number of ICAs. For example, China, formerly one of the countries with the highest numbers of children in ICA since 1993, peaked in 2005 with 14, 493 children placed but decreased to 4,418 in 2011 (Pinderhughes et al., 2013) and to 2,040 in 2014 (Bureau of Consular Affairs, 2015). Similar drops occurred with other ICAs. Adoptions coming into the United States went from 15,774 in 1998, rising to 22,884 in 2004 and dropping to 8, 668 in 2012 (Pinderhughes et al., 2013).

What is responsible for such drops in the numbers of ICAs? Not only has the complexion of world politics changed but the nature of the children available has also altered applicants' interest in adoption of children from other culture. A significant percentage of children available through ICA now have special needs.

As one veteran social worker explained:

> "At one time couples who did not want to wait a long time for an infant from a US adoption agency or were not interested in either an older child or a child with special needs might seek out international adoption as a way of getting a fairly young child sooner. But we began to recognize that overcrowded, understaffed, and poor quality orphanages; abandonment; poor nutrition; and inattention to healthy development meant that children were being adopted internationally whose problems would emerge after they entered their adoptive homes. This made some couples wary and they began to rethink their options."

Currently, for example, the China Center of Adoption Affairs specifically searches out families for children with special needs. Special needs may be mild physical conditions that might require minor surgery to more complex conditions that necessitate ongoing treatment or mental and emotional difficulties including attachment disorder, learning disabilities, ADHD, and other problems. In a recent study of ICA, special-needs adoptions, Pinderhughes et al. (2013) divided special needs into three categories: **initial diagnosis** or those that were identified by the child's birth country; **late diagnosis** meaning that the special need did not become apparent until the child was in the adoptive home, and **additional diagnosis** describing situations in which a child with special needs was discovered to have additional issues after placement. Of their total number of parents (1,034) who adopted children with special needs, 243 children had an initial diagnosis, 243 a late diagnosis, and 101 an additional diagnosis. In addition, the children's health records that accompanied them did not always reflect all the information (Pinderhughes et al., 2013, 34).

The international climate may also impact ICAs. For example, between 1995 and 2011 there were approximately 58,000 Russian children adopted by American families. However, on December 28, 2012, the Russian government banned the continuation of

such adoptions suggesting that these children might be better placed domestically. Critics of the ban such that it is politically motivated but the reality is that Russia infants and children can no longer be given homes in the United States (High, 2014).

If one is to see ICA as influenced by politics, it is important to assess the nature of what makes some countries open to such adoptions and others not. Breuning (2013) considered this question and postulates that the more severe the orphan crisis, the more likely countries are to favor ICA. On the other hand, when women have more presence in political decision making (e.g., are members of parliament), the policy toward ICAs is more restrictive. This researcher suggests that women in power positions may be more apt to want to protect poor women from being pressured to relinquish their children for adoption especially out of the country. Two other factors—the relative democracy of the country and what proportion of the population professes Islam was not statistically significant as the author wondered if it might be.

While ICAs continue, child advocates suggest that there is increased need for preparation for the adoptive parents as the complexities of this type of adoption add extra layers to the need for understanding, patience, and perseverance. In addition, follow-up services are crucial (Pinderhughes et al., 2013).

Adoption Disruptions and the Need for Follow-Up

Each year, 10–25 percent of adoptions are disrupted (Child Welfare Information Gateway, 2012b). The likelihood of disruption increases when an older child is placed for adoption.

Schwartz (2006) has suggested several reasons for disruption of adoption prior to legalization: The birth mother revokes her consent, the biological father objects to adoption, or the biological mother seeks to gain financially from the adoption. A lack of compatibility between the child and the adoptive parents may also be a factor. Sometimes adoptive parents have not resolved their own issues with regard to infertility or parenting a child who was born to another. Reality may not meet the expectations of adoptive parties in ways that hamper adjustment. Older children with many pre-existing issues may present additional adjustment problems.

Although placement assessment, education, and support are vital to a successful adoption, follow-up services also are crucial. Currently, agencies provide placement services to adoptive families for only short periods, and most do not provide intensive supervision. Most experts agree that postplacement services are vitally important and should be available whenever needed, throughout the life of the family.

Lack of postplacement services can be an important factor in adoption disruption. Adoptions are most likely to fail because the child exhibits behavior problems, is older, or has already had an interrupted adoption experience. Once the child has been placed in the adoptive home, adequate services often can prevent the adoption from ending. Increasingly, agencies are recognizing the importance of follow-up services.

It is not only domestic adoptions that disrupt. In 2013, Reuters released the results of their investigation on parents what they referred to as "rehoming" the children they adopted through ICA. The use of the word **rehoming**—a term usually used to describe giving a pet to someone else—has been criticized and replaced by some by the phrase "unregulated child custody transfers." According to the Reuters investigation, these were accomplished through the use of the Internet. Adoptive parents would place ads online offering their children to "good homes." Some of these arrangements are legalized through power of attorney documents. In fact, transferring children without agency intervention or approval is considered to be child trafficking and is illegal. Now states are moving to pass legislation that specifically prohibits this practice (Donaldson Adoption Institute, 2015b).

Summary of This Section

- The picture of adoption has changed over the last few decades, and these changes have brought a variety of issues to the attention to the public and child welfare professionals. Issues today are in the areas of the nature and number of children available, attitudes toward independent adoption, openness and information sharing, transracial adoptions, both domestic and intercountry, and issues regarding adoption disruptions.
- The numbers of children have decreased since the peaks in the 1970s and 1980s. There were an estimated 50,644 adopted in 2014 compared to about 175,000 adoptions in 1970. These changes seem to be related to abortion rates, a decline in teen pregnancy, an increase in single parenting, and various cultural practices.
- While at one time, healthy white infants were the most popular adoptees, fewer of such children are now available for adoption. Minority children, children with special needs, and older children are now more in need of homes. Many of these have been traumatized, resulting in behavioral and psychiatric issues in later life.
- With the shortage of healthy infants, some families seek out independent adoptions or those where no child placement agency is involved. These types of adoptions may create problems for adoptive families in that the rights of those involved may not be protected and confidentiality is not insured. These adoptions may be legally questionable, and there are usually no services provided for any of those involved.
- Today, there is increased openness in adoptions with only 5 percent of the closed adoptions of the past. Some adoptions are fully disclosed meaning that contact among children, birth parents, foster parents, and adoptive parents may be contracted at the time of the adoption. Mediated adoptions refer to some degree of openness but the agency becomes the intermediary between the parties' contacts. Those favoring openness in adoptions feel that these benefit all involved.
- Transracial adoptions may be either domestic (within the United States) or international—now referred to as intercountry adoption or ICA. There continues to be both advocates and critics of domestic transracial adoptions especially related to how effectively children are helped to understand their cultural roots.
- There are fewer ICAs than there were in the 1970s when Bertha and Henry Holt created the Holt Agency that would facilitate numbers of such adoptions throughout the next years. In 1993, the Hague Convention on the Protection of Children and Cooperation in Respect of Intercountry Adoption developed guidelines to protect the best interests of the children in such adoptions. Today, there are fewer ICAs due partly to international relations but also to the fact that many of these children have significant special needs that combined with cultural differences and lack of information may be overwhelming for some U.S. parents.
- Adoptions may disrupt or not work out for a variety of reasons, including legal issues, adoptive parents, own personal issues, or the inability of the child to adjust or the parents to cope with the issues he or she brings. There is a need for effective preparation and training of adoptive parents to be able to meet these needs. In addition, postplacement services are vitally important to the success of adoptions especially when the children have special needs. One type of disruption that has gained attention as a result of a Reuters expose is "rehoming" or **unregulated child custody transfers** when adoptive parents—often those who have been involved in ICAs—find adults via the Internet and place their adopted children with others without agency intervention. This practice is illegal and steps are being taken to pass legislation to respond to such transactions.

ADOPTIVE PARTICIPANTS

Adoption is a delicate balance of people all of whom have their own perspectives and feelings. The birth parents, the children, the foster parents, and the adoptive parents all have a part on the success of an adoption. While foster care was covered in the previous chapter, this section will consider birth parents, children, and adoptive parents and their role in an adoption.

Birth Parents

Giving birth to a child does not guarantee the parent's ability to care for that child or to fully face the responsibilities of parenting. Such responsibilities, with the many sacrifices involved, may overwhelm the woman or man whose own needs have never been fully met. Some parents recognize this early and give up their children at birth. Others believe that they can parent, only to discover later that they cannot meet the needs of either their children or themselves.

The Reasons Behind the Decision

Not every parent gives up his or her child voluntarily. Those who abuse or neglect their children may have the decision to release them made for them by the social service or court system (see Chapter 7).

There are three ways that children become available for adoption:

- Their parents voluntarily relinquish custody.
- Their parents abandon them.
- The court terminates parental rights.

Voluntary Surrender. Parents voluntarily surrender their children for a variety of reasons. When we think of birth parents who give up children, we often picture a pregnant teen who cannot keep the baby due to her immaturity, educational needs, or financial situation. Cultural values have a significant impact on who surrenders children.

Pregnant teens who decide on adoption may do so because they recognize their inexperience and inability to parent effectively. Chandra was 14 years old when she became pregnant. Initially, she decided to have the baby and raise him or her. But she soon realized that her emotional supports at home were minimal and that her options were few with a young child. Raised by an abusive, alcoholic mother, Chandra wanted better for her child (see O'Brien, 2007).

Not only adolescent mothers give up their children for adoption. Monica was 35 and separated from her husband when she realized that she was pregnant. Her career was thriving and rewarding; she could not imagine herself parenting at this stage of her life. Her strong religious beliefs ruled out abortion, so Monica took a leave of absence from her job, gave birth in another state, and placed the baby for adoption.

Bianca had a serious substance abuse problem. When she became pregnant, it was clear to her that she could never raise a child. Nor was she able to stay sober for any length of time. In addition, her child was diagnosed at birth with fetal alcohol syndrome. Her grief and guilt were too much for her endure, and she chose to surrender her child for adoption.

What of the biological father of the child given up for adoption? He, too, may be young and not ready for parenthood. Or he may not be in a position to parent this particular child. The father of Monica's baby was her husband, but he saw the pregnancy as

Monica's attempt to re-engage him in what had become a conflict-ridden marriage. He had children from a previous marriage and had no desire to support Monica's having this child.

Roger returned home from deployment in Iraq to discover that his wife Jennifer was pregnant. Tearfully she admitted that while he was away, she had an affair with another soldier on the base. Roger, already unsure of how he felt about his wife after his long time away from her did not feel that they had a future with another man's child. Their arguments about what to do ended in separation and Jennifer opted to give up the baby rather than raise it alone.

Other fathers may be concerned but unwilling to share their parenting with the baby's mother. Some putative or biological fathers have asked for custody of children their mothers intended to release for adoption. Whether this request is granted depends on the father's prior involvement, his plans for the child's care, and the laws in individual states. Some states require that the biological father also surrender the child.

Parents who give up children for adoption do so because they realize that their lives cannot accommodate the responsibility. Adoption is not a decision to be made lightly, nor is it one devoid of future conflicts. Some parents do not feel able to parent a particular child.

Case Example Joshua

Joshua was born with many medical problems. His young mother, Janet, already had two other children, ages 3 and 4. Joshua required frequent hospitalizations and consistent attention to giving him his medications. When his overwhelmed mother was unable to follow through with medical appointments and administering his medicine, Joshua lapsed into a coma. A neighbor rushed him to the hospital. Janet, frightened that Joshua would die and she would be blamed, took her other children and hid for several weeks. The local social service agency took Joshua into custody when he was released from the hospital. Janet returned and, learning that her son was in foster care, angrily called the social worker involved in the case. After counseling to see if she was able to have Joshua returned to her, Janet finally admitted that her son's care was more than she could handle. She signed adoption releases, and Joshua eventually was adopted by his foster parents.

Parents who voluntarily surrender their children do so by signing an adoption surrender. This document is a legally binding agreement by which parents give up their parental rights. To ensure that this document is legally binding, many states have stipulations that must be followed. In many states, a mother cannot sign a surrender for a newborn until she has left the hospital. The rationale is that she should be free of medications that might confuse her and have some distance so that she can be sure of her decision. There is also a trend toward encouraging birth parents to see their children at the hospital to determine if they are comfortable with their decision. Birth mothers who are ambivalent are given counseling to help them decide whether or not to relinquish their child.

Today, much more attention is paid to birth fathers than in years past. Numerous legal cases, such as *Stanley vs. the State of Illinois* (1972) and *Lehr vs. Robertson* (1983), have brought attention to the rights of fathers. As a result, the Supreme Court ruled that the rights of birth fathers must be protected when adoption is being considered (Jasper, 2008). Many birth fathers are interested in and concerned about the child (even if they aren't interested in or concerned about the mother). In their study of African American adolescent fathers, Dallas and Chen (2002) discovered that their lack of resources was a primary reason for not remaining involved with their children.

Abandonment. Parents may abandon their children because they feel they have no choice. A Hmong (a Laotian sect) baby was found in the back of a church. When the young mother finally was located, it was learned that her community had ostracized her. She felt her only choice was to abandon her baby, after which she had intended to kill herself, but she was unable to take this last step.

Other parents are so disturbed or caught up in their own dysfunction that they have little time or energy for their children. In a large city, neighbors called police to an address because they were concerned that three children had been left alone. The children's parents had left town for several days on a "drug run." The children were taken into the custody of the local child welfare agency. When parents abandon their children and show no inclination to resume their care, the court steps in. The children often are placed in foster homes and sometimes are placed for adoption.

Termination of Parental Rights. When parents cannot care for their children—because they have abused or neglected them, are using substances that hinder their ability to care for the children, or are unable to protect their children—the juvenile (or family) court may intervene (see Chapter 9). Usually, these children initially are placed in foster care. In the past, they may have remained in foster homes until they were 18. However, PL 96-272 (1980 and 1997) shifted the emphasis to permanency planning, finding children a permanent home. Thus, more children brought into foster care due to their parents' inability to care for them were effectively freed for adoption by court action.

The issue of permanency planning raises several questions. The primary goal of child welfare agencies is family preservation. Therefore, when children come into foster care, agencies stress that services will focus on reuniting the family. However, a dearth of available workers, funds, and resources in an agency may mean that insufficient services are available to reunite families quickly. In addition, change or rehabilitation is not an easy process. Thus, children sometimes remain in foster care for an inordinate amount of time. Many of these children, already dealing with the scars of abuse and neglect, must learn to adjust to living in limbo. To reduce the trauma of children's not knowing where they belong, many states now proscribe a period during which biological parents are helped. If the parents are unable to demonstrate stability within this period, their parental rights are legally terminated.

Some states require a process beyond termination of parental rights to free a child for adoption: The agency must petition the court (usually probate) for further termination of rights for the purpose of adoption. This extra step may mean an additional delay before the child can find permanency.

The Emotional Aspects of Losing One's Child

Parents whose children are placed, especially parents who voluntarily surrender their children, deal with the impact of placement for years to come. Their self-perception may significantly change. Plumer (1992) suggests that biological parents face separation from their children with diverse feelings:

- *Feeling that they lack control.* Even parents who choose to place their children often feel they had no choice. They may feel that others were telling them what to do or that no other action was open to them.
- *Feeling inadequate.* Our society assumes that parenting is something anyone can do. To admit that one cannot parent often makes an individual feel ashamed, guilty, and a failure.
- *Feeling stigmatized by the community.* Because everyone "should be able to parent," someone who cannot is "different" and may feel stigmatized by others.

- *Feeling that they would like to blame others.* When one is in pain, it is often easier to assume that another caused it. "If the baby's father had been more supportive" or "If my parents had not abused me" are classic ways that parents rationalize their separation from their children.
- *Feeling bitter or angry.* Unwilling to face separation, birth parents may project their feelings onto others, becoming bitter, angry, and sometimes abusive to those around them.
- *Feeling that they want to give up.* Losing a child is emotionally draining and, experienced with the preceding feelings, can overwhelm. Unable to cope, some parents become childlike ("the agency can take care of everything for me") or apathetic. Some seek to escape the pain through denial or even suicide.

Other sources identify feelings of sadness, worry, nervousness, emptiness, anger, and bitterness. For birth fathers, the feelings are similar, except for emptiness. Some also admit to feeling thankfulness that the problem is solved and the child provided for (Plumer, 1992; see also O'Brien, 2007).

Birth parents wonder what will become of their children. Will they be loved? Will they be safe? Will the children wonder about them? Numerous studies indicate that the stereotype of parents who easily forget the experience and go on with their lives is erroneous. Birth mothers have reported having nightmares about giving up their babies and having emotional reactions when they see children about the same age as those they gave up.

Services for Birth Parents

Despite research attesting to the significant effect that giving up a child has on birth parents, agencies do not always give these parents sufficient help. One social worker explained, "We are a child welfare agency. Once a mother has given up her children, she is technically no longer eligible for services. We can counsel her for the period right after the placement, but then we have to close the case. It's policy. We just have to hope that she finds a counselor later who can help her grieve."

The problem is that many birth parents do not recognize that their problems or feelings are related to the loss of a child. Many find it easier to deny. So, if birth parents are able to get help with their grieving, those who work with them suggest that they be allowed the space, empathy, time, and expression necessary to come to terms with their loss. They also point out that rituals can play a large part in the passages of our lives. Part of the grieving process may be acknowledging the day of separation or finding some other way to accept the separation as part of one's experience. Individuals who have been helped to put events into perspective can proceed with their lives in a healthy manner.

The changing face of adoption means that some birth parents will still have contact with their children once adopted. This is usually when the children are older, when they were removed, or have maintained an attachment with birth parents through visitation. This contact may be periodic visitation or through letters or gifts. In the case of open adoptions such as this, case management services are often extended to see that the best interests of all parties are served.

Children Available for Adoption

At one time, there were basically three categories of adoptable children: healthy infants; special-needs children, who included children older than age 3; and children from other countries. Now the picture is more complex. In addition to relatively few healthy infants of all races, numerous older children are awaiting adoption. Of these, a large percentage were

not released from their parents' care until they were older. Many of these older children also have siblings. Agencies must decide whether to place siblings together or separately. One adoption worker explained, "The problems is, adoptive families often want children as young as possible. Some will take sibling groups that have very young children just because they want the little ones. In these cases, the older children may get the short end of the stick."

Children currently available for adoption might be divided into these partially overlapping categories: healthy infants, older children and sibling groups, children with medical or emotional problems, and children adopted from other countries.

Whether children are infants or older, cultural variables may also come into play. Native American children were placed predominantly with white couples until the 1978 Indian Child Welfare Act. This legislation gave tribes the authority to make placement decisions for their own children. Preference was given first to the child's extended family members, then to other tribal members, and finally to other Native Americans.

Today, numerous children are available for adoption, and they represent all racial groups. Whether these children are placed with same-race parents or are considered special-needs may depend on their geographic area and that area's demographics, as well as on the types of parents seeking to adopt.

The Dave Thomas Foundation for Adoption and Evan B. Donaldson Institute (2002) polled Americans about the types of children they might consider adopting. Seventy-eight percent of respondents would want a healthy baby of their own race, 64 percent would consider siblings, with the oldest being younger than 4 years, 40 percent would accept a child of a race other than their own, 25 percent would adopt a child who had been in foster care for several years, 14 percent would accept a child with medical problems, and 11 percent would accept a child with behavioral problems. From these findings, one can deduce that the types of children available for adoption do not always meet the demand. Increased education and public service campaigns since this study may have helped potential adoptive parents to recognize what types of children actually need homes.

Healthy Infants

Fewer and fewer healthy infants are available for adoption. Although adolescents become sexually active at younger ages than in past decades, birth control and abortion are increasingly available. There has also been a trend toward young mothers keeping their babies. When these children enter the social service system, they usually are older; in many cases, they enter as a result of abuse, neglect, or family dysfunction. Increased substance abuse also has altered how many healthy infants are available. As more mothers abuse drugs and alcohol during pregnancy, more babies are born either addicted to drugs or suffering from fetal alcohol syndrome. The demand for healthy infants has always exceeded their availability, but this is especially true today. Commonly, families requesting a baby are told that they must wait 5–10 years. Some agencies refuse to study couples waiting for babies, and some applicants seek other sources, such as overseas or independent adoption.

Older Children and Sibling Groups

Children who are not released for adoption until they are 3 years old or older are more likely to have been abused or neglected, or to have witnessed domestic violence or drug abuse (Robinson, 1998; Maskew, 2003). Children who enter care at a later age do so because their parents' rights have been terminated or because their birth parents have determined that they are unable to care for them.

Case Example April

When April was a baby, her 16-year-old mother, Lara, found that parenting was a novelty. But by the time April was 3, the responsibility weighed heavily on the young mother. Lara had a new boyfriend, Zeke, who drank heavily and beat both mother and child. However, when he was not drinking, Zeke doted on April. Lara was jealous of his attention to her daughter and began leaving April home when she and Zeke went out. During one 2-day absence, a neighbor reported to the police that April was alone in the house. The police took April to a local child protection agency. Lara's inability to work consistently with the agency over the next year led to April's release for adoption.

Lara's inability to properly care for her child is not unlike that of other parents whose children are freed for adoption at a later age. Most of these releases are involuntary. The birth parents rarely recognize the need to help their children find permanency.

Children who have experienced dysfunctional homes bring feelings of loss as well as scars from the pain they have experienced and witnessed. For them and their adoptive parents, the adjustments may be many.

Sibling Groups. At one time, siblings who were free for adoption might have gone to different adoptive homes, perhaps not being allowed to maintain contact with each other. Increasingly, agencies are trying to keep family groups together. This sometimes presents a challenge.



Diversity and Difference in Practice

Behavior: *Apply and communicate understanding of the importance of diversity and difference in shaping life experiences in practice at the micro, mezzo, and macro levels.*

Critical Thinking Question: Do you think that any couple could adopt a child with special needs? What qualities do you believe are necessary to make this type of commitment?

Case Example The Russells

The Russell children were ages 3, 5, and 7 when the court terminated their birth parents' rights. Three-year-old Kit and 5-year-old Kerry were outgoing, responsive children who would adjust well to a new home. For 7-year-old Kim, life had been dedicated to taking care of her younger siblings. She had done this well, but it had taken its toll. Angry and sullen, Kim had no use for adults. They had betrayed her, and she would not trust them again. It would be years before Kim would see her adoptive parents as anything but a threat.

Although sibling groups can be a challenge, some couples value the prospect of a ready-made family.

Children with Medical or Emotional Problems

Children may have a variety of medical problems. Some examples follow.

- Addison was a perky, African American 3-year-old who had been born deaf. His mother's drug use during pregnancy had sent him into withdrawal soon after birth. The doctors were initially somewhat guarded about his prognosis, but at age 3, Addison's only apparent problem was his deafness.
- Helen was shaken by her abusive father when she was an infant. As a result, her retinas were detached. Surgery had been less successful than the medical community had hoped.
- Bobby was born HIV-positive. Soon after his birth, his mother and her boyfriend (Bobby's biological father) died from complications caused by AIDS. With no relatives willing to parent him, Bobby was placed for adoption. Some children with Bobby's diagnosis will test negative as they grow older. Others will remain HIV-positive and will eventually die from HIV-related causes.

Of all the medical issues, adopting an HIV-positive child is one of the newest and most uncertain. Families interested in providing a permanent home for an HIV-positive child must be prepared for the worst. Although the family may need to make only a few physical adjustments, the emotional issues are significant. There is still pronounced negative sentiment toward HIV-positive individuals. In addition, when parenting an HIV-positive child, common childhood illnesses become more problematic.

Significant developmental delay (once referred to as mental retardation) in children available for adoption can also present a challenge. In some cases, it is recognized before adoption that the child will be developmentally delayed; however, in other situations this fact does not become apparent until after adoption. Agencies are increasingly recognizing the need for postadoption support when such unforeseen problems arise.

Emotional or behavioral problems may be seen in children who are older or who have experienced dysfunctional family life prior to being released for adoption. Most of these children have experienced trauma in their lives. Some have failed to attach with caretakers (attachment disorder) and will have difficulty bonding with adoptive parents. Pain, trauma, and failure to bond take its toll on children, and the residual effects are apparent in children who act out their anger. Multiple moves may also intensify attachment problems that impede children's ability to trust enough to risk new relationships.

Children Adopted from Foreign Countries

The adoption of children from other countries has been formally practiced for about 50 years (see above). Who are these children who come from other countries to be adopted by U.S. families? Some of them have been abandoned by parents who cannot care for them due to poverty. In Delhi, India, Dara was born with a deformed arm. Her mother used the child to illicit sympathy when she brought her children with her to beg on the street. When the mother died, the children were placed in a home, and Dara was registered with an international adoption agency. As another example, U.S. military men have left behind their mixed-race children who were not accepted by either of their races; these children were placed in orphanages or foster homes awaiting adoption. In countries where illegitimacy is a stigma, unwanted babies may be given up to hospitals or agencies in the hope that they will be adopted.

Some children are orphaned by war. Some have medical or emotional problems and their poor and overwhelmed parents do not feel that they can do the best for them.

All of these children remain in an orphanage or foster home until they can be placed with adoptive families. Advocates for Intercountry adoption believe that for many of them, ICA is their only hope for survival. Cultural taboos such as illegitimacy or economic conditions may make it impossible for them to remain in their native countries. Because professionals feel that these children will face less stigmatization and have more resources available to them in other countries, agencies such as Holt arrange for them to be adopted in North America and western Europe.

Adoptive Applicants

The reasons people choose to adopt children are varied as are the applicants themselves. The first step in their journey for a child is recruitment.

Recruitment

Recruitment is an important part of the adoption process. Although some applicants seek out adoption agencies, others do not know where to start pursuing their interest in adopting or do not think that there is a need for agencies to find homes for children. Recruitment

is especially important for special-needs children. Sometimes when potential applicants become aware of a particular child, they are more interested in adopting. For example, television networks often provide profiles of waiting children, asking people to phone in their interest. Children who may have some special need are introduced, as viewers watch them on the TV screen. Invitations to call in often generate numerous applicants and may result in finding adoptive homes for the children.

Churches and a variety of other service organizations are sometimes helpful in spreading the word about the availability of children for adoption. The North American Council on Adoptable Children offers newsletters that discuss how to recruit from different racial groups. The Council suggests that many people from Hispanic, African American, and Asian cultures do not seek to adopt through agencies because they mistrust government agencies, fear the stigma that their culture attaches to infertility, are impeded by language barriers, or view the greater community as unfriendly to minorities. Various websites offer profiles of children in an attempt to find them parents.

Corporations, newspapers, and civic groups have implemented other innovative strategies, but more-widespread recruitment should be done to place the children who are available.

Profile of Applicants

Couples and individuals apply to adopt children for a variety of reasons. The traditional applicants are couples unable to have children biologically.

Case Example Sam and Melissa

Sam and Melissa married after both became established in their careers. In their early 30s, the couple decided to add children to their satisfying relationship. After several years, they became concerned about their fertility. Melissa sought help and underwent a series of fertility tests. Ruling out infertility on Melissa's part, her physician suggested that Sam be seen. Tests revealed that Sam was infertile, probably due to a childhood illness.

"It really upset him," Melissa recounts. "He was from a family of macho men, and he felt that this made him less of a man. It took a year of counseling to convince him otherwise."

No matter who is the infertile partner, or even if no cause is discovered, infertile couples often go through a grieving process. "You don't really question being able to have children," Melissa explains. "You just expect that you will."

Infertile couples experience not only disappointment but also anger and guilt. Often they describe difficulties in their relationship. Couples who do not adequately grieve their infertility may never fully accept an adopted child. They may have difficulty accepting their child's origins and be less able to discuss adoption openly with her or him (Robinson, 1998). For this reason, during the screening process, most agencies discuss in depth the couple's feelings about their infertility.

Preferential applicants are those who choose to adopt despite their ability to have a biological child. Some couples hope to complete an already-existing family with a child of the opposite sex. The mother of three boys, Arlene had always wanted a girl. "I worked so hard at being comfortable being female," she recounts. "I felt that I wanted a daughter with whom I could share all this."

Other couples seek to adopt children from other cultures. Bus Wagner had been in Korea during his military service. He knew the plight of many poor children in that country and had hoped to adopt one. After having a child, he and his wife felt ready to take a Korean child into their home.

Granted, not all couples who adopt foreign-born children have biological children. Many are able to have their own families but prefer to adopt children unlike the children they might have had. Although some couples adopt internationally for altruistic reasons, others feel that children are available from other countries more quickly and at a younger age.

Some couples decide to adopt because they perceive a need. Connie and George Adams had one biological child when they applied to adopt a disabled child. They had spent much time with Connie's sister, who had Down syndrome, and felt ready to parent such a child.

The term "couple" does not always refer to heterosexual partners. Increasingly, gay and lesbian couples are seeking to adopt. States and agencies differ as to their policies regarding these couples (Kimberly and Moore, 2015). Over the last few decades, an increasing number of single people also have become adoptive parents.

Studies show that single adoptive parents are most likely to be women whose occupations and skills promote an understanding of children's special needs. Nurses, social workers, and teachers are highly represented among single adoptive applicants. They usually have extended family backup, and a high percentage were themselves raised in single-parent homes (Adamec and Miller, 2006).

Foster parents are another relatively recent group of adoptive applicants. Although foster parents have always adopted some of their foster charges, the practice has not been encouraged. "We used to call it the back door to adoption," recounts a social worker who worked with foster parents in the 1960s and 1970s. "If you wanted to adopt, we felt you should apply for adoption, not do foster care. But foster parents grow to love children in their care, and the children become fond of them. Our old ideas weren't too realistic." In 2014, approximately 52 percent of the children adopted were adopted by their foster parents (Children's Bureau, 2015).

Today, people still are not encouraged to pursue adoption by becoming foster parents. Many children placed in foster care are not free for adoption. However, foster parents often are given the option of adopting a foster child to whom they have become attached if that child becomes available for adoption.

An increasingly popular type of adoption is kinship adoption, adoption by relatives. In 2014, 32 percent of all adoptions through public agencies were by relatives (Children's Bureau, 2015). In some kinship adoptions, the birth parents do not relinquish all parental rights but share in the child raising. Other kinship adoptions are more like traditional adoptions, in which the birth parent no longer is involved.

Adoptive Siblings

One often-forgotten part of the potential adoptive family is the couple's biological children. Wise couples explain their desire to adopt to their biological children and obtain some assurance that those children will respond positively to the adoption. Biological children may be extremely worried about their contribution to the homestudy and the adoption placement. One anxious 4-year-old refused to come out of his room when the social worker visited the applicants' house. Finally, the worker overheard the child's response to his mother's pleas to appear. "If you think I'm going to come out and blow this whole deal, you're crazy!" Knowing how much his parents wanted this adoption, the child was convinced that his reservations would spoil their chances (see Crosson-Tower, 2015).

Biological children often wonder and express, either verbally or nonverbally, their concern that they are not enough for their parents. They may fear that the new child will receive all of the parents' love and worry that they will be "left out." Children facing the arrival of any new sibling may have these fears, but the biological sibling may be much more aware of what the parents have been going through to get the new child. For this reason, most agencies encourage careful preparation of biological children.

Adoption and the Extended Family

Just like a marriage, adoption can have an impact on the extended family, the parents of the adoptive applicants and their siblings, aunts, uncles, and cousins and the attitudes of the extended family may influence the family's adjustment to adoption. Extended family members may have attitudes toward adoption that can either help or hinder the adoptive family.

Summary of This Section

- The adoption participants consist of the birth parents, the child, and the adoptive parents.
- Birth parents may seek adoption for their children voluntarily, abandon them, or have their parental rights terminate by the court. A voluntary surrender is a legal document that a birth signs to relinquish her or his rights to the child. This is a difficult decision and parents do so when they recognize that they are unable to care properly for the child.
- When birth parents abandon a child, the child is taken into CPS custody and if the parent cannot be found, CPS petitions the court to release the child for adoption or long-term foster care.
- Termination of parental rights can also result when parents abuse or neglect their children. This termination is granted by juvenile or family court. Some states require an additional step to free the child for adoption, while in other states termination of parental rights assumes that the child might be placed in an adoptive home.
- Most birth parents have difficulty losing their children, feeling that they have lost control over their lives, that they are inadequate, or that others will blame or stigmatize them. Some birth parents feel angry at themselves or at CPS and the courts while others re depressing and perhaps suicidal. They may also worry about their children's futures. Agencies strive to work with such parents to help them through the process.
- The children available for adoption may be healthy infants of any race, older children and sibling groups, children with emotional or medical problems, or children from other countries. Most if the older children placed for adoption have experienced emotional trauma that may have residual effects.
- Adoptive applicants are recruited in a variety of ways, including through the media, churches and service organizations, and through word of mouth. Individuals adopt for a variety of reasons, including fertility problems preventing them from having children, the desire for a specific kind of child (e.g., specific gender), or an ultraistic desire to give a home to a child especially one from another culture.
    - Adoptive siblings are often an overlooked piece in the family by adoption, but more recently agencies are recognizing the need to include them in the adoption process.

THE ADOPTIVE PROCESS

Adoptive applicants must undergo a process before they receive a child. This process from the initial information gathering to the placement helps them to consider, prepare for, and adjust to the reality of adoption in a manner not unlike the time afforded by those who have children through a lengthy pregnancy. Once they have been recruited possibly through an informational meeting, they begin their homestudy.

The Homestudy

A child has just become free for adoption, possibly through years of court appearances and/or counseling. Meanwhile, the couple (or individual) who will adopt the child has also been going through a process. Allison Kelly remarks:

> When we initially decided to adopt, we called an adoption agency we had heard about. They invited us to an information meeting the next week. Here we met with ten other couples who were interested in adopting, too. We learned what types of children were available for adoption, why they became available, and what we should expect if we adopted them. Some of these children came from rough home backgrounds and might have behavior problems. The logistics of the homestudy was also explained to us. After we left there, I was very excited but I also realized that things would not be as quick and easy as I had hoped.

Early meetings of this type have several purposes. First, they acquaint applicants with agency requirements. Second, they ask applicants to consider their suitability with regard to several other criteria by which they will be judged.

- *Motivation.* Agencies are interested in applicants' reasons for wanting to adopt. If couples are unable to have children, have they explored infertility issues? Are they trying to replace a child they have lost? Agencies wonder if an applicant's altruistic desire to take children ignores the fact that real children have real problems. For example, it may seem commendable to a couple to take a child who was maltreated, but can they cope with the scars that may result from this maltreatment? Most agencies expect applicants to be aware of their motivations (Steinberg and Hallinan, 2000; Malm and Welti, 2010).
- *Stability of the relationship.* Couples who wish to adopt are assessed with respect to their relationship. It is hoped that they have given their marriage/relationship a chance and that they do not hope that adopting a child will cement a faltering union. Single-parent applicants are expected to have support systems that will aid them in parenting.
- *Age.* Agencies usually consider applicants who are within normal child-rearing ages. Much also depends on the age of the child the applicants are considering. Couples in their 40s may be studied for an older child but might not be considered for an infant. When unmarried partners or gay/lesbian couples are being considered, it is usually expected that the relationship is stable and of some duration.
- *Physical and emotional health.* Because adoption is intended to provide permanency and a healthy environment for children, the applicants' physical and emotional health is important to agencies. Required medical examinations explore the potential adopters' physical ability to care for children. Social workers also look for applicants who appear emotionally stable, are mature, have a good self-concept, and are able to meet a child's emotional needs.
- *Financial stability.* Taking a child into one's home requires sufficient income to accommodate the needs of another individual. Although subsidized adoption is available, these monies are earmarked for special circumstances. In general, applicants (or at least one member of a couple) must be employed and financially secure. Mothers who intend to work are asked about childcare arrangements. Some agencies still prefer that at least one parent be the child's primary caregiver.

Despite these requirements, agencies often find that they must be flexible, respectful of cultural diversity, and increasingly different family values and lifestyles.

In addition to outlining agency requirements and informing applicants about the children who are available, informational meetings generate self-selection. Potential adoptive parents who perceive that they do not meet agency criteria or discover that adoption does not meet their expectations may opt to discontinue the process.

After the informational meeting, Allison and Dan Kelly decided to continue in their quest to adopt and were invited to be part of a homestudy group scheduled to begin several months later. "Homestudy" is the term agencies use to describe the screening, education, and selection of adoptive couples and individuals. At one time, the norm was to study couples individually. Now homestudies usually are initially done in groups. This allows applicants to gain support and learn from their peers. Allison Kelly describes the process:

> We met with five other couples with whom we became quite close. The groups met for a ten-week period, during which we were asked to explore our values and attitudes about such issues as biological parents, our infertility, disciplining children, and telling children they are adopted. Sometimes it was painful to look at our feelings. And sometimes it was funny. Danny and I discovered a lot about each other that we hadn't known after six years of marriage.

The model followed by the Kellys, called the Model Approach to Partnership in Parenting, is currently used by numerous agencies because it has been found to strengthen high-risk placements (Barth and Berry, 1988).

Placement and Legalization

Once adoptive applicants have been approved for placement, their names are kept on file until a particular child who fits their criteria needs a home. Depending on the child's age, the placement process may be fairly swift or spread over a longer period to ensure proper adjustment on the part of all parties.

Time from actual placement to **legalization** varies. Agencies usually maintain contact with adoptive families for at least 3 months, although research indicates that the length of this supervised adjustment period is insufficient. Having a "ready-made" child placed in one's home is quite different from knowing the child from birth. The older the child, the more adjustment issues there may be.

Legalization through probate court may mean that the agency's contact with the new adoptive family ceases. The child's birth records are sealed, and a new birth certificate is issued with the adoptive couple or individual shown as the parent(s).

Open Adoption

Traditionally, following their release for adoption, children's contacts with their birth parents terminate. This was felt to be best for all involved. Only then could children properly grieve over separation from their birth parents. This practice also allowed adoptive couples who were not entirely comfortable with their infertility to deny that the child had ever had another family.

More recently, adoption experts have begun to see that some children, especially those who were older when placed, needed continuity from the past. Some actually feel that the secrecy of traditional adoptions denies children their rights (Grotevant and McRoy, 1998; Herman, 2008).

Open adoption enables birth parents and adoptive parents to have contact with, or information about, each other prior to and after adoption placement. At one end of the continuum, parents do not meet but exchange letters and photographs through an intermediary. In other adoptions, the parties not only meet but also carry on relationships (e.g., adoptive parents become mentors for a young, unmarried birth mother). Various options lie between these two

extremes. The underlying criterion, however, is the birth parents' ability to relinquish their claims and recognize the adoptive parents as the child's legal and emotional parents.

As discussed above, studies of open adoption found that contact between birth and adoptive parents produces more empathy and therefore more understanding for the issues all face. When the adoptive parents were able to meet the birth parents before placement, there was greater comfort in postplacement contacts. These contacts went more smoothly if the adoptive parents felt they had some control over the arrangements. Contact between the adoption participants led to reduced fears, more honesty with the child, and more comfort with the adoption. Openness also alleviated the adoptive parents' anxieties about the child wanting to search for birth parents in later years (Wolfgram, 2008; Crea and Barth, 2009; Grotevant et al., 2011).

Most experts conclude that agencies should be more open in their adoption procedures. However, open adoption, like other types of adoption, requires a recognition that agencies must provide continued support, education, and counseling services.



Intervention

Behavior: *Use inter-professional collaboration as appropriate to achieve beneficial practice outcomes.*

Critical Thinking Question: One of your postadoptive parents comes to you concerned about some of the feelings he has been having about his adoptive child. He complains that your agency has little in the way of postadoption services. He tells you that he has talked with other adoptive parents assigned to other social workers and they too are having some issues. He wonders if your agency could provide a support group or if you could recommend another agency or organization that does postadoption support. What might you do to help this man?

Postlegalization Services

Services available to adoptive families following placement and legalization are both formal (agency-based) and informal (parent-generated).

Agency Services

Many agencies, recognizing that adoption is a lifelong experience, make support groups and educational programs available. Developmental milestones (e.g., adolescence) are as difficult for adoptive families as for any other parents, but the added issue of adoption makes the picture even more complex. Understanding these milestones through educational seminars may help adoptive parents anticipate and deal with them. Some agencies or community organizations offer workshops on parenting techniques, parenting toddlers, parenting adolescents, or even helping older children separate. Agencies may also provide libraries of or recommend films and books for those who are interested. Support groups consisting of other adoptive couples experiencing similar issues may also fill a need for families. Social events and retreats are an additional form of support for adoptive couples and children.

Agencies report that many adoptive families and adoptees return to agencies to request record reviews. At one time, families were given only scant information about their adopted children, but today agencies recognize that more information is necessary. Although agencies and state laws differ, many agencies will, at a couple's or an adoptee's request, review records and provide whatever additional health or background information is available that was not given at the time of the adoption (see Child Welfare Information Gateway, 2012a).

Counseling is also a service that should be available for postadoption families. Adopted children may have the same issues that other children present in therapy—for example, poor school performance, acting out, oppositional behavior, and poor self-esteem. Not all adoptive families remain functional. Any of these eventualities may bring adoptive families to counseling. In addition, several themes seem to be more prevalent among adoptive families than among other families:

- *Powerlessness.* Often the members of adoptive families feel powerless. The couple may bring with them their initial feelings of helplessness over not being able to

have children. They may feel powerless in their relations with the agency involved. Adopted children often feel that they had no say in their placement and feel powerless over their futures. All members may feel unable to deal with the early trauma the child experienced (Barth et al., 2001, Child Welfare Information Gateway, 2012a).

- *The "bad seed" myth.* Parents often fear that the child's biological past may predestine him or her to respond in negative ways. Or families worry that the child's past experiences will be unalterable. These "ghosts" become a part of family secrecy and may lead to dysfunction (Barth et al., 2001).
- *Adoptive issues.* Some families seek counseling to enable them to handle explaining adoption to their children. Often the sessions bring up the parents' old uncertainties about adoption. Parents may also seek help when they perceive that their adopted children may search for birth parents (Simon and Altstein, 2000; Trinder et al., 2005; Herman, 2008; Rosenberg, 2010; Child Welfare Information Gateway, 2012a).
- *Needing to be a perfect parent.* It is not uncommon for adoptive parents, who may have worked hard to become parents, to feel the need to be perfect parents. Caught up in a sense of failure over not being able to have children themselves, these couples often seek reassurance that they are doing a good job.
- *Identity issues.* Adoptees may seek counseling in an attempt to understand who they are and where they belong. They were born to one couple and are being raised by other people. Children whose adoption has been the traditional, closed, secretive affair wonder about their histories. They may feel the need for loyalty to both birth and adoptive parents and wonder how to bridge the gap. This is especially true of nonwhite children placed in white families. Nonwhite children often identify with both cultures but find it difficult to figure out where they feel comfortable (Simon and Altstein, 2000; Quiroz, 2007; Herman, 2008; Rosenberg, 2010; Child Welfare Information Gateway, 2012a).

Telling the Child About Adoption

In years past, there was some controversy over how and when to tell children that they are adopted. Although a few psychoanalytic theorists contend that discussing adoption before the Oedipus complex has been resolved causes psychic damage to the child, most adoption resources recommend using the word "adoption" early in the child's life. Children's understanding of adoption grows over time. Before they are 6 years old, children can accept that they are adopted but do not comprehend the significance. Statements about having "two mommies" are so far outside their frames of reference that they mean little. By the time they are close to age 6, children begin to worry and focus on why they may have been given up. Between 8 and 11 years of age, children finally begin to understand the complex nature of adoption, with its losses and changes, and some children fantasize that birth parents will appear to claim them. By adolescence, children are better able to understand the legalities, rights, and responsibilities of adoption (Simon and Altstein, 2000; Rosenberg, 2010).

Not telling children they are adopted until after they are 5 years old can have negative results. It forces adoptive parents into keeping a secret, and children may later resent not having been told. In addition, children may inadvertently learn from someone else before parents tell them. Adopted, Rob recounts:

> When I was twelve, my aunt, who was drinking at the time, told me I was adopted. At first I didn't believe it. When I was finally convinced it was true, I was angry. Angry that my parents didn't tell me. I had a right to know. It made me wonder what else they hadn't told me and how much I could trust them.

Parents who use the word "adoption" in a loving way early in the child's life help the child to gradually become comfortable with the idea. Adoptive parents who are unable to talk openly about adoption may have difficulty with the concept themselves. However, experts caution against overemphasizing the issue of adoption, suggesting that belaboring the issue may point to adoptive parents' discomfort. Open, honest, confident telling in age-appropriate ways appears to correlate with success of the adoption (Simon and Altstein, 2000; Rosenberg, 2010). Some proponents of open adoptions suggest that contact with birth parents alleviates the issues surrounding when to tell a child.

Many agencies currently provide **life books** to enable children to understand their histories. These books consist of pictures, letters, and narratives depicting the child's life from birth to adoption. "Life books" help children understand how they came to be adopted. Children are curious about why they were given up. It is important not to imply inadequacy on the part of birth parents because they are an integral part of children's self-perception. Children often fear that they contributed to being released for adoption by being intrinsically undesirable or by misbehaving. Adoptive parents must assure adoptees that they were wanted by both sets of parents. Describing as truthfully as necessary the circumstances of the birth parents' decision to give up their child while not portraying them as totally victimized requires a delicate balance.

Adoption Disruption

Not all adoptions are successful. Each year, about 10–25 percent of placements are unsuccessful or disrupted (Child Welfare Information Gateway, 2012b). There are two types of failed adoptions: **adoption disruption** when the adoption ends and the child is removed prior to legalization and **adoption dissolution** when the legal relationship between the child and the adopted parents is terminated either voluntarily or involuntarily. In both cases, the child is usually returned to a foster home or placed with another adoptive couple or parent (Child Welfare Information Gateway, 2012b). Some families at risk for disruption or dissolution receive counseling or find other ways to avoid a severed adoption. Often, however, families do not seek services or alternatives until it is too late (Schwartz, 2006).

Several factors put adoptive families at higher risk for disruption or dissolution. The seeds that grow into failed adoption relationships may have been undetected during the initial homestudy, may have been recognized but not explored, or may not have been predictable.

Case Example Roland and Bev

Roland and Bev Markham felt they had a good marriage. When it became apparent that a childhood illness had rendered Roland infertile, the couple dealt with the issue openly. Several years later, the Markhams were approved for adoption; they eventually received a 3-month-old girl who was the picture of redheaded Bev. After several years of successful parenting, the Markhams asked for a second child. This time a black-eyed, black-haired Native American boy of 6 months, who looked very much like Roland, was placed in their home. A Native American himself, Roland initially welcomed the boy. The child had minor medical problems, but recognizing how well the Markhams had done with their daughter, the agency felt that this was an appropriate placement. Six months after the initial placement, it became obvious that the family was in trouble. Roland, always very involved with his daughter, could not bond with the boy. Sensing the rejection, the boy had become withdrawn. After counseling the couple, it became clear to the agency that the child must be removed. Roland had come to recognize that the boy was too much a reminder of his own sickly childhood in a culture that stressed strength in males. He had also been helped to realize that these memories brought up his unresolved anger and guilt over his infertility.

The risk for disruption or dissolution is rooted in several areas. Certainly the adoptive parents' own issues may prevent them from being successful with adoption in general or with adoption of a particular child. The family balance may also be a factor. For example, a couple with older children may find that the family cannot sufficiently rebalance when a new child is added. This causes disharmony. Although some families can find solutions through counseling, others cannot, and termination of the adoption may result.

The adopted child also brings issues with which a family may have difficulty dealing. The child's age, behavioral problems, number of previous placements, and past history can influence his or her integration into the household (Robinson, 1998; Simon and Altstein, 2000; Herman, 2008; Rosenberg, 2010; Child Welfare Information Gateway, 2012b). Children may never have resolved their conflict over loyalty to birth parents versus adoptive parents. Some experience attachment disorder and have a great deal of difficulty with new relationships. Experts suggest that the adoptive family's ability to handle destructive, aggressive behaviors (often the result of the child's abusive history or multiple moves) and the adequacy of the family's support system are also key factors.

Effective casework on the part of the placement agency is vital when the family is at risk for disruption or dissolution, and indeed throughout the placement process. In her study of adopted children, Festinger (1990) found that continuity from the agency lowered the risk of disruption. For example, families who maintained the same social worker throughout the placement process were less likely to experience disruption. Helping families work out these issues is a difficult task but a vital one in the adoption process. Unfortunately, after the adoption is legalized, families usually lose contact with the adoption agency and there may be no way for the adoption agency to know that the family is in trouble. Some families—although not all—will reach out to the original agency for help.

The Role of the Adoption Worker

Adoption workers perform a variety of roles. In some agencies, they specialize (e.g., in home finding, recruitment, or placement); in others, workers vary their assignments. Stacia Fellows, who has been in adoption for close to 25 years, describes her experience:

> When I first got out of school, I worked for a large state agency, first as a placement worker. My role was to see children in foster homes and prepare them for adoption. Often I worked closely with their family worker, the social worker who was helping the family release the child for adoption. Once the child was legally free, I'd look for a couple or individual to meet the child's needs. I'd place the child and follow-up with the family until the adoption was legalized. I still have families who keep in touch with me.
>
> My role, once I transferred to home finding, was equally as satisfying. I ran group home studies for couples and singles and did a few individualized studies. I'd often become quite involved with these people. Their hopes for a family, so important to many of us, rested on my relationship and ultimate impression of them.
>
> Years later I worked at a small private agency. For this agency, adoption was one service of many. We were less likely to see older children, more likely to have infants. As a worker, I worked with both children and couples. Although it was nice to see all sides of an adoption, I found specializing somehow easier.



Evaluation

Behavior: *Critically analyze, monitor, and evaluate intervention and program processes and outcomes.*

Critical Thinking Question: In what area of adoption would you most like to work? What experiences have you had with adoption? What has been the outcome? What types of courses or information would best aid you in this field? What types of interventions would best serve these clients? What type of an agency do you feel would best suit you?

Summary of This Section

- When adoptive applicants first come to an agency seeking to adopt, they may be part of an informational meeting. If they want to continue, they are assigned to a worker for a homestudy. During this series of meetings—often in a group of other applicants—social workers ask them to assess and the agency evaluates the applicants' motivations, the stability of their relationships or support systems, the appropriateness of their age and physical and emotional health, and their financial stability.
- Once the parents have been approved through the homestudy, their names are filed until a child appropriate for them is in need of placement. Following placement of a child, there is a period of supervision and then legalization through the court.
- Although most adoptions were at one time closed, there is now more openness, which sometimes requires postadoption case management. Some families also need postadoption services to deal with a variety of other adoption-related and parenting issues.
- Not all adoptions are successful. An adoption may fail prior to the legalization—referred to as adoption disruption—or after the legalization, which is called adoption dissolution. In both these situations, the child is usually removed and placed in foster care or with another adoptive couple or single parent.
- The adoption social worker plays a crucial role in selecting adoptive parents and walking them through the adoption process.

THE SEARCH AND LIFELONG SERVICES

The term **search** refers to adult adoptees' interest in finding information about themselves and about their biological parents, with the possible end of locating and meeting with them. As mentioned earlier, at one time, legal adoption results in the child's records being sealed; they become available only to the child who, as an adult, requests access and then only if the court deems the request justifiable. Today, a sealed record occurs in only about 5 percent of adoptions. Openness in adoption means that information is often more readily available and adoptees may not feel the need to search for birth parents. However, some adoptees might want to meet their birth parents whether or not their adoption records were sealed at the time of the adoption.

Supporters of the Search

Over the last few decades, several women have supported and made contributions to adoptees searching for their roots. In 1954, social worker Jean Paton, an adoptee herself, searched for and found her 69-year-old biological mother. She wrote of her experience and founded Orphan Voyage, an organization that gives adoptees support and guidance. Paton lectured widely on adoption and advocated for a "reunion file" that would contain updated information on adoptees and biological parents. This file would be available to help either party in the search (Trinder et al., 2005; Lifton, 2009). These efforts also led to more openness in adoptions.

Florence Ladden Fisher, another pioneer of adoption searches, searched for her own parents for 20 years. She reported that her whole search process, including overcoming a variety of barriers to finding her biological parents, ended in success. Fisher said that she

learned that everything based on her biological and genetic heritage was negative, whereas her adoptive experience was positive. Her eventual reunion with her birth parents helped her to resolve her identity crisis and strengthened her belief that sealing records infringes on an adoptee's rights (Fisher, 1975). The writings of numerous authors have supported the need for some adoptees to search.

Who Searches

Fewer adoptees undertake a search than one might expect, especially given the openness of recent decades. Although there are few accurate statistics on how many adoptees actually search, females, perhaps more sensitive to feelings about identity issues, are more likely to search than males. Most searchers are between the ages of 26 and 30 (Trinder et al., 2005; Adamec and Miller, 2006; Lifton 2009). At one time, the prevailing view was that adoptees who searched for birth parents had not had a positive adoptive experience or were attempting to fill a void in their lives. However, with the renewed emphasis on learning about one's roots, as well as the increased openness of adoption, searching has become a bit less suspect. Adoptive parents who are not threatened by their children's desire to search for birth parents may promote a closer, more positive relationship with these children.

Search Outcome

Among adoptees who search, many experience a favorable reunion. Having an opportunity to search gives many adoptees a more positive view of life. Arlene was a college student when she began her search. She reports:

> I think it was just the typical college student's questioning mind, rather than any real disharmony in my adoptive family that made me want to find my biological parents.
>
> My search was actually fairly easy, probably because I knew the agency that had placed me. The social worker was still there. She located my natural mother and asked if she'd meet with me.
>
> I'm a carbon copy of my mother, and it was such a shock to see her. I was so nervous at our meeting! But I guess she was, too. I learned that she was a college student when she had me, had gotten into drugs, and had gotten pregnant. She actually was asked to leave school! Now she's in business and seems to have done well for herself.
>
> I don't regret finding her, or learning that my father was just a party date. I have no real desire to find him. I rarely see my biological mother now, but I feel more self-directed—like I know who I am. My parents had a tough time initially, but they're supportive. I feel more sympathetic now to what adopting meant to them.

Data on favorable reunions are collected primarily from cases in which birth parents have voluntarily relinquished children. The neglect and abuse underlying situations in which the court removes children may make for more-problematic reunions.

What is the effect of adoptees' need to search on their biological parents? Many who have given up children for adoption (or had them taken away) have rebuilt their life, and they experience various emotions when a living memory of the past enters their life. Yet, most birth parents are agreeable to a reunion once their children have requested it. "I felt like it was the last chapter in a book I'd never finished," explained Elaine, a 40-year-old birth mother. "I knew I had a daughter. But I had no idea what had happened to her. Once I knew, I was content to let things rest. She was, too, and it worked out."

Sealed Records

The frustrations of adoptees and birth parents gave rise to organized search efforts. As previously mentioned, Orphan Voyage aids adoptees in their searches. The Adoptees' Liberty Movement Association, which inspired Florence Fisher, publishes a handbook advising adoptees how to search. Other organizations have become involved in the debate about sealed versus unsealed records. Although United Birth Parents has advocated opening sealed adoption records when a child reaches a certain age, the Association for the Protection of the Adoptive Triangle, composed mostly of adoptive parents, insists that records should remain closed. CWLA, the primary standard-setting organization for children, still advocates sealing records, although other factions argue against sealing (see Carp, 1998; Carp, 2005; Trinder et al., 2005; Herman, 2008). Today in most states, an adoptee whose records were sealed at the adoption can obtain access to sealed adoption records only if she or he has "good cause" to petition the court for access. However, "good cause" is not adequately defined; in the past, concerns over genetic abnormalities, health, and contested inheritance have been considered "good cause." The subject of sealed versus unsealed records continues to be debated (Carp, 1998; Carp, 2005), but the increased openness in adoption practices has seemingly benefited all involved (Grotevant et al., 2011).

Consent Contracts

Many adoption agencies offer natural parents the option of **consent contracts**. These contracts assure the agency that the parents agree to be contacted if their children search for them in the future. Although they are not foolproof, such contracts eliminate some of the uncertainty of past years.

Some agencies also ask adoptive parents if they would be agreeable should their adopted child choose to search out his or her roots. These procedures are believed to help future adoptees in their searches.

Lifelong Services

Today there is increased recognition that adoption is a lifelong experience. Parent organizations support adoptive parents and their adopted children in a variety of ways. These groups provide education, social supports, recruitment, and advocacy for adoptive families. Many groups publish newsletters and hold support meetings, sometimes independently and sometimes working closely with agencies. Resources and support services can be found online through such groups as the North American Council on Adoptable Children that publishes a newsletter outlining activities, resources, and adoption news across the nation or other such agencies that provide additional services like lifelong support services or adoption-specific counseling.

When children are unable to adjust, they may later be removed from the adoptive home. Only recently have theorists and clinicians begun to recognize adoption as an important factor in children's problems. The already-turbulent teen years, when individuals strive to find their identity, can prove overwhelming for the adopted child. Birth parents and heredity can become such preoccupations that the adolescent's quest for understanding, combined with the insecurity felt by many adoptive parents, creates a dangerous imbalance in the family. The results usually seen in the adolescent—impulsive, provocative, aggressive, or antisocial behavior—can lead to placement outside the home. Residential treatment centers across the country attest to the upsurge in the number of adolescents coming to them from adoptive families. Professionals treating these individuals

are becoming increasingly aware that the experience of adoption cannot be ignored if one is to take a holistic approach to the adolescents' problems.

The adoption process is complex. Many variables affect the outcome for the created family. Those in the field of adoption strive to improve services to all involved in the process.

Summary of This Section

- At one time almost all adoption records were sealed at the time of legalization. Adoptees interested in knowing more about their birth parents and background often engaged in a search for this information through contact with the adoption agency that placed them or with organizations specializing in searches. Although some adoptees might desire more information than they are given about their backgrounds, there may be less need to search in more recent adoptions.
- Over the years, numerous books have been written on the experiences of adoptees who search for their birth parents or to learn more about their backgrounds.
- Those who do search for birth parents tend to be in their 20s or 30s and are often looking for medical information or seeking to find answers in their quest for the meaning of their lives.
- Searches may have both positive and negative outcomes. Positive outcomes are more likely when birth parents have voluntarily relinquished their children.
- While records were at one time sealed, consent contracts signed by birth parents opened the possibility for adoptees to undertake searches later in their lives.
    - Adoption is a lifelong experience that may require services throughout the life of the family and the adoptee. There is an increasing awareness of this fact and agencies and support networks have developed to meet these needs.

SUMMARY

- The adoption of children was originally designed to benefit adoptive parents by providing an heir or extra hands for work at home. Over the years, the needs and rights of children have been recognized. Adoption in the United States was based largely on English common law but it was not until the mid-1800s that states began to enact laws governing adoption. These laws required that the child be released for adoption, the adoptive parents both join in the petition and the adoption be legalized in court. By 1929, all states had some type of legal statute regarding adoption. In 1958, the first adoption exchange was developed that helped children to find homes outside of their geographic area. Over the years, there has been controversy about adoption across racial boundaries. Adoption can be related adoption (where relatives adopt) sometimes referred to as kinship adoption or unrelated adoption (adoption by those not related). Adoptions are usually arranged by an agency; those that are not are called independent adoptions. These may be direct placement by the biological mother or may involve a third party.
- The issues in adoption today are varied but include the decreased number of children available for adoption, the types of children available,

independent adoption, openness in adoption, interracial adoption, and adoption disruption. There are fewer infants available for adoption today. Older children often come with a variety of special needs and issues. Although almost half of the children available for adoption are white, there are also a significant number of African American and Hispanic children in need of adoption. When the waiting list is long, some applicants seek out independent adoption, which can range from a direct placement by the biological parent to the use of an intermediary sometimes for profit. These adoptions may be illegal (if for profit) but do not offer the same services and safety precautions to any of the participants than adoption through an agency provides. Today, there is increased openness in adoption meaning that adoptive parents and adoptees may have more information than in the past and may have contact with birth or foster parents under agency supervision. Transracial adoptions may be either domestic or intercountry, sometimes referred to as international. In both cases, adoptive families must be aware of the cultural differences and prepared to deal with them in a way that benefits the children. Adoptions may fail (called disruption before legalization and dissolution after legalization) for a variety of reasons whether as a result of the adoptive parent's issues, the child's inability to adjust or other factors.

- Children become available for adoption through either a voluntary surrender or abandonment by their birth parents or through the termination of parental rights by the court. Giving up or losing one's child involuntarily has an impact on birth parents, including feelings of guilt, anger, sadness, feeling out of control, feeling stigmatized, and wanting to blame others. Agencies attempt to help these parents with these issues. When children are placed for adoption, they too may have conflicting feelings especially when they are placed when older. These children may have experiences trauma in their young lives and some have difficulty adjusting to a new home. Children from other countries experience adjustment issues related to not only their past experiences but also the differences in cultures and language. Adoptive applicants may also have conflicting feelings. Those who have fertility issues may be grappling with self-concept, grief, and sadness made real by the step to adopt. Applicants may also worry about their abilities to parent and what challenges the child might bring. Adoptive siblings too may have concerns about how this will affect their roles in the family.
- After receiving information often through informational meetings, applicants are assigned to a social worker who completes a homestudy—a series of interviews either individually or in a group. This study looks at such issues as the stability of their relationship, their motivation, their age and health, and their financial stability. Once they are approved for adoption, their file is kept until an appropriate child becomes available. After a child is placed, the home is supervised by a social worker usually for a period of between 6 months and a year. At the end of this time, a petition to adopt is filed with the court and the adoption is legalized. Although the case is usually closed at this point, there is an increasing number of **postlegalization services** through agencies or community organizations. If a case fails during the supervision period and prior to legalization, it is

referred to as an adoption disruption. After legalization a failed, adoption is termed "adoption dissolution." The adoption worker plays a prominent role throughout the adoption process.

- Some adult adoptees seek more information about their background or want to meet their birth parents and may undertake a search for information. Early records of adoption were sealed meaning the information was not available to the adoptee unless he or she had a court order. Over the years, birth parents have increasingly been asked to sign consent contacts, which allow their children to receive information or even meet them if this is what the adoptee desires. Adoption is a lifelong experience, and there is increasingly recognition on the part of agencies and advocacy groups that lifelong services should be available.



13

Children in Residential Settings

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Discuss the historical roots of residential treatment for children and how these have led to the types of residential settings today.
- Describe how children progress through residential settings, from placement through termination.
- Discuss the work that is done with parents whose children are placed in residential settings.
- Explain the various roles of staff within residential settings.
- Discuss the trends in residential settings and how these influence the future of residential treatment.

CHAPTER OUTLINE

HISTORICAL PERSPECTIVE AND TODAY'S RESIDENTIAL SETTINGS 337
Historical Perspective 337
Types of Residential Care Today 340
CHILDREN IN RESIDENTIAL SETTINGS 346
Meeting Community Needs 346
Meeting the Child's Specific Needs 347
Adjustment to Placement 348
Life in a Residential Setting 348
Components of a Residential Setting 348
Level System and Token Economy 350
The Influence of Peer Culture 351
Handling Crises in Residential Settings 352
Sexually Acting Out in Residential Care 354
Sexual Abuse of Children in Residential Care 356
Termination from Residential Setting 357
Hospitalization 358
WORKING WITH FAMILIES OF CHILDREN IN RESIDENTIAL CARE 361
Motivation of Parents 361
Types of Family Treatment 363
Problems in Working with Families 363
THE ROLE OF STAFF IN RESIDENTIAL SETTINGS 364
Residential Staff 365

HISTORICAL PERSPECTIVE AND TODAY'S RESIDENTIAL SETTINGS

Residential settings for children have evolved as society's view of children and their needs has changed.

Historical Perspective

Early institutional care was based on the concept of providing homeless children with a place to stay. In France in the fifteenth century, St. Vincent dePaul established homes for abandoned children. The first U.S. institution

Educational Staff 365
Clinical Staff 366
Other Staff Functions 367
The Frustrations of Staff 367
TRENDS IN RESIDENTIAL SETTINGS 368
Environment 369
Staff Issues: Training, Support, and Self-care 369
Integration of Services, Program, and Culture Changes 370
Family Involvement 371
More Effective Evaluation 371
SUMMARY 372

to house children was founded by the Ursuline nuns of New Orleans to harbor children orphaned by the Natchez Indian Massacre (Askeland, 2005; McKenzie, 2009; Pecora et al., 2009; Rohs and Estrine, 2011).

For many years, poor children resided with their parents in almshouses. But critics of these institutions felt that they were unhealthy for young souls and bodies and encouraged separate sections of almshouses, if not separate institutions, dedicated to children's needs. In 1875, the state of New York mandated that children be removed from almshouses and placed in institutions specifically set up for children or in families. The movement to establish orphanages flourished. By the early 1900s, close to 125,000 children were living in U.S. orphanages (Holt, 2004; Reef, 2005). Most of the children's institutions that were built were designated for white children; they had policies excluding African American children (Billingsley and Giovannoni, 1972; Everett, 2004; Holt, 2004). Built mostly by charitable, benevolent, or religious organizations, these orphanages, sometimes called orphan asylums, served to house and feed children as well as instill in them a sense of order, good moral character, and obedience. The hope was to save children from both physical and moral degradation (Keith-Lucas and Sanford, 2011).

Using residential care as a tool to address psychoanalytic issues was first addressed in 1925 in August Aichorn's book, *Wayward Youth*. Following this, Barbara Dockar-Drysdale became a pioneer in her work with emotionally deprived children during World War II (Blau et. al., 2014).

As childcare institutions increased and flourished into the mid-1900s, there came the rumblings of criticism of the effects of institutional care on young children's development. In 1951, Bowlby, in **Maternal Care and Mental Health**, written as a United Nations Report, discussed considerable research demonstrating that institutional care had a negative effect on children. In 1961, Goffman wrote his well-known **Asylums**, in which he argued that children brought up in institutions learned behaviors that impeded their ability to adjust once they left the institutional setting (Kadushin and Martin, 1988).

While orphan asylums were built and debated, another type of institution for children came into being. **The House of Refuge**, the first residential setting for juvenile delinquents, was built in New York in the 1800s and was followed by similar institutions in Boston in 1826 and in Philadelphia in 1928. In Massachusetts, **the Lyman School**, a state-funded reform/training school for delinquent boys, opened its doors in 1847 and operated until the early 1970s on the model of the German agricultural reformatory (Pecora et al., 2009). The 1800s also saw the development of institutions for the mentally retarded, deaf, blind, and physically handicapped (Askeland, 2005).

Another type of institution for children, the residential treatment center, began in the 1930s. Residential treatment centers were based on an increased interest in mental health and the recognition that some families could not meet their children's needs. Emotionally disturbed children became a new interest of practitioners, and techniques to treat them as groups in congregate settings became popular. The movement toward deinstitutionalization in mental health and juvenile justice changed the complexion of residential services and creating an expansion in the types of clients served and in the provision of treatment both for the children and youths and for their families. In addition, there was an upsurge in community-based programs serving juveniles (Blau et al., 2014).

Pecora et al. (2009) suggest that the history of residential care can be divided into four phases: (1) provision of separate institutions for children, as opposed to mixing them with adults; (2) the move to cottage or family-style units, as opposed to barrack-style living;

(3) the psychological phase, which emphasized the introduction of treatment concepts, as opposed to maintenance of children in institutions; (4) the environmental or ecological phase, which emphasized evaluation of outcomes in residential care. One might propose a fifth category to describe the more recent trends in residential care; and (5) reorganization with emphasis on trauma-informed care.

The history of one large institution, the **Devereux Foundation**, exemplifies how institutions for children developed in the United States. In the early 1900s, while the Philadelphia media were expounding on the quality of local schools, there were few services available to address the needs of children who had fallen behind their classmates in school. One educator cognizant of this deficit was Helena Trafford Devereux, a young teacher who began to focus on children with special needs. Initially she taught mentally retarded children within the public school system. In 1912, she began a program in her own home, designing an around-the-clock program for three children in a homelike setting. In 1918, she moved the children to a home in Devon, Pennsylvania, and a year later she was ready to expand her program into an adjoining house. Parents of special-needs children began to seek out Devereux, and the school/residence expanded until it became the Devereux Schools in 1924. As Devereux's reputation grew, the program continued to expand. Additional components helped train male adolescents for trades, and a camp component offered therapeutic programs as well for children and adolescents who were brain-damaged, mentally handicapped, and/or emotionally disturbed (Devereux Foundation, 1987).

By 1938, Pennsylvania had granted the Devereux Foundation a charter that allowed them to study, treat, undertake research, and educate others about children and adolescents with varying psychological and psychiatric needs while addressing the intellectual, emotional, and vocational needs of these children and youths (Devereux Foundation, 1987).

During the 1940s, the Devereux Foundation opened centers in other areas of the United States as well as several new centers in Pennsylvania. From treating mentally retarded and emotionally disturbed children, the Foundation expanded its programs to serve children with the newly diagnosed condition of autism. The 1950s saw additional expansion, and in 1958 the American Psychiatric Association made Helena Devereux an honorary fellow; she was the first woman without a medical degree to be so honored. By the 1970s, Devereux's standards in residential treatment had become the model for other programs across the country (Devereux Foundation, 1987).

Today, the Foundation offers programs for mentally retarded/developmentally delayed children, emotionally disturbed and autistic children and adolescents, and individuals with head trauma. Programs serve 11 states and provide such services as residential treatment, group homes, supported apartment living, therapeutic foster care, day treatment, respite services, and partial and acute hospital facilities. In addition, the Foundation carries out research and provides training for those interested in therapeutic work with a variety of populations. Although not all institutional programs for children have the components of the Devereux Foundation, many provide such services on a smaller scale.

The complexion of childcare institutions has considerably changed since the nineteenth and early twentieth centuries. Once the most popular childcare institution, the orphanage has all but disappeared as a result of the recognition of the importance of a family setting to children's healthy development. This extinction began when cottage settings or family-style units began to replace the sterile barrack-style buildings of early orphanages. The deinstitutionalization movement of the mid-1900s continued the trend toward replicating family and community whenever possible. Despite the lessons of the past, today's political leaders have spoken of the reestablishment of orphanages.

Although some institutions for children with physical disabilities still exist, the move is toward having those who have disabilities live in the community, rather than an

institution, if they can. Often children with physical disabilities who need more care than can be given at home are housed in community group homes. The emphasis on the least restrictive environment and the preservation of the family has significantly changed the nature of residential settings.

In the last several decades, residential models have changed significantly. Not only have methods of treatment and best practices evolved, but the use of the **psychotherapeutic milieu** has continued to evolve. Today, the emphasis on trauma-informed care has challenged residential centers to revise their attitudes, approaches, and treatment methods (Hummer and Dollard, 2010; Hummer et al., 2010; Knoverek et al., 2013; Nisenbaum, 2013; American Association of Children's Residential Canters, 2014; Nowicki and Pestine, 2015).

Types of Residential Care Today

Currently, residential settings serve several different populations, but all of these are designed to meet the needs of children and youth who require more intensive services than can be provided in foster care family settings. It is important that residential settings not be seen as one entity and lumped together. There are many types of residential facilities, each meeting the needs of a different type of population. In addition, not every type of residential service is provided by one specific agency. Residential programs range from small group homes housing as few as four adolescents to large institutions that might service several hundred residents. All of these settings are designed to meet the various needs of their residents and often their families.

The Child Welfare League of America's (2004) Standards of Excellence for Residential Services identifies seven types of residential care settings. These are:

- Supervised Independent Living Programs (also known as supervised/staff apartments) or SILPs
- Community-based group homes
- Residential treatment centers (RTCs)
- Intensive Residential treatment (RTFs)
- Emergency shelter care
- Short-term or diagnostic reception centers (DRCs)
- Detention and secure (or nonsecure) treatment centers



Evaluation

Behavior: *Critically analyze, monitor, and evaluate intervention and program processes and outcomes.*

Critical Thinking Question: Residential services are some of the most undervalued services despite the fact that they can have a great impact on the children they serve. Research online various residential services, the populations they serve, and their goals with clients. What type of residential center would most appeal to you as a practitioner? Where might you have the most opportunity to use your knowledge and skills to be proactive?

Some settings have multiple units to serve clients with various types of problems. For example, a large center might have a cottage dedicated to diagnostic services, where children stay for a short period while a treatment strategy is devised for them. The same center may have another section designed to treat children over a longer period while working with their families and attempting to integrate them back into the community. Some centers have components that deal with children who are severely disabled and/or developmentally delayed and other components that deal with higher-functioning children. There are also residential centers that treat dependent children, who may be in the care of the social services agency, as well as children whom the court has adjudged delinquent. These centers also may see children on a short-term basis (an arrangement often called an emergency placement) or on a longer, ongoing basis. The combinations and possibilities are endless. There are also a few settings that specialize in the treatment of children with certain types of problems, for example, adolescent sex offenders.

As you consider the types of services provided in residential settings, bear in mind that a center may either specialize or provide a variety of services in one organization.

Supervised Independent Living

Supervised apartment or **supervised independent living** programs provide housing and supervision for up to four adolescents giving them an opportunity to try out some degree of independence. These programs may be housed within apartment complexes or in houses within a neighborhood. Some have live-in staff, while others use part-time staff depending upon the needs of the clients.

Community-based Group Homes

Community-based homes are small homelike settings (often a converted house) that house up to 12 children or youths. The residents use the resources provided within the community, including schools and educational setting, employment opportunities, health care, and recreational programs and opportunities. There is 24-hour staff coverage either by live-in staff or through staff on a shift basis. Such settings are often for higher functioning clients who are able to have some community involvement. Group homes may be for those with psychological, emotional or psychiatric issues, substance abuse, physical disabilities, or developmental delays.

Residential Treatment Centers

Residential treatment centers (RTCs) are perhaps the most common setting for children and adolescents who are in need of intensive, specialized care.

RTCs specialize in the therapeutic milieu, combining therapeutic services from residential, educational, and psychological perspectives (Harris, 2003). Children and youths are placed in residential treatment settings for a variety of reasons. The most common reasons are to protect the child, protect the community, or address the child's behavior when that behavior cannot be managed in the home, school, or community. Some children become so involved in self-defeating or destructive behaviors that it is necessary to treat them around the clock. Their disturbance may also require professionals skilled in addressing such behaviors. Residential treatment allows for the constant supervision and technical interventions that are not possible in the home. Children with psychiatric problems, or those who are in danger of hurting themselves or others, are especially appropriate for such out-of-home placements (Development Services Group, 2011a).

The following descriptions illustrate the types of children for whom residential treatment is appropriate:

- Donald, a 13-year-old who has been involved in criminal activity, was seen by the juvenile court for breaking and entering, assault, truancy, and drug possession. Due to his parents' inabilities to parent effectively and Donald's violent temper, placement was recommended by juvenile court. His volatile behavior precludes a foster home. Residential treatment was the alternative.
- Janis is 14 years old. She was severely sexually abused by her father and two of her uncles. She became pregnant at age 13 and gave up her child for adoption. Janis is extremely impulsive, very interested in boys, is bulimic, and into cutting herself with knives. Due to this mother's inability to cope with her daughter's behavior and Janis' obvious treatment needs, the social service agency working with Janis has recommended residential treatment.

Usually, placement in an RTC is initiated by one or more of four sources that may also assume the cost of placement: the school, the social service agency (often child protective

services), the juvenile court, or the probation officer or agency dealing with delinquent behaviors or the child's parents. With the recognition of the numbers of children who are victims of sexual abuse and who are acting out their victimization by sexually abusing other children, an increased number of centers have been established that deal specifically with these children. This allows staff to address sexuality as well as the myriad other issues that children bring to treatment. The uniqueness of the population enables the facility to tailor its structure (e.g., one person in a room to prevent sexual interaction) and services to these children's/youth's needs.

An RTC is usually seen as the last alternative for children and youth. Those who are placed in such settings have either had difficulties in foster homes or demonstrate behavior that would be difficult to handle in a family setting. Some have difficulty with attachment and forming relationships, so they may do better in a group than in the intimacy of a family (Owens, 2008; Holden, 2009; Oppenheim and Goldsmith, 2011; Levy and Orlans, 2014). Children and youth who are extremely self-abusive or suicidal cannot conform to family rules, are dangerous to others, or are exceptionally destructive of property may be candidates for residential care.

Case Example Nancy

Nancy was 12 years old when her mother was institutionalized. From the age of 4, Nancy had been in and out of foster care. "My mom had been sick for a long time," she recounts. "We never knew who she'd be and when. Sometimes she was like another kid, and it was fun to be with her. We didn't get meals and stuff, but we got used to that. But sometimes she'd sleep all day or scream at us and curl up in a ball under the table. That was scary. It seems like every few months we'd end up in a foster home. I got sick of it."

When her mother was finally institutionalized, Nancy ran away and was gone for several days. When she returned, she was once again placed in a foster home. "That was just it!" she explains. "I was sick of everyone telling me what to do, of new rules and new faces! The foster mother's kid really got to me. I couldn't stand the little brat! I got really mad one day and pulled a knife on him. I think I would've killed him, but the foster father talked me out of the knife and the foster mother called the social worker. The next thing I know, I'm in this place with other kids who'd blown out of foster homes too.

The trend is to place children in the least restrictive setting. Some settings are locked, and the staff-to-child ratio is high. Others are more like a community setting, and residents have considerable freedom. Each child's needs are considered when he or she is placed in an RTC with the hope is that will be enough structure to meet his or her needs.

What makes an RTC more beneficial than family environments for some children and youth? First, having a staff of several people provides residents with opportunities for diluted emotional interaction with others. Instead of one mother and one father, children and youth in residential settings have choices as to the parenting figure to whom they are exposed. Attachment-disordered children can feel comfortable with less-intense relationships while they learn to trust. They can also feel safe by knowing that there is structure with consistent rules that a family setting cannot always offer. For the staff, relating to the children and understanding their needs is their primary function while they are on duty. Not faced with the task of maintaining a family, as foster parents are, childcare staff can be more focused on their charges' needs (Anglin, 2003; Manso et al., 2008).

RTC programs are structured specifically to meet the residents' needs. The treatment environment can be orchestrated to address each child's therapeutic challenges. Each resident's day can be planned to be of maximum therapeutic benefit. If a child or teen is having difficulty with his or her program, it can be adjusted. If there are problems with roommates or cottage mates, the unit can be rearranged. These changes might not be possible within a

family setting. Educational programs can be geared to the abilities of the particular child and can be closely monitored if changes are necessary (Anglin, 2003; Manso et al., 2008; American Association of Children's Residential Centers, 2014; Blau et al., 2014).

Residential treatment settings can also accommodate a wider range of destructive behaviors. Although most foster parents learn to child-proof their houses, the fact remains that they have invested more in the preservation of their furniture, house, and possessions than do staff in an institutional setting. Residences also tend to be furnished with almost indestructible furniture and few fragile items.

Granted, the attributes of RTCs described previously represent conditions in the best-case scenario. In reality, staff is not always consistent; there is usually a high turnover rate. Training for childcare staff often is not given as much time and emphasis as would be ideal. Inadequate funding may mean that school supplies are in short supply, and vandalism still occurs. (Additional problems will be discussed later in this chapter.) However, on the whole, the comparatively impersonal structure of a group residence gives some children and teens better opportunities for therapeutic intervention.

Intensive Residential Treatment

Intensive residential treatment programs provide therapeutic services that are more intensive than typical RTCs. The staffing, structure, and environment provide more safety for complex behavioral and emotional issues and allow for more individualized services.

Children who have been exposed to extreme trauma in their families may need treatment or respite before they are able to respond to another family experience such as a foster home. These children are usually young, and their final plan may involve adoption.

Case Example Shannon

Shannon was the oldest of four children, all of whom had been severely neglected by their birth mother. For days at a time, the children were locked in a darkened basement with no food, water, or bathroom facilities. When they were taken from the basement, they were beaten for soiling themselves. These conditions persisted for several years before the children were discovered by a repairman and reported to CPS who removed them from the home. Shannon, then 10 was extremely protective of her younger siblings and adamant that they not be placed separately. Because the complexity of the children's needs, a foster home could not be found for the entire group, and the four children were placed in a small church-sponsored treatment residential center. Shannon was helped to feel safe and to overcome some of the residual behaviors caused by her mother's neglect and abuse. Eventually, an adoptive home was found for all four siblings.

Emergency Shelter Care

There are times when children or teens are in need of immediate and emergency placements. Shelter homes are used when children are awaiting adjudication in court, if they are unable to remain home but no other placement is immediately available, or when they are awaiting placement in a more structured residential center. Most of the residents of these programs have specific emotional and behavioral problems and other types of special needs. Short-term shelters usually keep residents for 30 days while children or youth may be kept in long-term shelters for up to a year. Such shelters provide intense client-staff interact, a specific daily schedule, and very little contact with visitors. Unfortunately, such centers can be crowded and despite the presence of staff, the mix of various types of clients can lead to a variety of problems like bullying and other behavioral incidents (Development Services Group, 2011b).

Diagnostic Services

When a child is in emotional distress, it is not always clear what has caused his or her behavior, suicide attempt, depression, or other manifestation of disturbance, or what type of treatment will be most helpful to him or her. In order to best serve the child, this information must be discovered. **Diagnostic service centers**, or diagnostic components of programs, observe children closely while having them participate in various types of testing and assessment interviews. These are time-limited intensive services that seek to determine what type of treatment or setting the child or adolescent needs. Children and teens stay in diagnostic centers from a day or two to several months, depending on their needs and the availability of services for them once they leave the diagnostic center. Some agencies use diagnostic programs not only as initial screening tools but also as evaluative services.

Secure Treatment for Delinquents

Case Example Harvey

Harvey was a 15-year-old with a long history of delinquent acts. He had been in and out of the court system since he was 10. When he pulled a knife on another student at school, he was arrested and again referred to the court. Harvey became out of control in the courtroom and threatened to "get that lousy kid who sent me here" (the child on whom he had pulled the knife). Feeling that Harvey was a safety risk, the judge sent him to a secure detention center until further plans could be made. From there Harvey was placed in a locked setting for delinquent boys.

The goal of secure treatment is to protect the community from delinquents while trying to change their behavior until it is possible to place them in a less-secure setting, usually a residential treatment center. Most secure settings are locked and have a high staff-to-student ratio. Residents are closely monitored, have educational services at the facility, and receive intensive therapeutic services. The hope is that the restrictive setting, combined with the intensity of the intervention services, will help the individuals gain sufficient control so that they can benefit from a less-restrictive treatment program.

Several factors determine if a child is placed in a secure setting or in a residential treatment setting that is less secure. First, the child's behavior must be assessed to determine how injurious it is to self or others and if it can be managed without constant attention from staff. Second, the child's potential to develop inner controls is important. Can he or she monitor himself or herself to some extent, or must the controls be totally external? Third, does the child have a history of running away? Many nonsecure centers have no recourse but to let the child run away. A locked center might be more appropriate for a chronic runner. Finally, the choice of where the child is placed may not be based as much on therapeutic considerations (although it should be) as on which institution is able to take a child at a given time (Harris, 2003).

Centers for Children with Severe Special Needs

In addition to the above mentioned programs, there are also those for children with severe special needs. When children have severe special needs, their parents may not be able to care for them. For example, one center for brain-injured children took those who could not do any self-care. Most of these children had become older, larger, and too heavy to carry easily, or their needs were too complex for their parents to handle. Many of the parents had been well-intentioned when their children were little and had

expected to keep them at home. But time had taken its toll. As their lives began to center exclusively around these children, many parents felt they no longer could care for them. This is not to say that many parents do not feel terribly guilty about their decision to place their child in a residential setting. But many also realize that the residence may be better equipped to deal with their child's issues. In addition, having a special-needs child in a family can be difficult for other siblings. Sometimes the parents must also consider the other children's needs.

Centers for the significantly developmentally delayed or physically disabled children are usually staffed by a variety of professionals, including medical personnel. The facility may look like a hospital when the population is more severely disabled, or it may look like any other institution or even a large private home. Services usually include medical care as well as residential and educational services for higher functioning clients. Some centers also have a day program in which children can spend the day, giving their parents respite to work or perform tasks for the rest of the family.

More recently centers for children with special needs have given way to smaller community residences. Often these are part of a network of residences that can provide the medical and psychiatric care needed for the residents.

Summary of This Section

- Early institutional settings provided homeless children with places to live. Poor children who had once lived with their parents in almshouses were placed in homes, which would soon be known as orphanages. Orphanages, usually under the sponsorship of religious or charitable organizations, flourished in the late 1800s and early 1900s.
- Following World War I, the interest in and study of psychoanalytic principles gave rise to institutions that addressed children's emotional issues.
- In the later nineteenth and early twentieth centuries, there was also an initiative to address delinquents in residential setting. New York and Massachusetts established several institutions—often called reformatories or reform schools—to address the rehabilitation of delinquent children and youth.
- The residential treatment center emerged to house and treat children and youth with mental health issues that could not be appropriately addressed in a foster home setting.
- But the tide turned once again in the 1960s and 1970s with the movement toward deinstitutionalization of those with mental health problems and delinquency issues. Now the trend was toward community treatment and smaller group homes rather than large institutions.
- The history of one large institution exemplifies the growth and diversity of residential settings. The Devereux Foundation began in Philadelphia during the early 1900s through the work of one educator, Helena Trafford Devereux whose focus was children with special needs. Her residential program began in her home in 1912 and expanded over the next few years.
- By 1924, the Devereux Schools were continuing to expand until in 1938 there were issued a charter by Pennsylvania that allowed them to operate centers for children with a variety of different special needs. Today, the Devereux Foundation operates a variety of programs in several different states.
- In the last few decades, services have been modified with the awareness that children and teens who come to residential settings have most likely been traumatized and are in need of trauma-focused care and treatment.
- Child Welfare League of America recognizes seven types of residential settings: supervised independent living also known as supervised or staffed apartments used

for youths who can handle more freedom; community-based group homes, which operate within the community helping youth and children make use of community resources; RTCs used for children and youth with emotional or psychiatric problems that cannot be handled in a home setting; RTFs for more severe emotional, psychiatric, or delinquent issues; **emergency shelter care** in case where children or youths need respite or are awaiting a more permanent placement; short-term or diagnostic centers used to assess the needs of clients to choose the best treatment or most appropriate placement; and detention centers that contain delinquents that might be a danger to society or themselves. Some centers specialize in one specific roles, while other centers may have multiple units assuming different roles. There are also a few centers that specialize in housing and treating children with physical disabilities.

CHILDREN IN RESIDENTIAL SETTINGS

Children and adolescents who are placed in residential settings often bring with them histories of trauma. Briggs et al. (2012) found that 92 percent of the children and youth in residential settings had experienced multiple traumatic events with 5.8 as the mean number of exposures. Of their sample of 525 youths, 68 percent had experienced severe emotional abuse, 62 percent traumatic loss, 60 percent an impaired caregiver, 58 percent domestic violence, 54.5 percent physical abuse, 40 percent sexual abuse, 31 percent violence within the community, and 20 percent school violence. Girls were slightly more likely than boys to have been sexually abused. In addition to being victims of traumatic events, many residents had also witness such things as school violence, community violence, and physical assault by peers (Zelechoski et al., 2013). Most children and youth enter residential treatment not from their birth family home but rather from another type of placement. One study indicates that the families of most of the youth had substance abuse problems (51%), used discipline inappropriately (47%), were neglectful (39%), had marital/relationship problems (38%), were incarcerated or had been arrested (30%), had mental health issues (24%), there was domestic violence (23%), the parents were unemployed (17%), or the family was isolated (11%) (Griffith et al., 2009). An examination of admissions indicated that 84 percent of the youth had at least one prior out-of-home placement and 35 percent were in-state care prior to placement in a residential setting (Briggs et al., 2012).

What might point to placement of a child in residential care rather than in a foster home? The earlier section "Types of Residential Care Today" alluded to some answers to this question. Basically, children are placed in these centers because their needs are beyond the domain of the foster care system. Some are placed due to the community's needs and some due to the child's own specific needs.

Children placed in residential settings tend to have a greater percentage of family problems (72%) compared to other children and youth receiving mental health services. They also exhibit more school problems (57%), have skills deficits (22%), exhibit delinquent behaviors (34%), and substance abuse issues (31%) (Briggs et al., 2012).

Meeting Community Needs

Some children are placed in residential settings because they cannot function appropriately in the community and are, in some cases, a danger to the community. These children may be homicidal, prone to setting fires, sexually abusive, or otherwise injurious to others.

Case Example Quentin

Quentin was 10 years old when he killed his younger brother. After a brief observation period, it was felt that he must be placed in a center for severely disturbed children. He had three other younger siblings and had threatened other children in the neighborhood. His parents admitted that even they were afraid of him.

Meeting the Child's Specific Needs

A child also might be placed for his or her own protection. Some children are suicidal or abuse substances to a degree that is unmanageable in a home environment.

Case Example Wendell

Wendell was a 14-year-old who had been taking drugs and drinking since he was 9. When he was 9, he and several friends stole cough syrup containing codeine and drank it in large quantities to enjoy the effect. Later, Wendell graduated to street drugs and alcohol. By age 12, he usually was drunk or "stoned" on some substance. A drug addict herself, with five other children, his mother had little control over his behavior. At age 13, Wendell was removed from his home due to severe neglect. Then followed placement in seven foster homes within a year. Finally, Wendell was placed in a secure residential setting.

Sometimes, a child's behavior is not necessarily dangerous to self or others but is so disturbed that neither the birth parents nor foster parents can manage it.

Case Example Marina

At age 9, Marina was diagnosed as psychotic. Her severely abusive background gave her little ability to trust adults, including the therapists who had tried to help her. She hallucinated and seemed unable to maintain touch with reality. After a series of placements in psychiatric hospitals, it seemed better, both emotionally and financially, to place her in a center for severely disturbed children.

There are also children who can benefit from the type of treatment provided in a residential setting. For those who have demonstrated a self-perpetuating cycle of dysfunctional behaviors that could not be dealt within less restrictive settings, a residential program may be the answer.

In some cases, a child needs treatment that requires skills that the parents do not possess; residential placement may be the solution.

Case Example Vivienne

Vivienne was adopted by the Reiners when she was 5 years old. Because of her bizarre behavior, the couple sought help from a therapist who believed that that Vivienne was having difficulty bonding with her new parents or anyone else. Several further diagnostic screenings made it clear to the distraught Reiners that Vivienne had "attachment disorder," a condition usually associated with early trauma that renders an individual unable to bond with others. As a result, the individual has little



Intervention

Behavior: *Critically choose and implement interventions to achieve practice goals and enhance capabilities of clients and constituencies.*

Critical Thinking Question: What have you learned about attachment disorder? What strategies might help with children with attachment disorder? How would this prepare you to work with a client like Vivienne? Do you believe that what you have learned would help you to work with her effectively?

feeling or empathy for others and may actually harm them. All concerned felt that Vivienne should be placed in a residential setting that was a pioneer in the treatment of attachment disorders.

For such children, a residential setting is used when all other attempts have failed. Some children perceive this and strive to make good in this new setting. Others feel that this is the "end of the road" and have difficulty with their residential experience. Effective casework with these children can often help them recognize that there is hope.

Adjustment to Placement

Often, placement in residential care is abrupt and children are given little opportunity to adjust to it. Children have feelings about the transition even if they are given time to acclimate to the idea and even if preplacement visits to the new site help them accept the fact of placement.

The predominant feeling among children who have been separated from their parents is that they are bad. This may be especially true when the placement is in an institution. Then children feel that they may have been "too bad" to live in a family setting. They may even feel that placement is a form of punishment. It may require intensive casework to help children recognize that there are problems but that it is possible for them to change their behavior.

We can probably all remember a time when we had to go from a family environment to an impersonal setting and how that felt. Perhaps your going to college was the first time that you were suddenly alone in a room with the bathroom down the hall and none of the little personal touches of a private home. Further, it may seem that there is no one there who cares exclusively about you. Children in residential settings may also have this isolated, impersonal feeling but often at a much younger age. One way to help placed children overcome this feeling is to allow them to bring personal items from home, such as special toys or other objects. These are sometimes referred to as transitional objects.

Feelings of aloneness may cause some children to isolate themselves from their peers. Children may need time and help learning to recognize their own and others' needs before they acclimate to congregate living. However, such living can provide valuable lessons in the development of social skills.

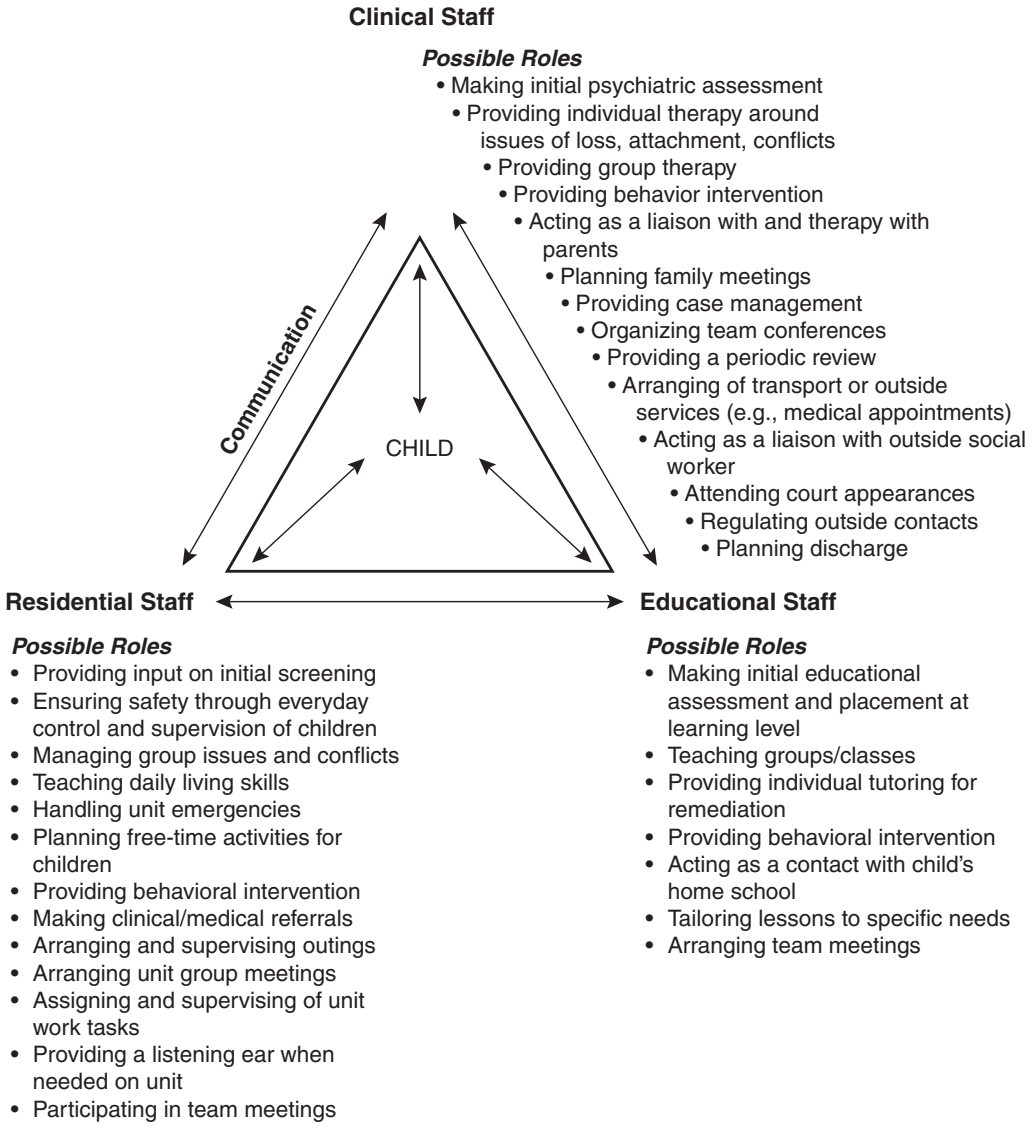
Life in a Residential Setting

Every residential setting interprets its mission differently. In general, a residential setting strives to provide a safe, structured atmosphere for children and to help them gain insight into and overcome their issues. At the same time, some of these centers work with families to help them understand and manage their children's problems when the children return home. The intent of an RTC for example, is to move the child, through treatment, to a less-restrictive setting, preferably his or her home or a foster home. The child's stay in the residence is meant to be temporary, usually no more than several months to a year or two. Residences for more chronically involved children may expect to keep them until their majority, although this is the exception rather than the rule.

Components of a Residential Setting

Most residential settings have three components: **residential**, **educational**, and **clinical**. Although the components of group care are designed to work together in a total program for each child, called the therapeutic milieu, each component provides a different service

Figure 13.1 • Milieu Therapy



Source: © Cynthia Crosson-Tower.

(see Figure 13.1). The residential component comprises staff members who interact with children in their living space and guide them through daily routines (meals, bedtime, etc.), ensuring that the environment is stable, safe, and as consistent as possible; seeing that peers interact appropriately; and providing residents with positive, caring adult role models and opportunities to interact with these adults. It is not always easy to maintain consistency or positive relationships with children who have behavior problems. The role of residential staff can be as challenging as it can be rewarding (Harris, 2003; Smith, 2008; James, 2011; Fulcher, 2012; Nisenbaum, 2013).

Children may live in dorms with **childcare workers** who monitor them while they are in this setting. Childcare workers or residential staff may continue to be with their charges at any time when the children are not with their therapists or in school. Or children may

reside in smaller, more-homelike settings, often referred to as "cottages" or "houses." In these settings, there may be **houseparents** who act almost like surrogate parents. The type of setting children reside in differs from agency to agency and is sometimes based on the children's ability to function independently. For example, one residence for disturbed girls operates on a **level system**. When a girl first comes to the agency, she is placed in a dorm with childcare workers who monitor her progress. When the girl has integrated into the program and seems to be following the rules, she achieves a higher level and may be moved to a residential setting that is more like a cottage. There are houseparents here, but the girl has more freedom. When a girl is almost ready to leave the center, she moves to a house that operates like an apartment. Although there is a housemother, the girls are expected to care for themselves as they would in an apartment setting. This prepares them for living on their own.

The educational component is designed to provide specialized instruction to the children to enable them to realize their scholastic potential. Many children who come to residential settings are behind educationally because their individual problem has hindered their ability to learn, they have missed too much school, or the school they attended found them difficult to teach due to behavior problems. For this reason children are tested scholastically, and their educational plan is geared toward their own level, often requiring remedial work. Teachers also maintain close contact with residential and clinical staff to ensure that they are aware of any nonscholastic issues (e.g., residual issues from the past or disputes with peers) that are impeding the student's learning or ability to concentrate (Harris, 2003; Fulcher, 2006; Manso et al., 2008; Blau et al., 2014).

The clinical component is dedicated to counseling services to help children understand themselves and their needs. Programs recognize that children and youth who come to residential settings have often experienced trauma in their lives. Thus trauma-based intervention is at the heart of the work that is done in these settings (Hummer et al., 2010). Children are seen, both on an individual and a group basis, by staff trained in social work, psychology, or mental health. Some programs offer a once- or twice-a-week individual therapy session as well as group sessions that deal with a variety of issues. Other centers offer more intensive therapeutic services. For example, one program for boys of latency age offers individual therapy with a caseworker for an hour three times a week. The boys are also involved with at least one group a day on weekdays. The groups address such issues as **anger management** and understanding their past abuse; there is a group for boys who show signs of sexually abusing others, a group that addresses substance abuse, and a group that helps them understand how to live and deal with one another in the residential setting. Almost all programs feature groups designed to enhance children's social skills and ability to problem solve and an increasing number of programs have groups to help children deal with their past abuse in their homes.

Traumatize youths also need opportunities to make choices, test their own power, and feel empowered. While at one time, RTCs especially were well-structured and regimented in ways that minimized the resident's ability to become empowered, the current emphasis on trauma-informed care has led to changes in the way that programs are now structured.

Level System and Token Economy

Many residential centers, especially those for disturbed or delinquent children, have been set up along **behavior modification** lines. There are levels, usually based on how much independence children are allowed. When children have earned a certain number of points, they may progress to the next level and be given more privileges.

For example, when a child comes to the Holyrood Center, he is on Level 1. This means that he resides in House #1 (Forrest Hall), where there is a high level of supervision and structure. While he is in this house, he cannot receive outside phone calls or leave the grounds, and he is not allowed visitors. Most boys, by following the rules, progress to Level 2 fairly quickly. This enables them to move to House #2 (Sherwood Hall), where they can decorate their rooms with their personal items, make two outside phone calls a week, and have visits from parents and siblings. Although they may leave the grounds, they must be accompanied by a staff member. Boys who achieve Level 3 move to House #3 (Garland Hall), where they have considerable independence. They can make off-campus calls and receive visitors whenever they have free time. The atmosphere at Garland House is collegial and informal, and the boys learn to do many of the house tasks themselves. They can leave campus alone with permission. If children in this system do not continue to progress, they can be dropped back down a level. It is not uncommon for children to move back and forth between levels as the events in their lives put stress on them.

Case Example Judy

Judy had been in the residential treatment center for 9 months. She had done well and had progressed to the highest level. Judy had come to the center after her 80-year-old grandmother had found her behavior too difficult to manage and Judy had been unable to adjust to two foster homes. She enjoyed the residential setting, and it was expected that, due to her excellent progress, she would be returned to the last foster home. Shortly before Judy was released, her mother, who had abandoned her as a toddler, returned and wanted to resume a relationship with her daughter. Judy, angry and confused by the attention of a woman who she had always assumed "did not want her," began to act up in the residence. She fought with her peers and finally pulled a knife on one of them. Feeling that she needed much more supervision to contain her behavior, the residence dropped her back to Level 1. It took numerous family meetings between Judy, her grandmother, and her mother before Judy was able to control her behavior to the extent that she could progress to a higher level again.

Many of these programs have used points or tokens as rewards when children abide by the rules or follow their treatment plans. The assumption is that children often feel safer with a **token economy** because they can measure their progress. Some centers use tangible rewards such as chips, but more use points, which are accounted for on a chart.

Some centers are seeking other organizational structures as critics of token economies suggest that the restraints and seclusions that has often gone along with how RTCs and RTFs especially are especially detrimental for children who have experiences of trauma. The move in some centers is to transition from level systems to youth-centered programming. Nowicki and Pestine (2015) suggest that systems that control all residents in a like manner are not effective. Instead, they suggest collaborative, youth-centered, and individualized programs that take into consideration the specific needs of each client. A variety of models have been or are being developed that attempt to address these concepts (see more under Trends).

The Influence of Peer Culture

A major factor in the rehabilitative process for children in residential treatment is their contact with their peers. These are usually children whose relations with others have been extremely problematic. Now they are faced with a group of other children, all of whom have had similar negative experiences. These children are often hyperactive, overly

aggressive, antisocial, impulsive, and troubled with a variety of other ego deficits. Even though the peer interaction may be negative, developing the ability to interact with these peers helps children develop many skills (Arieli, 1997; Anglin, 2003).

Some programs use this group environment to build a sense of group responsibility and group problem solving in a safe environment. Children and youth may have been in groups where competition and hostility were present. Other groups—such as gangs may have been more cohesive but were dysfunctional in their interaction with the community. The peer culture can be used to develop positive teamwork.

Understandably, peer interactions may have negative as well as positive influences on children. For example, children may learn antisocial and aggressive behaviors from one another, or peer acceptance may reinforce negative behaviors. It is the task of staff to intervene in such circumstances so that peer interactions reinforce functional rather than dysfunctional behaviors.



Ethical and Professional Behavior

Behavior: *Use supervision and consultation to guide professional judgment and behavior.*

Critical Thinking Question: If you worked in residential treatment, when do you feel that you might most need supervision? When might your own attitudes or values need to be processed with those of someone else in the interest of your learning?

Peer culture can also have a positive influence. In their peers, children find examples of others with similar backgrounds of abuse and family dysfunction. There is comfort in knowing that others have shared your experiences, despite the fact that children may not recognize or admit it. Further, peers give children an opportunity to try out a variety of relational styles in the relative safety of a structured environment. Whether the peer culture teaches children negative attitudes or behavior or provides support for them, it plays an extremely important role in their residential experience and treatment.

Handling Crises in Residential Settings

What is a crisis when you are dealing with a group of emotionally needy, disturbed, or delinquent children? The term "crisis" is often used when one or more children lose control. Children who feel especially vulnerable may express it by losing control. Sometimes staff can predict what might cause a child to lose control and prevent it, but a crisis often occurs when staff are unprepared for the acting-out behavior.

Case Example Dillon

Dillon had not had a self-abusive episode for months. The staff had begun to relax and not keep up their constant vigilance. When Henry was admitted to the center, his intake profile had not mentioned any self-abusive behavior, but Henry got into a fight with Yanus and became very angry. He grabbed a bottle someone had left in the kitchen, slammed it against the refrigerator to break it, and began cutting himself. Dillon, observing the scene, began to gouge deep cuts in his arm with his fingernails. Yanus, who was terrified of the sight of blood, began to scream and run around the room.

Understandably, the two staff members who were in the kitchen area saw this as a crisis and called for help. But crises are not always so unpredictable or dramatic. For example, holidays often cause crises for children in residential settings. Christmas, Easter, Thanksgiving, and birthdays may not have been the happy times most of us remember. Instead these holidays, and the excitement usually associated with them, may have pointed out to children who eventually are placed in a residential setting that their life is not as idyllic as they perceive the lives of other children to be. This may cause them to feel anger or sadness, and these feelings are often acted out. Anniversary reactions (reactions to the dates of past deaths or traumas) may also send children into crisis. And the trauma that

these clients have experienced means that there may be triggers that cause them to relive the experiences, and this may result in out-of-control behaviors.

Everyday events may also contribute to crises. Certain types of situations can increase the risk of some children going into crisis.

1. ***Lack of sufficient structure.*** Structure is an important part of residential treatment. When there is less structure than usual or less supervision, children may feel vulnerable and unsafe and lose control.
2. ***Competitive situations.*** Children who have a history of failures are often oversensitive to being placed in situations in which they feel they can fail again. Whether the event is a sports competition or doing school work and being compared to others, these fears may cause them to lose control.
3. ***Contact with family.*** Children in residential settings have usually had problematic relations with family members. Seeing them again, whether during home visits or family sessions, can generate feelings of anger, rage, sadness, and longing. Hurt children must deny these vulnerable feelings, and the way they deny is often by acting out. This out-of-control behavior can either precede or follow the contacts with family members.
4. ***Changes in relationships with staff.*** Children who have finally allowed themselves to trust another, to whatever degree, are often overly sensitive when staff leave, are inconsistent, or in some way change. Sometimes, staff will discover a change in the behavior of children who learn that a staff member is getting married. "It's like she was no longer just ours," one adolescent girl explained, remembering the time when her social worker returned from her honeymoon. The girls had been particularly difficult in therapy, and it soon became obvious that they were jealous of the new husband.
5. ***Ability to deal with stress.*** It is not always easy for children in residential treatment to deal with stressful situations. Instead of being able to handle these situations calmly, they may overreact and lose control. The stressful events can be minor or major, and even happy events can cause children's behavior to escalate. "Not only holidays but the end of school is hard at this center," one childcare worker explained. "The kids know there will be an award ceremony, and they are excited to find out who got awards. And many of them will go home in the summer, and these changes always create crises (Katz, 1988; Manso et al., 2008)."

In handling crisis events, many settings physically restrain children who are so out-of-control that words cannot calm them. Although not all agencies use physical restraints, most do have some preferred method. Usually, newly hired staff are trained in whatever method the center uses. Most techniques stress a continuum of restraint, teaching the worker first to try to de-escalate the problematic behavior and, if all else fails, to physically restrain in a manner that will not endanger the child or staff member. Increasingly, residential settings are taking another look at the idea of restraining children physically as will be discussed shortly.

Staff in residential centers learn that they can often anticipate problematic behavior. If they can recognize the child's precursors to out-of-control behavior, they can sometimes prevent it. In time, they may also be able to teach the child how to recognize what leads to crisis and seek help or activate his or her inner controls before things get out of hand.

More recently, those interested in reforming residential care have criticized the use of physical restraints and seclusion. Some researchers report that programs have found success and a reduction on restraints by using more modern methods (Nowicki and Pestine, 2015). This will be discussed shortly.

Sexually Acting Out in Residential Care

One of the most difficult problems for staff in residential care is residents' sexually acting out (see Farmer and Pollock, 1998; Anglin, 2003; Northrup, 2014). Crenshaw (1988) postulates that sexually acting out should be seen within a broader Freudian psychosocial framework. In the course of their development, children experience sexuality in different ways. Psychosocial theory maintains that the first area of sexuality is the mouth; oral gratification is the child's first contact with the world. If that contact is inconsistent or unsatisfactory, the child can develop an oral fixation. Because many children in residential treatment have experienced neglect, physical and sexual abuse, or a lack of attention at the hands of caregivers in their early years, food becomes an issue. A tendency to withhold food as punishment (e.g., "You'll go to your room with no dinner" or "You'll miss your snack") can be extremely counter-therapeutic for the orally deprived child.

A child's oral deprivation may also account for the problems many centers have in enlisting his or her cooperation in taking oral medication. Staff may assume that a child does not want to take the drug that will help him or her with depression, hyperactivity, or seizures. But the child is not necessarily avoiding the drug's effect; he or she may be experiencing conflict about the dispensing of it. Medication is often dispensed by a female nurse who appears to be the mother figure from whom the child did not receive early nurturing. Thus, anger and rage about this early deprivation are often unconsciously centered on this medical person (Crenshaw, 1988).

When a child is 1–3 years old, the bowels and elimination become the focus of psychosexual development. Thus, it is not uncommon for children traumatized during this period of development to smear feces or engage in inappropriate elimination. In addition, control becomes paramount; children can go to extraordinary lengths to control childcare staff (Crenshaw, 1988).

Case Example Juanita

Juanita, a 14-year-old who had been severely abused as a toddler, was a staff favorite. She was small for her age and had leg braces that impeded some of her activities. She sought the help and attention of staff and usually got it. She did not get on as well with peers and took a particular dislike to Dawn, a new girl in the unit. After an especially heated fight between the two girls, staff sent both to their rooms. When she was allowed to come out, Juanita was at first sullen and then extremely clingy and manipulative with staff. That night at bedtime, Dawn came crying hysterically to the staff member in charge and said, "There's crap in my room!" Indeed, there was a pile of feces on her pillow. Staff questioned everyone but could not uncover the culprit. Two days later, there was another deposit of feces. Several days after that, Juanita started another fight with Dawn. That night, Dawn's whole bed was smeared with feces, and staff began to recognize a pattern. Each time, Juanita had been particularly endearing to staff after she had apparently placed the feces in Dawn's room.

In the course of psychosocial development, ages 3–6 are characterized by preoccupation with the genital area. Masturbation may be practiced often, and it is not uncommon for children to masturbate in front of others. This behavior may also develop into a desire for sexual acting out with others, usually exhibitionism, touching, or competitiveness (e.g., "My penis is bigger than yours"). Sex talk is common. For children arrested in this period of development, genital preoccupation is quite common. One of the most difficult tasks for residential staff is to determine what types of behavior involving exposure, mutual viewing, and touching are curiosity and exploration and which are exploitive (Crenshaw,

1988). Most residential treatment settings prohibit all sexual contact. Some allow teens to masturbate when they are alone in their bedrooms. Other centers frown on this.

For several reasons, some sexual acting out in residential settings is to be expected. First, most children in these settings have had inappropriate models for sexuality or insufficient or inappropriate sexual education. Children who observe parents having sex with each other or with someone else are usually traumatized by the experience. Children who are sexually abused are not allowed to develop sexual attitudes and behavior normally. And children who are denied healthy information about sex may develop their own distorted ideas and try them out. Second, children who learn about sexuality by being victimized or watching others in adult sexual pursuits become confused. This confusion may result in a need to "try out" this behavior on others (Johnson, 1997), or they may have a psychological need to replicate the relationship they had with their parents or caregivers by setting up that same type of relationship (including the sexuality) with their current care providers (Charles et al., 2014). Also, children who have not been taught appropriate sexuality may confuse it with attention or caring or use sexuality to act out rage, control, or dehumanization. Finally, because staff do not want to jump to conclusions, they may not intervene when residents are debatably sexually acting out (e.g., brushing past a staff member somewhat seductively, touching other areas of the body such as the hair or the back) until the behaviors are obviously sexual. This is often because the staff member was abused himself or herself and cannot recognize the behavior or because the staff member has been sheltered from abusive situations and is inexperienced at the job.

The types of sexual behaviors that staff in residential settings usually identify are masturbation, especially in the presence of others; obscene sexual talk; sexual interactions between residents; exhibitionism; and exploitive sexual contact (Powers, 1993). It is vitally important that staff receive adequate training to deal with these behaviors. Powers suggests that staff may actually contribute to sexual acting out by not having resolved their own sexual conflicts, overstepping boundaries by talking about their sexual prowess or pursuits to residents, being seductive with the children in their care or with other staff members in front of the children, wearing seductive clothing, or inappropriately touching children (children may misinterpret nonsexual touching as sexual).

Group homes are increasingly undertaking the treatment of **youthful sex offenders**. Although there is some question as to whether grouping youthful offenders together is the best treatment method, such youths usually cannot be handled at home or in foster homes. Thus, the move has been to create centers, or at least units, that specialize in their rehabilitation (Cunningham and MacFarlane, 1997; Kendrick, 2007). Certainly, placing children who have sexually abused other children with others who have done the same involves some serious considerations.

Screening, Training, and Supervision of Staff

It is vital that the staff working with abuse issues and youthful sex offenders be thoroughly screened for their past involvement with sexual abuse issues and attitudes toward sexuality. Punitive attitudes or unresolved sexual conflicts in staff leave young offenders vulnerable to being revictimized because they themselves have been early victims of abuse. Staff must be well trained not only in sexual abuse issues but also in **behavior management**. And, because sexual abuse may well bring up personal issues for staff members, careful supervision is a must (Ross and deViller, 1993; Arieli, 1997; West, 1998; Kiraly, 2003). Staff also can have a significant positive impact on the outcome for youth in residential care (Quisenberry and Foitz, 2013).

Managing the Living Space

Sex offenders should be housed separately from those without a history of sexual aggression. In addition, most programs for youthful offenders provide single rooms whenever possible. When single rooms are not an option, careful supervision of residents is necessary (Ross and deViller, 1993).

Adequate Treatment Plans

Sex offenders require intensive treatment, including group and individual counseling. Therapy usually includes groups led by both a male and a female therapist. The treatment addresses such issues as denial, the offender as a victim, victim personalization (seeing the victim as a person and trying to understand how he or she might feel), social skill training, human sexuality, and relapse prevention.

Staff Protection

Some youthful offenders may pose a threat to staff members. Thus, in addition to screening for such offenders, the center must ensure that staff members never are placed in a vulnerable position. For example, a staff member should not be alone with a child or enter a bedroom or shower area without being "covered" by another staff member. The agency must protect staff boundaries, such as home addresses and phone numbers. When incidents do occur, they must be dealt with immediately, and staff members must receive adequate support (West, 1998; Lemmond and Verhaagen, 2001; Harder et al., 2013).

Sexual Abuse of Children in Residential Care

Although the residential care system is set up to protect children and have a therapeutic effect on their lives, it is always possible for someone in a helper role to further victimize the child (see Johnson, 1997; Stanley and Manthorpe, 1999). Sexual abuse in institutions has been documented by numerous studies (Johnson, 1997; Stanley and Manthorpe, 1999; Barter et al., 2004) and continues to be a concern necessitating careful screening of employees.

What causes someone who cares for children to sexually abuse them? First, those who have the inclination to sexually abuse will be attracted to settings that give them access to children. Second, the frustrations of the job, along with the closeness to children, may bring out tendencies to abuse that individuals did not realize they had. Third, childcare workers are among the poorest paid in the mental health field. Due to the low pay and long hours, agencies do not always have an easy time finding staff and so may not do sufficient screening.

Case Example Horace

As a child, Horace Milner was sexually abused by his father, a priest, and two uncles. He had forgotten much of the abuse (and would not think of it until he ended up in therapy years later for sexually abusing two children). When Horace was in his early 20s, he knew he wanted to help kids. He had finished a stint in the army and was looking for a job he could do while he went back to school. A local home for disturbed boys had been having a difficult time finding staff for the night shift. When Horace applied, they asked if he could start immediately. Horace enjoyed the contact with the boys. The dependence some of them developed on him made him feel needed. For Horace, extremely needy himself, these boys' neediness fed into a pathology in himself of which he was not yet aware. Several weeks after he began working at the center, several boys reported that he was sexually abusing another boy. The reports turned out to be true.

Clearly, centers must recognize that abuse can occur and make provisions for the safety of children and staff. Many institutions now have processes whereby both child and staff are heard and fair attention is given to the allegations and reports of each.

Termination from Residential Setting

When children leave a residential setting (often referred to as **termination**) they usually go to one of several settings: their parental home, a foster home, a less restrictive residence, a more restrictive residence, a hospital, or independent living.

Return Home

Children who return to their own homes may do so because the center feels they now are able to sufficiently control their own behavior and/or the parents are able to handle the child's problems. Return is not undertaken without a great deal of thought. Usually, the parents have participated in family therapy, and the child has progressed well in the residence. The agency social worker has met with the school, and school staff feel able to provide educational services. Other therapeutic resources have been arranged, such as therapists, support groups, or remedial help. This planning has probably taken weeks or even months. The parties are motivated and feel that the child's return will be successful. This is a best-case scenario. Even with such a scenario, the plan may not succeed.

There are other reasons why children return home. Residential treatment is funded by the social service agency or the child's school department and, very rarely, the parents. If any of these parties feel they are unable to continue funding the placement or any other out-of-home placement, the child may return home. In such a situation, it is unusual for a sufficient amount of progress to have been made, and the child is often the one who suffers.

Children occasionally return home because their parents do not feel that the children are being well served by the agency. This may be true, or the parent may find that the problems are not as easy to solve as she or he first thought.

Case Example Mrs. Kaiser

Mrs. Kaiser urged the school to place her daughter, Stephanie, because neither she nor Stephanie's teachers could handle Stephanie's oppositional behavior. After several psychiatric evaluations, the school agreed to fund a placement in a residential center for disturbed girls. Soon after placement, Stephanie became a model resident, obeying all the rules and complying with her treatment plan. In family sessions with Mrs. Kaiser, the agency social worker tried to explore the reasons why mother and daughter had such a troubled relationship that Stephanie became uncontrollable when at home. Incensed that the center was "blaming her," Mrs. Kaiser immediately removed her daughter from placement.

Family work is an extremely important aspect of treatment if it is expected that the child will return home. Without such intervention, the problems that brought the child to placement often go unsolved. As one director of a residence explained about family work, "I have seen some very concerned, motivated families try their best to raise a child and find that the child ends up in placement. It might not even be what the family is doing that is the problem but how the child interprets it. So often it is communication, or the lack of it, that is at the core of family problems."

Placement in a Foster Home or a Less Restrictive Environment

Some children progress in the residence but are not yet ready to return home. For example, a child might be placed in a secure setting because he or she might be a danger to self or others. As treatment progresses, it becomes clear that he or she can benefit from a less restrictive setting in which internalized controls are necessary. From this new setting, the child might either return home or go to a foster home. Or, if he or she is not ready for the amount of freedom given, the child might again return to a more restrictive setting.

A child may no longer need the structure of a residential setting but may not yet be able to cope with the issues at home. Or a child may not have a home to return to, for whatever reason. In such instances, children may be placed in a foster home until they can return home or until they are able to live on their own. The foster parents often work with the residential center during the transition period to acclimate the child to the new foster home. The child may visit the home prior to placement to facilitate the move.

Placement in a More Restrictive Setting

As previously mentioned, some children need more structure than was anticipated when they were originally placed in a residential setting. Several factors might alert staff to this fact. A child may run away from the center. Less restrictive centers may have little recourse if a child decides to run away. Children who run away may need a locked facility or an environment in which there is a higher staff-to-child ratio.

Sometimes children become so out-of-control that they abuse other residents, themselves, or staff. These children may require a more highly structured environment to ensure their safety. When children begin to act out their sexual abuse history by abusing other children, they may be moved to settings that provide better treatment for these issues.

The more structured settings to which children are transferred may be more secure residential facilities or even psychiatric hospital units.

Hospitalization

Children who are in residential settings may require hospitalization in psychiatric facilities. Some aspect of the treatment process may throw the child so off balance that he or she cannot cope.

Case Example Lana

Lana had been ritualistically sexually abused by her father. She had forgotten much of the abuse, but the residual effects came out in her oppositional behavior. When she was placed in the residential center, she had been in three foster homes. None of the foster families had been able to deal with her. Probably due to the less-intensive relationships, Lana settled easily into the residential setting. She was assigned a therapist, and the two began to work on helping her understand her past. Then the memories began to return. At first they came through in terrifying dreams. Eventually Lana began remembering in therapy sessions. But these memories were too frightening, too overwhelming. Lana became so terrified that she curled up in a ball and could not be reached. After numerous unsuccessful attempts, the decision was made to hospitalize her.

Children who are hospitalized usually stay in the hospital for only a short period, while they are stabilized. After this, they may return to the same residential setting or go to another.

Independent Living

A child may remain in a residential setting until he or she is old enough to become independent. Increasingly, centers, much like foster care agencies, are developing programs for this possibility. Centers may have job-readiness programs or teach specific independent living skills. They may also transfer teens who are almost ready for emancipation to small group homes, which are often off the residential center's main campus. These homes operate much like an apartment and give the teen a chance to try out such tasks as buying food and keeping house. Such programs have been found to be fairly successful.

Jennifer, a former resident, recalls her experiences:

> What was it like to be a kid in a residential treatment center? I guess I have a lot of responses to that! Some parts were great, but some weren't.
>
> When I was eight years old, my brothers [ages six and four] and I were taken away from our mother. She was always boozed up and used to bring men into the apartment. We were neglected, and one of her boyfriends actually sexually abused me. One night my mom and this guy got into a fight, and someone called the police. I guess when they saw our place (it was a real pigpen), the cops figured we shouldn't be there, so they took us to a foster home. We stayed in foster homes for a couple of years, until my mom got her act together. Then she got us back. But that didn't last long. The guys started coming again, and this time she did drugs as well as booze. But before the child welfare people could take us again, she shipped us off to an aunt. That was really bad news, and I ran away. When they found me, I was put in a foster home by myself. But I was real angry and hated it and the other two after that. I wouldn't go to school, and finally some kids and I stole a car, but they caught us. They bailed me out, and the foster parents took me back, but I was real angry by then. I said I was going to kill myself, and when the foster mother tried to stop me, I turned the knife on her.
>
> There was a mess of legal and court stuff, but then they sent me off to this place for girls way out in the country. No one was going to tell me what to do, and at first I guess I gave them a real hard time. I was about fifteen, but I was a big kid, and I think some of them were afraid of me. At first I was on this unit with about six other kids. They watched us every minute. It was awful. We had to eat in the unit and sleep there. We went to school on the grounds, too. The classes were small, and we got a lot of attention, but at that point I was so angry at the world that I didn't care. There was this one teacher I liked, though. She was young and could make stuff real interesting. She used to bring me books to read from her house—like her own books, I mean. That made me feel good, like someone trusted me.
>
> I saw a social worker once a week, and we tried to figure out what had gotten me there. She was also supposed to see my mother, but Mom only came when she felt like it, which wasn't too often. She was pregnant again and sick a lot, and then she had the baby, and that was her excuse. The social worker also helped me learn how angry I was at Mom. We talked about that a lot.
>
> The director of the place was great, too. He was an older guy who had had daughters, but they were grown. They came down sometimes to see the kids at the center. One of them had a little kid she used to bring, too. I played with him a lot and figured out that I liked little kids. And I made a bunch of friends there, too. The kids were from all over the state. They were in there for lots of different stuff like running away, and drugs, and just being obnoxious to people. I still write to one of the girls.
>
> After I'd been there a couple of years and they couldn't get my Mom to straighten out, they transferred me to a group home. I was seventeen, and it looked

like I could never go home. The group home was a house with six girls, each in her own room. We were supposed to think of it like an apartment. We got jobs after school and had to pay rent. It wasn't much. It just was supposed to teach us to budget and stuff. They also made us take classes on budgeting and other things we had to do on our own, like cooking and that stuff.

A week before I was 18, I found out that I was pregnant. I was going to leave the home when I was 18, and I think I was a little scared. The guy who got me pregnant was 26, and I figured we'd get married. Right! When he found out I was pregnant, he took off, and I never saw him again. So the center helped me get welfare and an apartment until I got a job at this fast-food place.

That was five years ago. My daughter and I are doing pretty well. It's tough being a parent, but I'm going to be a better one than my mother! Looking back, the center was probably better than any of the foster homes I was in. But who knows? I don't think I gave any of them a chance.

Summary of This Section

- Children and youth who come to residential settings often bring with them histories of trauma, including physical or sexual abuse; neglect; exposure to violence within the home, the community, or school; traumatic losses; or caretakers whose abilities to parent are significantly impaired.
- In general, youth in residential settings have more family problems, skills deficits, school problems, and substance abuse issues than others their age.
- Residential centers serve to protect and treat children and youth addressing a variety of needs but may also protect or help the community to deal with these issues. Residents of residential settings may have been placed there because they were a danger to themselves or others. They may also exhibit behaviors that are unmanageable in a home environment.
- Children and youth placed in residential settings may feel that they have been "bad" and are therefore being punished. Some feel alone and have trouble initially relating to peers. It is the role of the residential setting to help their residents to learn that there is help for them and to build relationship with staff and peers.
- There are three components of most residential settings: residential, educational and clinical services. Residential or childcare staff monitor their charges as they perform the tasks of living. Some settings use house parents while others have staff who work in shifts both day and night. The educational component attends to the residents learning needs, including remedial or special-education needs. Clinical staff offer therapeutic services to the residents including one-on-one therapy and group and experiential therapies. All of the components work closely together in the interest of serving clients.
- Some programs may have only residential services contracting out with local schools for education and with local mental health clinics for clinical services. Where educational and clinical services are provided may depend on the population the residential setting serves.
- Traditionally, many residential settings have used behavioral modification as part of treatment organizing services around levels or using tokens to reward desired behavior. Some centers are now favoring other methods and models to address problematic behaviors.
- The peer culture is an important component of residential setting. Peer interactions may be positive or negative but the hope is that the residential setting will be able

to help the residents rebuild interpersonal relationships through peer interactions, develop feelings of safety, and develop a sense of group responsibility.
- Life in residential care is not always tranquil and easy. Crises may develop when there is lack of sufficient structure, when negative competition develops among residents, and sometimes as a result of the residents' family interactions that spill over into the residential setting.
- Sexual acting out does occur in residential settings especially since a number of the residents were sexually abused prior to coming there. Some forms of sexual expression (e.g., masturbation) might be normal but residents must learn when and where it is appropriate. Inappropriate sexual acting out become fodder for therapeutic intervention.
- When children and youth leave residential settings, it is for one of the following settings: They are ready to return to their homes, they are ready for a foster home or a less restrictive setting, they are in need of a more restrictive setting often due to behavior or mental health issues, or they are ready to transition into independent living.

WORKING WITH FAMILIES OF CHILDREN IN RESIDENTIAL CARE

Often the least emphasized part of the therapeutic process, working with the families of children in institutional care can be frustrating. Yet, the importance of this work cannot be overestimated; the children may well return to their families someday. The focus of family work is usually threefold: to help the family maintain a functional relationship with the child in placement, to aid the family in preparing for the return of the child (if this is the plan), and to help the family sort out and cope with the dysfunction that caused the placement of the child in residential care (Powell, 2000; Harris, 2003; Fulcher, 2006; Kendrick, 2007; Walter and Petr, 2008; Griffith et al., 2009; Holstead et al., 2010; Hummer et al., 2010; Knoverek et al., 2013). These factors usually are intertwined.

Motivation of Parents

Parents of placed children range from very concerned, involved parents to disengaged parents who would rather forget that they have a child in placement. However, before we criticize disengaged parents, we must remember that by the time a child gets to residential care, many other solutions have probably been tried. The parents may have invested heavily in those attempts to solving their problems. Mostly likely, the parents' patience and resources have been exhausted. To have someone else be responsible for their child may be a relief.

Some authors divide parents into several categories: absent, ambivalent, impoverished, addicted, and abusive (Van Hagen, 1988). The absent parent is not available because of mental illness or incarceration. The lack of parental visits may be a problem for the child, who feels abandoned and resentful. The child may also harbor fantasies about the absent parent, and therapeutic work with that child may focus on the resolution of these fantasies.

When a parent is ambivalent, the child may have spent much time outside of the home, and reunification may have been tried before. The ambivalent parent feels exhausted by these efforts and is not sure whether she or he wants the child at home. Sometimes the placed child is scapegoated; all of the family's ills are attributed to him or her. The family has deluded itself into thinking that, if this child is gone, the family will be fine.

Case Example Coraleen

When Coraleen was placed in residential care, her family seemed to breathe a collective sigh of relief. The family had been dysfunctional for years. The father, now dead, had sexually abused his two daughters and physically abused his son and wife. But the family had guarded the secret of its pathology. The oldest girl had been the "good child" and had excelled in school. The boy had remained quiet, drawing little attention to himself. Then Coraleen revealed the family secret in her attempts to deal with her own eating disorder. The family was furious with her for "tarnishing" the father's name. After years of rejection by them, Coraleen began to act out. After a brush with the juvenile justice system, she was placed in residential care. Coraleen's mother constantly postponed or cancelled visits to Coraleen, claiming one schedule conflict after another. Not having Coraleen at home allowed the family to pretend that the secret had never come out. Although the mother loved her daughter and wanted to see that she was well-cared for, the burden of having her at home was too great.

The problem for such families is that placement is rarely permanent; they need to come to terms with the fact that the child may come home.

Impoverished parents are overwhelmed by external problems that require the family to put a great deal of effort into merely surviving.

Case Example The Harbingers

The Harbingers were beset by problems. Although a steady worker, Mr. Harbinger found it difficult to make enough to support their six children, who ranged in age from 20 to 9. The oldest child, Ned, had suffered a spinal injury and was now quadriplegic and living at home. Seventeen-year-old Fran had just announced that she was pregnant and that the father was HIV-positive. Fifteen-year-old Justine had recently been placed in residential care after years of running away and using drugs. Fourteen-year-old Suzie appeared to be copying her sister's drug abuse. Twelve-year-old Gary and 9-year-old Farley appeared to have no problems as yet, but the Harbingers were sure they would in time. Adding to the Harbingers' problems, Mrs. Harbinger's father was living with the family. He had sexually abused her as a child, and she suspected him of abusing at least one of the older girls. He had recently been diagnosed with Alzheimer's and could no longer live alone.

For this overwhelmed family, Justine's placement seemed like a respite from one small part of their problems. Although they worked diligently with the social worker at the residential treatment setting, they clearly had little investment in having her home.

The addicted parent is often too caught up in her or his addiction to be much of a resource for the child. Only after he or she is willing to deal with this problem, can work with the family be effective. And the abusive parent may be a threat to the child if he or she is returned home. Such a parent will need additional services in order to be an appropriate resource for the child.

Some parents are eager to have their children home and work well with agencies.

Case Example The DeRosas

The DeRosas adopted Angela when she was 3 years old. As a young adolescent, Angela became quite difficult. She would not go to school, and she was promiscuous and generally difficult to handle. The school recommended that she be placed in residential treatment. Not knowing what else to do, the DeRosas agreed. After a year of intensive family work, Angela returned home.

For Angela and her parents, family therapy proved quite effective. The more successful the work with the family is, the smoother the child's transition from the institution to the home.

Types of Family Treatment

Each agency has a different commitment to family treatment and therefore different techniques and procedures. Some see families once a week or even once a month, depending on the needs of the family and how often they can come to the center. Families may be seen individually or with their institutionalized child. All members may be present or just one parent. Sometimes one parent is comfortable working with a therapist, but the other is not. Some agencies feature group treatment for parents or parenting-skills classes.

Not only therapy sessions but also visits are part of family work. Families are usually encouraged to visit so that the child will not feel abandoned. Visits may be made at the center, or the child may be allowed to have supervised visits off site or at home. When children progress in their program, they may be allowed home visits for a day, for a weekend, or over a holiday or vacation.

Visits can be extremely conflictual for parents and children. Children may harbor unresolved resentments toward their parents. They may feel that they were abandoned and feel angry. If parents cancel at the last minute, children feel betrayed, or they may not want to see their parents at all. The day preceding or following visits often is emotionally difficult for children.

Parents, too, might feel some ambivalence. After all, this is the child whose problem caused them trouble in the recent past. This is the child who has caused society to question them as parents and who has made them feel inadequate. They may feel anger toward the child, or they may not trust the child and may fear how the child will behave. Visits may be as much of an adjustment for parents as they are for their children. Often, much social worker time is dedicated to helping parents and children with visiting issues.

What if a child does not have a family that is willing to visit or available for the child's return? These children are either kept in long-term residential placement or, more likely, placed in a foster home when they are ready to leave the residential setting. Some agencies provide children who do not receive visits from their parents with a visiting resource. This visiting resource might be an adult friend or family member, a concerned member of the community who volunteers to visit, or a potential foster parent who may someday receive the child in placement.

Problems in Working with Families

Parents whose children have been placed in any type of setting may feel ambivalence. The fact that their child is not home with them may make them feel that they have failed. They may believe that people in the community will criticize them. Many parents do not tell their neighbors that their child is in placement. They may feel hurt if their child does better in residential care than he or she did at home. For all these reasons, parents might act in a variety of ways. They may approach the agency with hostility. Some parents, either consciously or unconsciously, sabotage their child's treatment.

Case Example Sabotage

Kelly was extremely obese when she came to the center. She was so ostracized by her peers that she became angry and would try to hurt them. At the center she was put on a rigid diet, a plan with which she cooperated. After a month of placement and 10 lost pounds, she went on her first home visit. She returned with a large selection of sweets bought for her by her mother, who was fully aware of Kelly's diet. When the mother was confronted about this, she apologized, saying that she had "forgotten." But the same thing happened after each of Kelly's visits home. Formerly motivated, but now confused about her loyalties, Kelly stopped complying with her treatment plan. It took several months of intensive casework before the social worker was able to enlist the mother's full cooperation. Having been pregnant herself at age 15, the mother was finally able to recognize that she feared that Kelly, too, might become pregnant if she became "too attractive and desirable." The mother was helped to see that there were others ways to break the pattern.

Family work can also create difficulties for staff, whether they are working directly with the family or dealing primarily with the child. For clinical staff who work with the family, the missed appointments, the parents who arrive drunk or high, the hostility, and the sabotage can take its toll. Staff members must remember how difficult it may be for these parents to cope with having lost control over their children's lives. Staff who see a child who has been maltreated, rejected, or hurt in some other way may have difficulty understanding the parents' motivation. Staff may feel a need to protect the child from further parental abuse. However, parents are an integral part of the child; it is not possible to fully separate the two.

Summary of This Section

- The importance of working with the families of children and youth in residential settings cannot be over emphasized. Family work helps the family members not only to relate to the child or teen in placement but also helps to prepare them for the release from residential care.
- Parents have different involvement and motivational levels. Some have totally disengaged with their children possibly after years of attempts to help them. Some parents are overwhelmed by their own problems while others are ambivalent about their degree of involvement.
    - Families may be seen on a regular basis either separately or with their child or teen. They are also encouraged to visit their children at the residential setting. Visits may be difficult for both families and their children and this becomes part of the therapeutic work.

THE ROLE OF STAFF IN RESIDENTIAL SETTINGS

The quality of the staff in residential settings is vital to the progress that the children in their care are able to accomplish. Experts suggest that building attachment is an important component of the therapeutic milieu as these children must learn to trust those in their environment (Knoverek et al., 2013; Quisenberry and Foitz, 2013; Zelechoski et al., 2013). Residential care staff accomplish this by offering children the availability of staff, sensitivity to their needs, acceptance of them as individuals with all their issues, behaviors and readiness to change and by making an investment in each child and his or her therapeutic process.

The roles performed by staff members in a residential setting differ according to the department they are involved with and the agency itself. As previously discussed, most agencies comprise three departments organized by function: residential, educational, and clinical.

Residential Staff

The residential component oversees the children's everyday life, from their waking hours to bedtime and through the night. Childcare workers or residential counselors work in shifts and are the backbone of the residential component. They help the children get up and get ready for the day. They are often responsible for preparing or serving breakfast. Some residences serve all meals in a common dining room; in others the children eat some or all of their meals at their living units. If not responsible for food preparation, workers must monitor the children's behavior while they eat in the dining hall.

While the children go to school, whether on the grounds or off, the residential staff help with transitions, assist the educational staff, or return to their units to do housekeeping in anticipation of the children's return. Afterschool and evening hours may be punctuated by a series of activities or groups, often led by childcare workers. If the children have therapeutic activities, such as counseling appointments or therapy groups, childcare staff are usually responsible for getting the children there. Although this may not sound like much of a task, many children have difficulties with **transitional periods**.

Bedtime, too, can be problematic, especially for sexually abused children who do not remember their beds as safe places. Childcare workers report talking to children before they go to bed and comforting them after they awake from nightmares. Night terrors can be common among children whose early lives have been filled with trauma.

Although childcare workers spend most of their time with children and can be one of the most influential aspects of their therapeutic program, they are often the youngest, most inexperienced, and most poorly trained agency staff members. This can be problematic for all involved. Childcare workers are usually supervised by a staff member who oversees their work. In turn, these supervisors may answer to a program director or the agency director, depending on the agency's size and organization.

Instead of childcare workers, some agencies use housemothers or houseparents, with a single woman (or man) or a married couple acting as surrogate parents. They are relieved for time off by other staff but remain the primary resource for childcare responsibilities. Although these individuals may have more life experience, they too are usually undertrained.

The training required for each staff position differs according to the population served, the agency's organization and needs, and, in some cases, supply and demand. Most agencies will hire childcare workers with little experience or education if their need is great enough and the applicant seems qualified. Many college students work as evening or overnight childcare staff while they pursue their degree. Increasingly, agencies are asking for workers who have had more education or experience with children. Retired people or parents can bring parenting skills to a residential setting, but without training they may not be prepared for the fact that the children placed in residential care may present many more challenges to patience than their own children did.

Educational Staff

Children in residential settings usually are educated on the grounds of the agency, although there are exceptions: Some children attend local schools. Most staff who teach on site are teachers trained in special-education techniques. However, many states do not require that

teachers in residences be licensed. These teachers may use aides because it is important that the teacher-to-child ratio be high enough to maximize learning.

Children are usually tested when they enter a residence to determine their educational level and their remedial needs, if any. Then teachers work with children to help them achieve their academic potential. Classes may be organized according to ability rather than age or grade-level as in public school.

Teaching in a residential setting is not dedicated solely to academics. A significant part of a teacher's role may be removing the barriers to learning that have prevented the children from achieving on the outside. Children who come to residences often feel they have failed; as a result, they may exhibit behavioral problems. They may also have difficulty with their peers and therefore cause trouble in the organized classroom.

Gordon Howly had taught in a public high school for 10 years. He relates his experience teaching in a residential setting:

> I just needed a new challenge when I took a job in a residential center for disabled and disturbed kids. I had completed most of a master's in Special Education and thought I would really like to work with kids like this. I taught history and English, and the kids rotated classes. I had about five adolescents in a class with an aide. The aide was there mostly because some of the kids needed help with manual tasks. Each child had different educational needs, and I found myself working with most of them individually. For example, one child had cerebral palsy and couldn't talk. He used a board with letters to communicate. He would spell things by pointing to the letters. But he got frustrated very easily, and when he was not understood, he would hurl the board across the room. I learned to duck very quickly. But all in all, I loved the job. The drive that some of those kids had was an inspiration.

In addition to teachers, most educational departments have administrators and other educational staff who oversee the child's academic progress.

Clinical Staff

Social workers, counselors, psychologists, and psychiatrists make up an agency's clinical component. These individuals may be on staff or may operate on a consultant or part-time basis. These social workers see the families, arrange home visits, and keep in touch with the residential and educational staff to monitor each child's progress. In addition, a psychologist may be used on a part-time basis to do psychological testing and make treatment recommendations. Some agencies also employ a psychiatrist to review children's medications and prescribe other medications as needed.

The number of clinical staff depends largely on the agency's mission and the population served. Because clinical staff may be the most highly trained, and therefore command higher salaries, fiscal constraints may mean that there are fewer clinicians than would be optimal.

Clinicians see children on a regular basis to help them sort out and understand the issues that brought them into care. These issues may be their own behaviors, family dysfunction, or abuse/neglect. In addition to individual meetings with children, clinicians may hold groups to help children with such issues as anger management, divorced families, abuse/neglect, substance abuse, and social skills. In centers for juvenile offenders, groups help the youths confront their problems, understand their victims, understand their own cycles, and take steps to interrupt their abusive patterns (Farmer and Pollack, 1998; Lemmond and Verhaagen, 2001; Anglin, 2003; Manso et al., 2008). Group work in these settings is an integral part of treatment.

Todd, who has a master's in social work, is a therapist in a residential setting for sexually abusive boys. Formerly he worked for a protective services agency studying families in which abuse had occurred: "I was always fascinated by the motivation of the offender, especially when he or she was young. I find doing groups with these kids very enlightening. It is amazing that being a victim is so traumatic for some of these kids that victimizing someone else is the only way they see to escape that victim role."

The treatment of children in residential settings requires communication between the components; it is often the role of the clinician or case manager to facilitate this communication. Having knowledge of abnormal psychology, he or she might also consult with staff in other components to help them understand children's behaviors and problems.

Other Staff Functions

There are important functions, and therefore integral staff members, that may not fit neatly into the previously mentioned categories.

The nurse is extremely important in residential settings. Although sometimes one person fills this role, with contracted services from the outside as needed, other agencies have whole medical units. A residence for physically disabled residents requires a larger medical component than a center in which physical health is not the primary issue.

The program to rehabilitate children must be carefully planned. Many agencies hire a program director, and often other program staff, to do this planning. These individuals may be part of the previously mentioned components or may make up a component by themselves. The importance of an agency's administrative staff cannot be overestimated. These individuals oversee the running of the agency and may also need to raise funds for its continued existence. The director, especially, may set the tone for how an agency operates.

Some agencies also have a component responsible for in-service training of all staff. Many larger centers have instituted quality-control specialists or units to ensure that the quality of service remains consistent and high.

No residential agency could function without some form of intake. The admissions specialist or unit reviews applicant files, interviews children and their parents before acceptance, and determines if the agency can meet the potential client's needs.

Other support personnel, such as chaplains, transportation specialists, and visiting coordinators, may figure in a particular agency's plan. Other agencies operate with minimal staff who perform a variety of roles. Some agencies also use the services of consultants who bring additional expertise or assume duties that there may not be sufficient agency staff to cover. For example, one residential treatment agency for adolescent girls used a consultant whose expertise was in child sexual abuse to help the staff deal with a high population of residents who had been sexually abused. That same agency hired a consultant to do supervision of the predominantly associate and bachelor's level staff.

The Frustrations of Staff

One of the most widely discussed frustrations of staff in residential settings is the work itself. Children who are placed have had lives filled with abuse and injustice; they mirror the way they have been treated in their treatment of others. Also, it is difficult to constantly be a secondhand witness to the inhumanity that has been perpetrated on so many children. Their pain is not easy to watch; burnout is common (Corcoran, 1988; Kiraly, 2002; Harris, 2003).

Corcoran (1988) describes **burnout** prevalent in professions that involve one-to-one contact with people who have problems. A practitioner becomes burned out when he or

she experiences depleted energy and a waning interest in doing one's job. Dealing with problems daily can leave one short-tempered and emotionally exhausted. Although this can be true in any helping profession, residential treatment, because of staff's continually close proximity to clients, can make staff especially vulnerable to burnout.

The turnover of staff in frontline positions (e.g., childcare workers) can be especially high. Some centers estimate that, on average, they keep a childcare worker 6 to 18 months. It is not surprising that many centers do not invest a great deal of time in training such transient staff members. Yet, some would argue that better trained workers would not burn out as quickly (Whitaker et al., 1998; Bertolino, 2014).



Evaluation

Behavior: *Critically analyze, monitor, and evaluate intervention and program processes and outcomes.*

Critical Thinking Question: It is not always easy to see beyond the challenges presented by the children who are placed in residential treatment. How would you go about identifying a client's strengths? How might you work with these while still addressing his or her limitations? What factors and practices might insure the best outcomes for youth in residential settings?

The high **turnover rate** can frustrate staff members as well as administration. When the work is taxing, it is important to trust and depend on fellow workers. When there are constantly new faces to relate to, workers feel isolated and perhaps more vulnerable.

Another issue for staff and residents is inconsistency among childcare practices. Each staff member has a different idea of how children should be dealt with. As shifts change, so do the approaches of the staff. Thus, the very thing needed most by the child—consistency—is lacking. Consistency requires good communication as well as adequate training. When there is poor communication, staff become frustrated and children feel unsafe.

Although there are frustrations in residential settings, many staff say that the rewards outweigh them. "Just to see a child who is so out of control at intake become a more stable, happier child is worth all the insults and grief you get while that's happening," one childcare worker reports. Staff often report that being prepared for the frustrations at the onset, through an effective orientation program, goes a long way toward helping them deal with their jobs.

Summary of This Section

- The staff within a residential setting falls into three categories: residential or childcare, educational, and clinical.
- Residential staff, usually working in shifts, is responsible for the day to day activities in the residents' lives.
- Educational staff are responsible for educating the residents according to their own individual needs.
    - Clinical staff provides therapy both one and one and for groups of residents.
    - Working in residential settings can have its frustrations. Turnover part of the and burnout are high. Staff members have different styles and this may create inconsistency.

TRENDS IN RESIDENTIAL SETTINGS

The recognition that youth who come into residential care are often some of the most traumatized of those in the child welfare system has prompted changes in residential settings. Although these settings always recognized that their clients had experienced trauma, there is an increased awareness that work with these clients must be trauma-informed in all of its aspects.

Hummer and her colleagues (2010) point out that there are two types of trauma treatment: trauma-specific and trauma-informed. **Trauma-specific treatment** seeks to address the complex trauma—that is, trauma that results from exposure to multiple

events and circumstances—experienced by an individual—in this case a child or youth—using group or individual therapies that focus on trauma recovery. The goals of such treatment are to provide safety, help the client to develop skills in regulating his or her emotions and with interpersonal relationships, helping him or her make meaning from the traumatic events and enhance skills in making social connections. A variety of specific therapies (e.g., psychological debriefing or education, cognitive behavioral therapy or psychotropic medications) might be employed to reach these goals.

Trauma-informed treatment addresses the impact that complex trauma has had upon the individual youth while focusing on not retraumatizing him or her while providing mental health assistance. While such a setting continues to use trauma-specific techniques, each member of the staff is trained in the awareness of the client's needs and what can be done to avoid retraumatization. For example, proponents of trauma-informed care suggest that the restrictive environments that give youth few choices and physically restrain them perpetuate the impact of the physical abuse or restrictive and abusive treatment they may have experienced earlier in life (Hummer and Dollard, 2010, James, 2011; Nowicki and Pestine, 2015). Instead of relying on these methods, the newer focus strives to involve youth in decision making and help them in regaining and maintaining their own self-control.

Using a trauma-informed approach may necessitate an extensive reorganization on the part of many residential settings.

Hodgdon et al. (2013) suggest such a reorganization using the **Attachment, (self-) Regulation and Competency Model (ARC)**. The ARC model is a framework created by Blaustein and Kinniburgh (2010) that builds upon the resiliency of children who have experienced trauma. Applying the model to residential settings, Hodgdon and her colleagues used two residential programs in Massachusetts chosen due to the substantial number of children in these settings that had experienced child maltreatment often resulting in complex trauma. Assessing the programs, the researchers identified five core areas that needed to be addressed in order to implement a trauma-informed care program: environment, training, staff support and self-care practices, integration of services, and milieu/program culture.

Environment

To create a **trauma-informed setting (TI)**, the environment must feel to the residents like a safe place. A warm, homelike setting may be the most conducive for most clients to feel safe with visual aids to enhance the ambiance. In addition, the leadership and staff of the agency must be committed to implementing a TI care environment, including a willingness to address cultural barriers and policies that might hinder implementation even if this require a time-consuming process (Hummer and Dollard, 2010).

Staff Issues: Training, Support, and Self-care

Readiness for a TI approach requires that staff be trained to increase their readiness and competence in using this approach. As one staff member explained:

"After many years working in residential treatment I learned that I needed to think differently. I always thought that I looked at every resident as an individual but the training made me even more aware that—although these boys had similar experiences, every

one of them was unique with different responses and results. We had to be aware of our body language and what that was saying to the kids. Did it replicate someone's attitude that had traumatized them in the past? For example, I'm a really big guy and I have to be careful how I work with the kids. Some of them were abused often by men and I came across in what seemed to them as a threatening manner, it cause really upset them. I learned subtle things like lowering the pitch of my voice. Those are just a few things, but what I found was that the training changed my whole attitude toward working with kids in residential care."

Staff must also be trained on the development of trauma and how to recognize what their clients may be experiencing. Training also asks staff to imagine their own responses to the behaviors following trauma in an effort to promote understanding. In addition, staff working with traumatized and often acting-out clients who may share the stories of abuse and violence in the backgrounds can develop vicarious trauma reactions. Thus, support for staff is crucial in such settings. Further, staff must be taught to monitor their own responses, recognize when they are responding to client issues in dysfunctional ways, and practice adequate self-care (Hodgdon et al., 2013).

High staff turnover can promote inconsistency for residents. The differences in staff styles and the overlap in roles may also be confusing when one is trying to provide a consistent environment to promote healing. Burnout among staff can contribute to all of the above. When staff fail to communicate adequately with one another, this may actually replicate the child's dysfunctional home environment. Programs using trauma-informed care with clients often find that staff too benefit evidenced by better relationships between staff and clients, which often resulted in less burnout, more retention of staff, and better communication promoting more consistency (Cimmarusti and Gamaro, 2009; Chance et al., 2010; Nowicki and Pestine, 2015).

Integration of Services, Program, and Culture Changes

When children and youth have been traumatized, they develop the beliefs that the world is a dangerous and unpredictable place, which in turn leads them to feelings of helplessness and powerlessness. Any unpredictability, loss of control, or lack of consistency in the residential setting has the potential for increasing anxiety among traumatized clients. Thus, TI care residences strive to increase program consistency and predictability. One method for doing this is to enhance communication and open communication among childcare, staff, and clinical components. This necessitates that all departments of the residential setting (e.g., classroom teachers, dining hall staff) be on the same page and share the same therapeutic goals, attitudes, and information (Farragher and Yanosy, 2005; Hodgdon et al., 2013; Nowicki and Pestine, 2015).

In addition, clients are engaged in being an integral and contributing part of creating their own treatment plan. Treatment plans are individualized to reflect the unique needs of each individual client. Further decision making within the organization involves the residents as well as the staff (Hodgdon et al., 2013). Fostering a sense of clients having more control of their lives inthe residence promotes an atmosphere that reduces helplessness and promotes empowerment. Childcare staff focuses more on relationships than rule enforcement, which has been found to reduce the need for restraints and seclusion so common in the past (Nowicki and Pestine, 2015). As residents are encouraged to be more accountable for their actions—termed **compassionate accountability**—through recognizing their feelings and helping them to accept them and problem solve, youth develop more effective ego functioning, increased responsibility, and better self-control (Cimmarusti and Gamero, 2009).

Family Involvement

Two factors speak to the need for increased involvement of families in their children's residential treatment. First, the shift toward helping children rebuild relationships necessitates more family contacts. Second, the move in human services away from institutional settings and toward treatment within the community requires strengthening the parents' own resources to cope with their children's needs. Parental involvement is a critical part of the therapeutic picture (Chance et al., 2010; Blau et al., 2014).

Some programs are beginning to put more emphasis on family meetings during which the attempt is made to further engage families in the treatment and future of their children. The families are helped to move beyond their difficulties with their children and encouraged not only to consider their strengths but also problem solve on ways to build upon the progress made in residential treatment (Chance et al., 2010). Granted not every family is able to have or interested in having their children return home, but providing support and teaching them skills helps to reunite many more families. Sometimes, families are aided in offering support to their children as they transition to community-based settings.

More Effective Evaluation

As residential settings face their critics, they are called on to demonstrate the efficacy of their services. Yet, how effectively children have been treated cannot always be measured by the children's future directions. The question "What if . . . ?" is always at issue. For example, what if Jennifer (introduced in the earlier section "Independent Living") had not been influenced by the residential setting in which she was placed? Would she have become a substance abuser, following in her mother's footsteps? Or did the fact that she became pregnant before leaving the center mean that treatment and therefore the attempt to help her live a productive life were unsuccessful?

Children from dysfunctional backgrounds may not have an easy time. However, rather than looking at their life as a whole, it is important to monitor the coping mechanisms they have developed as a result of residential treatment. The current emphasis on helping children in residential settings to learn how to build relationships presents an even greater challenge to evaluation efforts. How does one measure successful relationships? This conundrum will be faced by those who try to develop evaluation tools that accurately assess the efficacy of residential treatment.

Summary of This Section

- Children and youth who are placed in residential settings may be some of the most traumatized of those in the child welfare system. Therefore, there is an increased awareness of the need to address their trauma as an integral part of their treatment.
- There are two types of trauma treatments: trauma specific and trauma informed. Trauma-specific treatment addresses the complex trauma experienced by clients and uses specific therapeutic interventions to help them to cope with and overcome the effects of that trauma. Trauma-informed treatment addresses the impact of the resident's trauma by being aware of it and not retraumatizing them in the process of helping. This mindset forces staff to be aware of the impact that practices such as restraints and seclusion for example might have on clients.
- Using a trauma-informed approach may necessitate the reorganization of a residential setting as well as staff retraining.

- The environment must feel warm and safe to residents while also taking into consideration, cultural barriers. Policies may need to be changed to accommodate this.
- Staff training should promote awareness of trauma and the impact that trauma may have on clients. Relationship building, consistency, and sensitivity to client needs are paramount in staff interaction with clients.
- Treatment plans should reflect individual client needs and have client input to a greater degree than in the past. Relationships are at the core of this as well.
    - More emphasis must be given to family involvement and contacts as well as therapy to help families cope and adjust.
    - Programs should be regularly evaluated to determine if these new policies are effective.

In the future, there will be numerous challenges inherent in the provision of child welfare services. With our nation's increasing failure to support the family, as well as modern technology's impact on the decline of meaningful face-to-face communication and building relationships, RTCs will have their work cut out for them.

SUMMARY

- Children and youth are placed in residences when they are unable to thrive in a home setting. Most of these clients have had significant traumas in their backgrounds, including abuse and neglect, violence, domestic violence, mental health issues, or parents with significant issues. The children and youth themselves are more likely to have mental health issues, school problems, deficits in social and relationship skills, and exhibit delinquent behaviors. A residential setting is designed to provide a safe therapeutic environment that uses three components: residential, clinical, and educational services. The staff of these components work together to create a therapeutic milieu for residents. Traditionally, residences have been organized by a level or token system but more recently trauma-informed thinking find some settings organizing with different emphasis. Problems do arise in centers including sexual acting out and abuse, staff inconsistency, and staff turnover. Staff screening, training, and support is crucial. When children leave residential settings, they may return home, be placed in a foster home, be placed in a more or less restrictive environment or transition into independent living.
- Family work while children and youth are in residential care can help both the residents and their families to resolve a variety of issues. Some parents are hesitant to enter into therapy due to their own issues, their guilt over the treatment or experiences of the resident, or because they feel that they have done all that they can for their children. Some parents are unable to participate due to alcohol or drug addiction, mental health issues, or other individual or family issues. Some parents may sabotage their children's treatment either consciously or unconsciously.
- The roles of staff vary depending upon their designation or their job description. Residential or childcare staff help residents with everyday living tasks when they are not in school. Educational staff are responsible for assessing and addressing the residents' learning needs. Clinical staff

provide therapeutic experiences, including one-to-one and group therapy. Other crucial staff members may be nurses or other medical personnel, program directors, and admissions and administrative staff. Some agencies use consultants for consultation and services that the center cannot provide. Working in residential settings can be frustrating as the work can be long and hard, the pay low, and the turnover high. Working with residents with a variety of issues and problematic behaviors can also be draining. However, those who enjoy working in residential settings argue that the rewards are also numerous.

- The current trend in residential settings is to recognize and focus on the fact that these clients have probably experienced a great deal of trauma. There are two types of trauma treatment: trauma-specific treatment and trauma-informed treatment. Trauma-specific treatment addresses the traumas that residents have experienced by enhancing their skills to deal with the traumas and with their lives. Trauma-informed treatment involves staff awareness of the impact of trauma that allows staff members to help residents without further traumatizing them. Further, clients are involved in problem solving and helping to plan their own treatment goals. Creating a trauma-informed setting often requires some changes, including assessing and changing the environment to feel client friendly, training and supporting staff, and enhancing communication throughout the agency. There is more emphasis on family involvement and more attention to evaluating the efficacy or services.

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14

Our Children's Future

LEARNING OUTCOMES

After reading this chapter, you should be able to:

- Discuss the various issues that will need to be addressed or continue to be addressed by child welfare agencies in the future.
- Discuss what must be considered when preparing child welfare workers to address the needs of children.
- Describe what potential child welfare workers will face in this century.

The future of children's services depends on us. It is up to each of us to see that the rights of children are protected and their needs met through the formation of effective policies and programs.

CHAPTER OUTLINE

ISSUES FOR THE FUTURE 375
Children's Status 376
Children in Poverty 377
Children at Risk 377
Complex Populations 379
Children and Health 380
Children and Education 380
Children and Technology 381
PREPARING THE CHILD WELFARE WORKER 382
CHILD WELFARE IN THE TWENTY-FIRST CENTURY 384
SUMMARY 385

ISSUES FOR THE FUTURE

Although we have made some headway in the last few years, children continue to be brought up in poverty and to be abused and neglected. Children continue to be victims of all types of trauma at home, at school, in the community and in the culture. Our juvenile courts continue to be overworked, and children's health care is regulated largely by those who can or will pay the bills. These facts do not present an ideal picture for the future of children.

Solutions to the problems that face children are far from easy. One impediment to finding adequate solutions is the fact that Americans



Policy Practice

Behavior: *Assess how social welfare and economic policies impact the delivery of and access to social services.*

Critical Thinking Question: How might you learn more about the problems that will affect children in the future? Consider some of the social and economic policies that impact your community or a particular population. How might these policies shape the future of child welfare services?

are often split on a number of questions that impact our youngest citizens. For example, controversies over welfare reform, the educational reform law, the reinstitution of orphanages, and the child abuse reporting backlash represent only a few of our difficulties with regard to agreeing about the issues.

The resolution of the dilemma of how best to serve our children may fall largely on the shoulders of the next generation of citizens, policymakers, and child welfare advocates and workers. For this reason, a text on child welfare would be remiss if it did not address the issues at hand. The issues discussed here will be **children's status**, poverty, **children at risk**, **complex populations**, health issues, and educational concerns. This list is by no means exhaustive, but it does cover some areas in which there is currently debate.

Children's Status

"If I was taller, bigger, and my voice had changed," my son told me when he was 10 years old, "people would listen to what I had to say. But as soon as they see a small person and see that I am just a kid, nobody listens to what I have to say about anything important. Everyone thinks they know what's best for me better than I do!" In this world of consumer rights, we adults sometimes forget to consult one group of important consumers—kids! The old expression "out of the mouths of babes" comes to mind as we read the words of an articulate 10-year-old. How many times has a child dreaded unsupervised visits with a sexually abusive parent only to have the court, unable to prove beyond the child's word that the abuse has occurred, order that the visit must take place? And how many children have told their parents by their behaviors that they are not comfortable in a particular setting, but, not being heard, they are sent anyway?

Admittedly, today's world is not always a friendly place for adults either, but so often the adults' needs come first. For example, in many families both parents must work in order to support their family, yet the childcare services provided for children across the United States are at best uneven and at worst grossly inadequate. Currently, there are no national standards for centers providing childcare, and many states have few, if any, guidelines with regard to teacher qualifications or group size. Not only are children as a group not "heard" in terms of their needs, but in some areas there are marked gender and cultural differences in the services available. For example, several studies found that boys were more likely than girls to commit suicide or drop out of school, yet there are no more services relevant to this problem offered for one gender than for the other (Garfinkel et al., 2004).

Why are children discounted? The most obvious answer is that they cannot vote. If one cannot vote, one's rights and needs may be overlooked. It therefore falls to those working with and advocating for children to advance their causes. This situation also necessitates that those advocating for children listen to them. This is not always easy for adults who have learned that money drives the mechanisms to provide service, and marketing creates the money. Thus, even if children are "heard," what they need may not be provided.

The first and most involved advocates for children can be their parents. When parents can make themselves heard, children can benefit. Thus, support groups for parents that empower them to help their children go a long way toward ensuring that children's needs are met. One neighborhood of concerned parents proved this point. A nearby intersection had become busy, but it was the only route to school for neighborhood children. The children had expressed their fear of crossing the street, even when monitored by parents, but the city

took no action. Finally, the concerned parents took a stand. Through an intense community awareness effort, they convinced the city of the need for a stoplight. It was a proud group of parents that watched the light being put up so that their children could cross in safety.

Although a stoplight may seem minor in the total lives of children, it would have acquired increased importance if a child had been hurt or killed by oncoming traffic. For this group of low-income parents, who had never felt in control of their own lives, advocating in this way was not only beneficial for their children but also a lesson in empowerment for them. Parents must be helped to recognize that they have the power to speak for their children.

When parents are unable to speak for children, others may need to. Advocacy for children necessitates recognizing and weighing all the issues. Changing children's status will require serious attitudinal changes on the part of society. This may never happen. Meanwhile, it is up to child advocates to exert sufficient influence to protect children's rights.

Children in Poverty

Poverty among children and their families is a major problem in the United States (see Chapter 3). Not only does poverty cause health and educational problems, but some argue that it also creates conditions in which parental maltreatment of children is likely (see Milner, 1994; Ambert, 2000; Fong and Smith, 2004; Jenson, 2010; Lamy, 2014). What would be involved in ending poverty?

The Future of Children (Haskins and Sawhill, 2007) focused on policies that may help reduce poverty. The editors recommended work incentives as well as tax incentives. Specifically, they suggested that more attention be given to work incentives for men instead of continuing the tendency to emphasize single mothers. At the same time, there should be more work supports—primarily health care and childcare—directed toward working women and men. Greenberg (2007) proposes a major overhaul of childcare subsidies and tax credits in order to guarantee childcare to income-eligible families. Weil (2007) suggests a **tax credit program** guaranteeing health insurance for low-income families; other health insurance options would be available for purchase through employer contributions, government contributions, and individual earnings. Contributors to *The Future of Children* also suggested long-term solutions, including increased services for teen parents, premarital education, improved preschool education targeting disadvantaged children, improved education in low-performing schools staffed by ill-prepared teachers that emphasizes retention of children and system accountability, and greater assistance to and resources for low-income mothers.

In Chapter 3, Kellner and Craigen refer to **wraparound services** that would provide an intensive array of services for families who are struggling with a myriad of problems often rooted in, related to or resulting in poverty. These authors also suggest the need to empower poor clients and promote self-sufficiency, which can be difficult tasks when people do not believe that they can achieve any more than they have. Education and support are key to reaching out to such families.

The solutions to child poverty are extremely complex. They require financial backing, creativity, and compassion.

Children at Risk

When we speak of children at risk, we think first of children at risk for abuse and neglect. Over the last few years, there has been much debate over what is best for maltreated children. Attracted to high-spectacle events, the media do not effectively raise

American consciousness of the realities of child abuse. Instead, reporters focus on well-known perpetrators and bizarre or sadistic cases. They present a distorted picture of maltreatment and almost negate the seriousness of the plight of low-income children. Ironically, these high-profile cases can move legislatures, public officials, and agencies to assess and change systems and policies but at what price. Effective prevention might save children from a myriad of traumas.

Some critics argue that the public needs to be more involved in the hands-on approach to child welfare rather than sitting back and being fed the information through the media. **Foster Care Review Boards** involve private citizens to aid child welfare professionals in reviewing the progress being made in foster care placements for specific children as the agencies strive toward permanency (Collins-Camargo et al., 2009). As one social worker commented:

> The insight brought to the table by these men and women went a long way toward helping us to improve services. Many of us [social workers] have been doing this work for so long that a fresh approach is much needed.

Citizen Review Panels also invite citizens to become more involved in the formulation of policies regarding child welfare services (Collins-Camargo et al., 2009). Such volunteer involvement requires training that serves to help the public gain a more accurate view of the workings of the large bureaucracies often involved in services for children. In turn, studies have shown that judges and child welfare staff see citizen recommendations as an important aspect of program implementation. Understanding also breaks down the barriers to misperceptions between child welfare agencies and the public. Admittedly more research is needed to determine the best manner in which such volunteers might be utilized (Collins-Camargo et al., 2009).

Waldfogel (2009) contends that the child welfare system has traditionally overemphasized reporting and investigation rather than prevention and treatment. Treatment resources are difficult to find and even more difficult to see funded. The more recent efforts toward prevention on the part of **CPS** have focused on both high-risk families as well as lower risk families with varied results. High-risk families receive such services as counseling, parenting education, respite care, housing assistance, substance abuse treatment, childcare, and home visits. However, the recent research questions whether these services actually do reduce the risk of subsequent child maltreatment. In reality, many high-risk families receive only periodic visits. Waldfogel questions whether the fact that these are often made by overburdened caseworkers diminishes the quality of this service.

Services to lower risk families tend to be centered around information on developmental stages and child-rearing practices and the evidence for the efficacy of these is also in question. Perhaps the fact that many of the families seen by CPS have lives complicated by substance abuse, mental health issues, and domestic violence suggests that emphasis on preventing and treating these issues might be more germane to preventing child maltreatment. What really works in preventing maltreatment is something that continues to need exploring (Waldfogel, 2009).

Maltreated children are not the only ones "at risk." The term "at risk" has broadened to include children whose dysfunctional family or whose poverty puts them at risk for a variety of social service needs. Since the late 1980s, the literature has been filled with ways to address the problem of children "at risk." Throughout this text we have considered different ways that children are put at risk and possible solutions to protect them. Some have suggested that "at risk" be replaced with "at promise," to emphasize strengths rather than deficits. *Many theorists and practitioners* are convinced that we must move beyond what is wrong with families to explore and emphasize what is right in order to build on these strengths.

The movement toward addressing the trauma that children have experienced as it impacts their lives and how they respond to efforts to help them may sound like looking at risk rather than strengths. However, Bloom and Farragher (2011) suggest that it is our delivery systems that must change in order to better meet client needs. Recognizing that clients have experienced trauma and reorganizing our intervention approaches to minimize retraumatizing them, then allows us to recognize and build upon the strengths that may actually have been created by their attempts to survive. This requires an attitude change on the part of helping professionals.

Although attitudinal changes will not completely protect children from harm, it may well enhance our ability to protect them, reach them, and help them. Instead of looking to "fix" broken families, we might reframe in this way and thereby become more creative and proactive about services for children.

Complex Populations

The populations we are seeing in child welfare are more complex than ever before. There is an over representation of minority children in the child welfare system requiring increased cultural sensitivity on the part of helpers. Service to rural communities may require different skills than working in urban neighborhoods. Values in rural settings may differ while communities are closer knit and may be more distrustful of outsiders and organizations seeking to serve. Rural communities also have limitations in what services and resources are available to people (Raphel, 2012).

Approximately 2 million children today have parents who are incarcerated. These children and their caretakers face a variety of challenges to their development and their mental health. Families of incarcerated parents may suffer financially, as well as coping with stigma, prejudice, and shame (Raphel, 2012).

There are also approximately 2.5 million children in the United States who are Native American—both American Indian and Alaskan Natives. The majority of Native Americans are settled in 13 states. Tribal child welfare laws cover these populations but may not always have the resources needed requiring interface with state child welfare agencies. The relationship can be complex and requires cultural awareness and sensitivity (Raphel, 2012). There is also a shortage of social work graduates to serve tribal communities. Cross et al. (2013) suggest that schools of social work have fallen short on their ability to recruit Native Americans as students. In addition, the lack of cultural mentors and faculty knowledgeable in what the students would need to return to their tribal communities combined with racism and feelings of isolation makes advanced social work education unattractive to this population.

With the increase in immigrants and refugees coming into the United States, the child welfare system is feeling the impact. One report indicated that 8.6 percent of those children that come to the attention of the child welfare system are living with a foreign born parent. More than two-thirds of these (67.2%) are Hispanic. Cases of substantiated maltreatment among immigrant families found that physical and emotional abuse were more prevalent than with their non-immigrant peers. However, immigrant parents were eight times less likely to neglect their children than native-born parents. And native-born parents are three times more likely to abuse alcohol and drugs—thought to be significant contributors to abuse—than immigrant parents (Dettlaf and Earner, 2012).

The desire for a better life is the motivation for many who come to the United States from other countries. This is one strength that can be a building block for service to such families who do come to the attention of the child welfare system. It will also be the task of child welfare workers to educate immigrant families about the laws and policies that

impact them in this country. At the same time, it falls to social workers to expand their cultural awareness in order to best serve these families.

Children and Health

More than any other area, health care would benefit from a proactive state of mind. One problem for poor children seeking medical care is finding a doctor who will accept Medicaid. A high percentage of doctors refuse to accept Medicaid due to the long delays in reimbursement. One pediatrician from a low-income area commented:

> It got so I literally could not pay my bills. With 90% of my patients covered by Medicaid and the very long delays before I was reimbursed, I could be seeing patients for weeks with no income at all. I am certainly not in medicine for the money. If I was, I would not be practicing where I do, but I also need to feed my family.

Poor families who are ineligible for Medicaid may have trouble paying medical fees. Even middle-income families who have no or minimal insurance coverage may find themselves bankrupted by one medical crisis. A family may even forgo regular checkups when they have difficulty meeting the costs.

A variety of health problems threaten children today. Successions of environmental hazards take their toll on our most vulnerable. The toxins in our air and water affect children's small bodies more quickly than those of adults. More must be done to protect children from these threats. Even the food we serve our children in public places has been found to cause harm. The rate of childhood obesity has become alarming, enabled by this country's love affair with fast food (Isaacs, 2010; Waters, et al., 2010). Some suggest that major attitudinal changes may be crucial to protecting the future health of children.

The good news is that schools are taking an active part in assessing the health and nutritional needs of children. Many are offering healthier food and snack choices in an effort to develop a generation of adults more aware of and diligent about good health. But more could be done for all children. The next generation of child welfare professionals will need to advocate for primary health care for every child.

Children and Education

Much controversy also surrounds our educational system. Innovations in the inclusion of special-needs children as well as the total Educational Reform Act have sought to make the educational experience rewarding for every child. But we are far from that goal.

Some school learning goes beyond reading, writing, and math. Children come to their learning environment with a set of cultural values as well as familial values. As our country becomes increasingly diversified, it has become even more important to sensitize educators to the diversity that each child brings to the educational experience. In addition, school violence, including bullying, must be curbed so that schools are a safe place to learn.

Children also come to school with a variety of **barriers to learning** including traumatic experiences. The residual effects of abuse and neglect, conflict over domestic violence in the home, scars of poverty, health issues, and the threat of community violence all affect a child's ability to learn. We cannot remove the barriers to learning for all children until we fully address these other social issues. In the meantime, educators must develop a sensitivity that goes beyond the ability to communicate information.

Fortunately, more teachers are recognizing their need to be aware of the whole child and to gear education toward that child. Increasingly, educators value and use the services

provided within the school system (see Chapter 6) and within the community. Preparation for the future necessitates that education, health, and child welfare professionals work together for the whole child within his or her total environment.

Children and Technology

Media and technology are integral parts of the lives of today's children. Because children's exposure to cell phones, iPods, video games, the Internet, and e-mail is so significant, it is vital that we consider the impact that such stimulants have on their lives and well-being. Although some argue that the media are helping children to become better educated and more connected to the world, there are drawbacks. Exposure to violence, contact with sexual predators, and physiological and neurological dangers are of special concern. In addition, critics suggest that online relationships are creating a generation that is more isolated and less interested in person-to-person intimacy, including family interaction.

The contributors to the recent edition of *The Future of Children* suggest that families, educators, and policymakers need to pay particular attention to the content of what children are being exposed to through the media and make efforts to shape that content to enhance children's well-being (Haskins and Sawhill, 2007; Brooks-Gunn and Donahue, 2008; Blackwell et al., 2014).

Summary of This Section

- Despite some of our efforts to create better lives for children, some children still experience poverty, maltreatment, and other types of trauma at home, in school, and in the community. The services in place to deal with these are often overworked or underfunded.
- Children continue to be seen a second-class citizens whose needs are not heard except through concerned adults. While some parents do advocate for their children, there is a need to inform and empower other adults to recognize and advocate for children's needs.
- Poverty continues to be an issue in the United States. Although some policies have been suggested and institutes there is much more needed to address and attempt to eradicate poverty.
- Children are at risk for abuse and neglect. Although intervention and treatment is vital, prevention efforts must also be strengthened. Citizen involvement, educational toward awareness of the problems, as well as addressing some of the underlying causes of maltreatment are important while strengthening the attention given to high-risk families. It is also crucial to look at family strengths and determine how these can be built upon.
- The populations serviced by child welfare agencies are increasingly complex in nature. Rural settings may require different services than urban settings, and these services are not always available. Children of incarcerated parents have their own unique needs. Native American families often governed by tribal agencies and courts need services, and workers who understand and can provide for their needs may not always be plentiful. And immigrant families also require cultural awareness on the part of helpers.
- Health care for children and families suffers when providers will not accept Medicaid. Rising cost make health care prohibitive for some households. Environmental

hazards continue to be a concern. Nutrition is also an important part of health care. Poor food choices available for children have impacted their health. Fortunately, there is a move to improve the foods that are available in schools and other settings that serve children.

- Although there continues to be controversy about some types of reform in education, there is an increasing awareness of children's needs in educational settings. There is more emphasis on the whole child and awareness that the learning of many children is impacted by the trauma they have experienced.
- Although children benefit from the advances in technology, there is also a need to guard against and monitor children's exposure to violence, predators, and other dangers through the Internet.

PREPARING THE CHILD WELFARE WORKER

The role of the child welfare worker is important, whatever the discipline or agency. It is vital that child welfare professionals be well-trained, not only in their particular job but also in all issues concerning children. The child welfare worker should have training in at least the following areas:

- Child development
- Interviewing (especially as it applies to children) techniques
- Child welfare services
- Child abuse and neglect
- Systems theory (so that the worker sees the child as part of the family system, the neighborhood, the community, etc.)
- Other theories, such as crisis intervention, attachment theory, and functional theory (which emphasizes strengths)
- **Trauma theory** including the specific impact of trauma
- Formulation of social policy and grant writing
- State, urban, and federal government
- Cultural diversity
- Computer skills

Given the increase in the number of immigrant children in the last few decades, cultural competence, especially, is essential for child welfare workers (Dettlaf and Fong, 2011; Dettlaf and Earner, 2012).

Many of these areas should be covered in college courses. Agencies do not always train their workers in skills or knowledge beyond the definition of their particular jobs. Thus, when a worker is faced with interviewing a young child for the first time, he or she may be hampered by a lack of knowledge of child development and/or interviewing. When an agency needs a new program to better serve clients, the worker would be well advised to have knowledge in grant writing and/or the political workings of the community in order to be best able to apply for or negotiate for such a program. Also, most agencies now are computerized; workers must do their own documentation on a personal computer. Thus, computer skills can be invaluable.



Ethical and Professional Behavior

Behavior: *Demonstrate professional demeanor in behavior; appearance; and oral, written, and electronic communication.*

Critical Thinking Question: Social work with children requires a variety of skills especially in the area of verbal and written communication. How will you ensure that you have developed these skills? What courses other than in social work will aid you in this endeavor?

Once one is hired by an agency, training is likely to be brief and often is incomplete. Consider the thoughts of this inexperienced social worker:

> When I started as a worker in a foster care agency, I had just graduated from college as an English major. I could do great dictation, but I didn't have a clue if a child was acting normal for his or her age or not. I started work on Monday, got a brief training in forms and policies on Monday and Tuesday, and was sent to my first foster home visit on Wednesday. I had no idea what to say or how to talk to young children. Later my supervisor told me that we were short-staffed that day or they would have let me shadow a worker for a day. Even a day would not have helped!

Training is vital to child welfare staff, especially in the field of child abuse and neglect. Fortunately, agencies now recognize the need for **formal agency-based training** and workers usually attend some type of orientation program as opposed to the on-the-job training that was once the norm. The training environment should be well organized, with attention to such things as selection of the trainers, seating arrangement, timing, and group interaction. "Good training also promotes a good team," one agency director explains. "My agency training consists of team building right at the onset. Experienced workers join new workers in training groups and we do problem-solving exercises. This helps the new workers see how the work is done without just talking at them. I have had workers come to me years after they have been with us, telling me what a valuable experience that training was."

Child welfare workers also have ongoing **supervision**; the quality of this supervision is extremely important. "I tell my workers that quality supervision is their right. If they aren't getting it, I'd like to know why," the same agency director said. It is through supervision that one learns how to prioritize difficult cases adeptly, receives support when making decisions, learns more about the agency, and has an opportunity to process one's feelings about particular cases. "One case was giving me a lot of trouble," one new child welfare worker said. "I couldn't figure out why. It was only after supervision that I realized that this mother was pushing old 'buttons' in me that reminded me of things I hated when I was growing up."

In addition to weekly training, many agencies provide ongoing in-service training or give workers the opportunity to take workshops, training sessions outside the agency, or courses at a local college. This is a valuable chance to maintain up-to-date knowledge of the field. The preparation of child welfare workers cannot be taken too seriously. These individuals may be responsible for major decisions in the lives of children.

Summary of This Section

- It is important for child welfare workers to be adequately prepared before they undertake the role of intervening in children's lives and providing service to them and their families. The areas that are especially important to be trained in include child development; interviewing; child welfare and child maltreatment; systems theory; other pertinent theories, including trauma theory, social policy, and grant writing; government; cultural diversity; and computer skills.
- Mot child welfare agencies offer training and orientation to new workers rather than just the on-the-job training of the past.
- Supervision is a vital part of child welfare practice and good supervision is the right of every worker. Supervision provides support, helps with decisions, and educates the worker about the clients and the agency.

CHILD WELFARE IN THE TWENTY-FIRST CENTURY

The challenge to social workers of the twenty-first century is to fully tailor the services we provide to children to their needs. Many experts express concern that efforts to preserve families have not been working. Granted, the divorce rate may have stabilized and the rate of teen pregnancies decreased slightly, but there are many stresses still causing family breakdown. Some critics (see Hegar and Scannapieco, 1999; Altstein and McCoy, 2000) argue that intensive family preservation services have been ineffective and should be evaluated and refined. Hegar and Scannapieco recommend increased legislative support for kinship care as one way of redefining family preservation.



Ethical and Professional Behavior

Behavior: *Make ethical decisions by applying the standards of the NASW Code of Ethics, relevant laws and regulations, models for ethical decision-making, ethical conduct of research, and additional codes of ethics as appropriate to* context.

Critical Thinking Question: How do you know when you are making a good ethical decision? Where do you think the ethical pitfalls in child welfare exist? How will you ensure that you are making ethically sound decisions?

The driving force in today's child welfare is the understanding of trauma and the practice of trauma-informed intervention and treatment. More and more agencies are seeking to re-organize and re-educate with trauma-informed care in mind. New models to address child protection are also much needed. Changes must take place within child protection agencies and within the larger community (businesses, churches, schools, and neighborhoods). New approaches to prevention are vital. Siegel and Welsh (2014) stress the importance of continued reform of the juvenile justice system. Some feel that welfare reform will aid needy families and stimulate additional services; others insist that the more stringent requirements for receiving financial support only will increase the burden of impoverished families and children. These changes must be attitudinal as well as program-related.

There are some positive projections for the future. Demographic trends indicate that there will be fewer unwanted children. This fact may influence the number of children being abused or neglected. Improved medical care and biotechnology may result in fewer medical problems and developmental disabilities for children. In addition, with updated research the medical and social service community will be better able to deal with children who have these problems. And as women rise higher in institutions and influential professions, more attention will be paid to children's needs.

Whatever the demographics tell us, experience has taught us that our only hope of meeting the needs of all citizens, especially children, is through a unified team approach. We cannot afford the luxury of **turf-ism**, in which each profession stakes out a territory that it fiercely guards. Only through sharing our knowledge and ideas with others who are concerned for children can we solve the problems that we all face in the provision of services for them.

Most likely, you have read this text because you are considering child welfare as a career or are teaching prospective child welfare professionals. Providing services for children is an exciting and challenging endeavor. It falls to you and others like you to make a difference for children. Holocaust survivor and noted author Elie Wiesel has spoken of ensuring the future by building a moral society. He postulates that in a moral society, people listen to one another and value one another. No one is sacrificed for a specific goal but everyone's needs are taken into consideration. It is indifference to another's plight that is more hurtful than perpetration.

It is up to all of us to build a moral society in which children are heard. As advocates for children, we must help children be heard. Our efforts may include promoting pro-child/pro-family federal legislation, searching for creative agency responses, supporting clients to empower themselves, or a variety of other responses. We must not see our clients as doomed to fail but filled with promise. Only when we begin to recognize the importance of children as our future, and value the strengths their families can give them, will today's children receive adequate services. Being a voice for children is the only way we can help them be heard. It will be a challenge but one well worth meeting.

Summary of This Section

- The challenge of the next decade is to tailor the services to the needs of families and children. Theorists wonder if family preservation is working or if there need to be other solutions to protect children.
- The driving force in today's child welfare system is trauma-informed care and practice. Agencies may find that attention to the needs of traumatized children necessitates changes in staff attitudes and agency organization.
- New models must be sought to address child protection and juvenile justice.
- There are some positives for the future, including advances in medical care, improved technology, and more attention to children's issues.
- If we are to build a moral society that respects the needs of all families and children, our efforts must involve every citizen.

SUMMARY

- Child welfare agencies must be mindful of the fact that their clients have experienced trauma and what this will mean to working with them. Keeping this in mind, there are several categories that must be addressed as we move into the future. Since children still have little status as non-voting members of society, it will behoove adults to be good advocates for them. Numerous children are still born into poverty, and there is a need for solutions to improve their lives. Children at risk for maltreatment and other forms of trauma need citizen involvement to aid CPS and to help with news ideas about prevention. The populations currently served by child welfare agencies are complex and the future will bring even more diversity challenging us to become more culturally aware and sensitive to diverse needs. Health care is of concern not only in the need to provide health insurance or ways in which the uninsured can find health care but also in such areas as seeing that our children are well nourished and protected from environmental toxins. And while technology has brought a great deal to the lives of all including children, there is also a need to protect our youngest citizens from some of the more concerning aspects of technology like exposure to violence, access by perpetrators, and physiological and neurological impacts.
- Child welfare workers require preparation for the important work that they do. They should receive training either at the college level or in orientation to a job in the areas of child development; interviewing; child welfare and child maltreatment; systems theory; other pertinent theories, including trauma theory, social policy, and grant writing; government; cultural

diversity; and computer skills. While at one time, training was on-the-job, now most agencies offer an orientation that acquaints the new social worker with agency policy and necessary skills. Once on the job, good supervision is vital as it provides support, help with problem solving and decision making, and ongoing educational information.

- The driving forced for child welfare practice in the twenty-first century is trauma-informed care and practice. Agencies are now mindful of the fact that many if not most of those they see have experienced trauma, and this will impact how these clients must be served. New models of trauma-informed care as well as other ways to address key populations are constantly being explored. Increased attention must be given to promoting pro-child/pro-family federal legislation, searching for creative agency responses, supporting clients to empower themselves, as well as a variety of other issues to help improve the lives of the children and families we serve.

Glossary

16 and Pregnant TV show that chronicles a teen's journey into early parenthood.

1935 Social Security Act legislations that established mother's pensions and mandated states to strengthen child welfare services.

1978 Indian Child Welfare Act sought to protect the tribal rights of Native American children who were being removed to white homes and deprived of their heritage.

abandonment when a child is left for extended period without care or supervision.

aberrant behavior behavior that violates social norms.

absolute poverty a fixed measure of how much a family of a particular size needs to attain basic goods and services, such as food; this does not include the cost of rent, transportation, childcare, or home heating.

abstinence-only sex education teen pregnancy prevention programs that advocated that abstaining from sex was the only appropriate means of preventing pregnancy.

accommodations strategies that allow disabled students to learn the same curriculum with the same expectations as their nondisabled peers.

acculturation the process of adopting the social norms of another group.

acronym an abbreviation formed from the initial letters of words in the full title.

acute stressor an event that is experienced, witnessed, or learned about that causes a relatively short-term stress reaction (no more than 6 months after the stressor is eliminated).

Adam Walsh Child Protection and Safety Act sought to further improve services to children who were victimized by abduction, child pornography, and solicitation through the Internet.

Addiction Theory postulated by Patrick Carnes, this theory treats sexual offending as a form of addiction.

additional diagnosis describes situations in which a child with special needs is discovered to have an additional issue after placement.

adjustment disorder an emotional or behavioral disorder that develops within 3 months.

adoption a legally sanctioned arrangement whereby usually unrelated adults assume parenthood of a child or children on a permanent basis.

Adoption Assistance and Child Welfare Act (PL 96-272) passed in 1980 to discourage long placements in foster care and encourage permanency planning for all dependent children, including those who were abused and neglected in their own homes.

adoption disruption when an adoption fails in that the child or family is unable to adjust and the child must be removed before legalization and the child returns to a foster home or is paced with another adoptive couple.

adoption dissolution when the legal relationship between the child and the adopted parents is terminated either voluntarily or involuntarily and the child returns to a foster home or is paced with another adoptive couple.

Adoption and Foster Care Analysis Reporting System (AFCARS) provides annual statistics on children in out-of-home placements.

adoption resource exchange a service that connects children in need of adoptive homes with potential adoptive parents outside of their agency or geographical area.

Adoption and Safe Families Act legislation enacted in 1997 mandating time limits on how long children could be in out-of-home placements before permanency planning is commenced.

Adoptions Assistance and Child Welfare Reform Act emphasized permanency planning for dependent children and encouraged child welfare agencies to make these provisions in a timely manner.

adverse birth outcomes negative birth outcomes, including infant and neonatal death, prematurity, and low birth weight.

Adverse Childhood Experiences (ACE) negative experiences of childhood, commonly defined as child maltreatment, exposure to domestic violence, parental dysfunction, or divorce.

aging out when a child reaches the age at which he or she becomes no longer eligible for foster care. In most states this age is 18 years old. However, some states extend this limit if a child is attending college or has special needs.

Aid to Families with Dependent Children (AFDC) a program to provide income for impoverished families with children so that they did not need to relinquish their care of the children.

almshouses locally administered public institutions for homeless, aged persons without means. These often became dumping grounds for the poor, mentally ill, and disabled. Children might also be sent to such houses with their poor parents.

American Association for Organizing Family Social Work an organization advocating for family services that was established in 1911 and later became known as the Family Service Association of America.

Americans with Disabilities Act Amendments Act (ADAAA) the 2008 law that expanded the definitions of disability, making it easier for individuals to be covered by the ADA.

amygdala an area of the limbic system implicated in emotional functioning.

anger management training in the ability to understand the source of control and redirect one's anger in appropriate ways of expression.

anterior cingulate cortex a cortical area closely located and connected to the limbic system that is implicated in both cognition and emotion.

antisocial behavior disruptive acts characterized by aggression and hostility toward others.

appellate court part of the judicial system that is responsible for hearing and reviewing appeals from legal cases that already have been heard by a trial-level court.

arraignment a criminal proceeding at which the accused (defendant) is officially called before a court of competent jurisdiction.

assessment the process through which a case of child maltreatment is investigated and assessed to determine what can be done to help the children and family.

asylums a well-known book by Goffman that argued that children brought up in institutions learned behaviors that impeded their ability to adjust once they left the institutional setting.

attachment the bonding that takes place between an infant or child and his or her caretaker.

attachment disorder when bonding does not occur for some reason between a child and the caretaker. This may result in the child's dysfunctional feelings and behaviors.

Attachment, (self-)Regulation and Competency Model (ARC) a model that builds upon the resiliency of children who have experienced trauma.

attachment theory describes how children use their early relationships with caregivers to model all subsequent personal relationships.

barriers to learning factors that make learning difficult for children. These may include the residual effects of trauma.

base the term used by the Navy and Air Force for a military installation.

battered-child syndrome the term coined by C. Henry Kempe to describe children who were physically abused by their parents.

behavior management the ability to recognize and respond to behaviors in ways that de-escalate them from being problematic.

behavior modification a system of rewards and sometimes punishments or the withholding of rewards in an effort to change dysfunctional behaviors.

best interest of the child optimal conditions for fostering the child's development.

birth parents one term used for biological parents. The parents who gave birth to a child.

black market adoption when a third party profits by receiving money for placing a baby for adoption.

boundaries delineations between one system and another or one individual and another.

brief a written legal argument usually in a prescribed format.

bullying the repetitive and harmful misuse of social or physical power over another.

burnout the condition of being depleted of energy and waning interest in one's job, often after a period of time dealing with the same duties or clients. Individuals may also become irritable, short-tempered, and emotionally exhausted.

C. Henry Kempe a pediatrician, child advocate who coined the "battered-child syndrome" and did much to advance the intervention on behalf of abused children. Kempe became a central figure in the movement to identify and treat child abuse.

case manager the social worker who works with a family to help them arrange for services. This worker then monitors the case over time.

Cesarean section surgical removal of the child when vaginal delivery is compromised.

Charles Britwell of Boston Children's Aid Society instituted supervised boarding home for children rather than placing them in orphanages.

Charles Loring Brace an early reformer (1800s) who with a group of like-minded clergymen designed a plan for children who were orphaned or whose parents could not care for them. The plan was to place children with families who would care for or adopt them. Some children were transported by train to the Midwestern United States to waiting families.

Child Abuse Prevention and Enforcement Act another step to reduce child abuse and neglect by improving prevention programs and improving the interface with the criminal justice system.

Child Abuse Prevention and Treatment Act (PL 93-247) the act enacted in 1974 that established the National Center on Child Abuse and Neglect, which would administer funding for a variety of programs and research to help abused and neglected children.

Child Abuse Victims' Rights Act passed in 1986 to improve investigation, court intervention training, victim protection, and treatment for maltreated children.

Child and Family Services Improvement and Innovation Act legislation passed in 2011 that fine-tuned services provided to children through child welfare agencies.

Child Pornography Prevention Act the 1996 legislation that outlawed the production or sharing of child pornography over the Internet.

Child Protection and Penalties Enhancement Act of 1990 fostered improvements in record-keeping and more stringent penalties for offenders.

Child Saver Movement founded chiefly by middle- and upper-class women whose aim was to protect children from abuse, at the same time influencing child labor practices and legal practices affecting children.

child support court-ordered payments to a custodial parent to support one's minor child or children.

Child Welfare League of America prominent organization that still exists to advocate for children.

child welfare worker a social worker whose role involves serving children as part of a social service agency.

childcare a childcare setting where child development and learning are integrated into the curriculum.

childcare assistance federal or state subsidies that help to defray the costs of childcare.

childcare workers residential staff who interact with clients teaching and supervising daily living skills.

children at risk children who have the potential of being abused or neglected or exposed to trauma or unfavorable conditions.

children having children popular term to describe adolescent pregnancy but does not connote status of mature decision-making person.

Children's Defense Fund founded by Marion Wright Edelman in 1973 in an effort to advocate for children throughout the country regardless of their race or class.

children's status the worth placed on children's needs compared to the needs of adults.

chronic health conditions a disease lasting 3 months or more such as asthma, diabetes, obesity, mental illness, or cancer.

Citizen Review Panels when citizens are involved in the formulation of child welfare policies.

civilian counselors those not employed by the military.

clinical component provides therapeutic services to residents, including one-on-one therapy and group therapy.

closed adoptions information is kept confidential and there is no contact between birth parents and adoptive parents.

clothing neglect when a child is deprived of appropriate clothing like shoes of a coat in winter.

cohabiting parents two people who live together and raise children without being legally married.

collusive mother one of Johnson's categories of non-abusive mothers. This mother is described as withdrawn, cold, or psychologically absent and pushes her daughter into her own role in the family.

colonias semirural subdivisions of substandard housing that operate outside the benefits of incorporated towns and cities.

communication the way in which families transmit information and feelings among members. Communication may be verbal or nonverbal.

community-based homes small homelike settings (often a converted house) that house up to 12 children or youths who are provided shelter and some therapeutic services while receiving other services within the community.

Community Initiatives programs targeting at-risk teens, particularly those of ethnic backgrounds, and reach a broad spectrum of the community.

community resources agencies and partnerships that can help those in need find support for basic living necessities and services, including food, shelter, and counseling.

compassionate accountability helping residents to be accountable for their actions through recognizing their feelings and helping them to accept them and problem solve and develop better self-control.

complex populations reference to the fact that there are varied types of families and their children served by child welfare, including minorities, immigrants, children of incarcerated parents, and so on.

complex trauma trauma resulting from multiple experiences of exposure to violence or abuse or exposure over a prolonged period.

Comprehensive Programs provide information on sex and contraception and experiences/training to help youth define other opportunities besides early parenthood.

concrete resources environmental supports, such as housing, transportation, food, and/or clothing.

concrete services assistance programs that help to alleviate the stress of poverty almost immediately through referrals for food pantries, occupational housing, and childcare vouchers and similar practical services.

concurrent planning a mandate of the Adoption and Safe Families Act, in which simultaneous plans are made for a child who has been in care for a while to both reunite the family and discuss options in case the child cannot return home.

conditioned emotional learning a pattern of behavior where emotion becomes associated with a previously neutral stimulus, resulting in emotional responses to that once neutral stimulus.

conditioned fear response a pattern of behavior where a fearful stimulus becomes associated with a previously neutral stimulus, resulting in fear responses to that once neutral stimulus.

consent contracts contracts signed by birth parents prior to or at the time of relinquishing their child for adoption that agree that the child may receive information about them and perhaps search for them at a later time.

corollary a proposition that follows from one already proved.

Corporation for National and Community Service federal agency comprised of four programs (AmeriCorps, Senior Corps, Social Innovation Fund, and Volunteer Generation Fund) that focus mainly on disaster services, education, veterans and military families, and economic opportunity.

CPS child protection service, the agency responsible for intervention in child abuse and neglect.

crack babies infants addicted at birth to crack cocaine as a result of their mother's use of the drug.

crisis homes foster homes that accept children on an emergency basis for a limited period of time.

crisis nurseries provide a safe haven for the youngest children when their parents cannot take care of them.

cultural competence an ongoing skill set that encompasses the ability to have an open mind and avoid making assumptions based on stereotypes.

culture of poverty intergenerational continuation of poverty; family lacks the social and economic capital necessary to improve their socioeconomic status.

custody having the protective care of someone.

cyberbullying harassment or inflicted harm through words or pictures via the Internet.

cycle of poverty a phenomenon where poor families become impoverished for at least three generations, that is, for enough time that the family includes no surviving ancestors who possess and can transmit the intellectual, social, and cultural capital necessary to stay out of or change their impoverished condition.

date rape refers to sexual assault by a peer.

delinquency a minor crime committed by a young person within a proscribed age range.

deployment the movement of military personnel, equipment, and support into an area where there are military operations or conflict.

depressed neglect these parents guard against expressing both affect and cognition. For them, nothing is worth doing; they, too, become withdrawn and lack in emotion.

designer street drugs drugs that are created in labs or at home through changing the property of another drug using chemistry.

Devereux Foundation a large network of residential centers started in the early 1900s by educator Helen Trafford Devereux who believed that the special needs of children should be addressed. In the 1970s, Devereux's standards became the model for residential treatment across the country.

diagnostic service centers provide short-term diagnostic services so that the best plan can be determined for the child or youth.

direct placement where the adoptive parents contract directly with the birth mother.

discretion the freedom to decide what should be done in particular situations.

disorganized neglect the parent who lives from crisis to crisis, feeling rather than problem solving. Their children learn that crisis is a way of life and may actually use extremes of emotion to manipulate their parents and, later, others.

domestic transracial adoption the placement of children from the United States with adoptive parents of a different race.

domestic violence the physical harm of family members within a home. This usually refers to battered women, although men are also battered on occasion. May also encompass child abuse.

drug gangs smaller and more cohesive than organized gangs but their object is selling and distributing drugs.

drug-free treatment refers to treating an addicted individual without the use of other (prescription) drugs.

dual-wage-earner family a family in which both parents are employed and expected to support the family financially.

due process fair treatment through the normal judicial system, especially having to do with legal rights and entitlements.

Early Head Start a federally funded, comprehensive childcare program serving infants and toddlers living in poverty.

ecological system theory the various environmental factors impacting an individual's development.

educational component responsible for educating children, especially catering to their special education needs.

educational neglect encompasses failing to enroll a child in school, permitting chronic truancy, and failing to attend to the special education needs of a child.

educational setting any place where learning is a primary goal of a child's participation.

emancipation a term that refers to a child's aging out of foster care.

emergency shelter care provide short-term temporary services for children often while they are awaiting a court appearance or placement in a foster home and cannot remain in their homes.

emotional abuse refers to undermining a child's self-esteem or humiliating, belittling, rejecting, isolating, or terrorizing a child. Also referred to as psychological abuse.

emotional neglect is difficult to assess but refers to the failure to meet a child's emotional and affection needs.

enculturate to help the child through teaching or modeling to learn and espouse the values of a particular culture.

enculturated taught to fit into the mores and values of a particular culture.

environmental neglect refers to some of the above but is basically when a child is not protected from harm from the environment.

evidence-based practice integration of research with clinical practice.

explicit memory the form of memory responsible for conscious, intentional recollection of knowledge.

exposure to hazards refers to not protecting children from such hazards as poisons, electrical wires, stairs, drug paraphernalia; exposure to secondhand smoke; availability of guns or other weapons; unsanitary household conditions such as rotten food, animal excrement, infestation by insects, lack of clean water; or lack of appropriate caregivers.

expulsion the refusal to care for an underage child by expulsing him or her from the home without adequate arrangement for other care.

extrafamilial abuse abuse that is perpetrated outside of the family.

extreme poverty less than 50 percent of the poverty level, or under $11,746 annually for a family of four; characterized by deprivation of basic human needs such as food, health, shelter, etc.

family boarding homes foster homes that care for children for extended periods as part of the therapeutic team.

Family Care Plan a plan required of military parents that designates an arrangement for the care of minor children during the service member's deployment or other time away from home.

family continuity the emphasis on attempting to strengthen the family unit and placing children out of the family only when absolutely necessary.

Family Drug Courts (FDC) provide case management and coordinate services between substance abuse treatment and child protective services.

family preservation services programs that serve families in which out-of-home placement is imminent.

Family Preservation and Support Services Program the part of the Omnibus Budget Reconciliation Act of 1993 that provided money for states to develop family support and preservation programs.

family resilience the ability of the family to overcome difficult or traumatic experiences and bounce back.

family resource specialist a more recent title given to the home-finder or one who conducts the homestudy.

family roles a set of expectations dictated by society and family members that an individual family member is expected to assume. Each family member has a role in the family system.

family rules repetitive patterns of interactions that family members develop with each other. Rules may be formal and spoken or implied.

family support services help families build on their strengths in order to resolve problems that might have otherwise led to child maltreatment, developmental delays, or family dysfunction.

family-based services target the family and view the clients as the total family system.

Fatherhood Initiative Obama administration's programs designed to support fathers.

fetal alcohol effects (FAE) less-serious effects of maternal alcohol use during pregnancy.

fetal alcohol spectrum disorders (FASD) refers to a continuum of abnormalities in infants and children caused by the abuse of alcohol during a mother's pregnancy.

fetal alcohol syndrome (FAS) at the far end of the continuum, this refers to variety of physical and psychological defects in children resulting from maternal alcohol abuse during pregnancy.

fixated offender one of Nicholas Groth's two categories of sexual offenders. This is the classic pedophile whose abuse is premeditated and who prefers children to adults.

food insecurity the state of being without reliable access to a sufficient quantity of affordable, nutritious food.

formal agency-based training training—often classroom-based—provided to workers before they begin their job or provided for ongoing workers as in-service training.

Foster Care Independence Act legislation passed in 1999 that increased the funds available and made other provisions for children who were aging out of foster care.

Foster Care Review Boards involve private citizens to aid child welfare professionals in reviewing the progress being made in foster care placements for specific children as the agencies strive toward permanency.

Fostering Connections to Success and Increasing Adoptions Act sought to further support relatives who are caregivers, improve outcomes for children in foster care, and enhance incentives for adoption.

free and appropriate public education (FAPE) the provision of a publicly funded education that meets the needs of the disabled child such that the child has every opportunity to achieve academic success commensurate with their potential.

free boarding home when children were placed with families who assumed their care with no compensation.

fully disclosed adoptions completely open with contact among birth parents, foster parents, and adoptive parents. The degree of contact is usually agreed upon during the adoption process.

functions of a family procreation, enculturation, and protection of children.

gang a group of like-minded individuals who band together with similar interests for the purpose of belonging and protection. There is often criminal activity involved.

gang migration the movement of gangs from larger cities to smaller cities, suburbs, and rural areas.

generational boundaries refer to the delineations between one generation of a family and the previous or next generation.

Genogram a diagram that depicts family relationships.

grade the term used for pay functions.

gray market adoption independent adoption that does not go through an agency but rather from birth parent to adoptive parents or through an intermediary. Money does not change hands for the transaction but the adoptive parents may assume the costs incurred in the birth.

Great Recession of 2008 sharp decline in economic activity that is generally considered the largest downturn since the Great Depression.

grooming the process through which sexual offenders engage their victims by desensitizing them gradually to sexual interaction.

guardian ad litem an individual—often an attorney or private social worker—appointed by the court to represent the best interests of the child.

Hague Convention on the Protection of Children and Cooperation in Respect of Intercountry Adoption the meeting in 1993 of several countries to forge an international agreement about standards governing international adoptions. The agreement (convention) applies to all residents of the United States who adopt children from other countries outside of the United States.

Head Start a federally funded, comprehensive childcare program serving preschool children and families living in poverty.

Head Start Trauma Smart a federally funded, comprehensive, trauma sensitive childcare program serving traumatized children and families living in poverty.

hedonistic or social gang uses drugs but limited other criminal activity.

hippocampus an area of the limbic system implicated in memory functioning.

the Holt Agency one of the earliest, largest, and best-known adoption agencies that specialized in placing children from other countries with parents in the United States.

HOMEBUILDER program the "gold standard" of family preservation programs serving multiproblem families.

homefinder the social worker who conducts the studies of potential foster parents. This role may also involve recruitment and approval of foster parents.

homelessness The Department of Housing and Urban Development defines four broad categories of homeless people, including those living in a place not meant for human habitation, an emergency shelter, or transitional housing; or those exiting an institution where they temporarily resided.

Homer Folks a New York City reformer who extolled the virtues of family life for children.

homestudy an investigation of potential foster (or adoptive parents) conducted by the agency seeking to employ their services.

The House of Refuge the first residential setting for juvenile delinquents built in New York.

houseparents a couple who takes on the role of residential staff helping and supervising residents in their daily living skills.

hyperarousal a persistent state of stimulation or awareness that can interfere with daily functions such as sleep.

hypervigilance a persistent state of alert that leads to intense emotional and behavioral responses to threatening and nonthreatening stimuli alike.

identify with the aggressor when a victim finds siding with the abuser emotionally safer than remaining a victim.

imminent risk of serious harm harm that could cause permanent or long-term injury and is likely to occur at any moment.

improvised explosive devices (IEDs) essentially homemade bombs that have caused a good many injuries to U.S. military personnel.

in care refers to children being in the foster care or child welfare system.

inadequate supervision encompasses the lack of supervision in terms of children being left unsupervised when it is deemed that they are not yet able to care for themselves.

incest sexual abuse within the family. Also referred to as intrafamilial abuse.

indenture the placement of an individual—often a child—with a tradesman who is expected to teach the apprentice a trade. The apprentice then owes the master his or her free labor for a prescribed number of years in exchange for room and board.

independent adoption (also known as targeted or designated adoption) is when potential adoptive parents contract with a third-party or a birth mother to legally adopt a child.

Indian Child Protection and Family Violence Act further extended the provisions of the services for Native American children.

individualized education program (IEP) a legal document written to detail all aspects of a special education child's learning needs and how those needs will be met.

Individuals with Disabilities Education Improvement Act (IDEA 2004) the current iteration of the law that covers special education services for children with disabilities.

Industrial Revolution change in the economy that resulted from the introduction of power-driven machinery.

infanticide the killing of unwanted children.

infertile couples those who adopt because they are unable to have their own children.

informal and natural helpers individuals within a child or family's environment who may or may not be trained as helpers but can nonetheless provide support and sometimes services for families and children in treatment. An example might be a religious leader or faith community.

initial diagnosis refers to the diagnosis of special needs made by the country of birth of a child adopted internationally by U.S. citizens.

instrumental gangs engage in property crimes and may use but rarely sell drugs.

intake the process through which a report of child maltreatment is taken and screened for its validity.

intensive residential treatment provide therapeutic services that are more intensive than typical residential treatment center.

intergenerational family systems a group of related adults of multiple generations who carry out the roles of a family and raise children.

intermediate placement where a third party (e.g., lawyer or doctor) is involved.

intermediate placement for profit where a third party receives money for placing the child, sometimes referred to as "baby selling."

international adoption when a child is adopted from another country. Also called intercountry adoption.

intimate partner violence (IPV) physical, sexual, or psychological harm by a current or former spouse or partner.

Jane Addams an early reformer and the founder of Hull House, one of the first settlement houses in the United States.

John Bowlby prominent researcher on attachment theory.

John Caffey the radiologist who first publically postulated the theory that unexplained and poorly healed fractures in children might be indicative of child abuse.

Julia Lathrop an early reformer who worked with Addams at Hull House and was instrumental in the developing the juvenile court system.

jurisdiction the official power to make legal decisions and judgments.

Juvenile Court Act of 1899 established the juvenile court system to address the needs of dependent children.

juvenile or family division the branch of the civil court that oversees matters concerning dependent children and their families.

juvenile offenders individuals under 18 who abuse other children.

K–12 school the term used to refer to the educational system serving children from kindergarten through 12th grade.

kinship adoptions adoption by relatives of the child.

kinship care when a relative, close friend, or godparent assumes the role of foster parent for a child they know.

kinship caregivers relatives of children who raise them instead of their parents.

Lanham Act of 1940 early legislation that first provided funds for the development of childcare during World War II.

late diagnosis when children adopted internationally are not diagnosed with special needs until after they reside in the adoptive home.

least restrictive environment (LRE) the requirement that disabled children will be educated within the general education classroom whenever possible, with removal from the general education classroom only when necessary.

legalization when a petition to adopt is granted by probate court giving the adoptive parents complete legal rights to parent the adopted child.

legal-risk adoptions when a child who is not yet legally free for adoption is placed with adoptive parents with the assumption that the adoption will be allowed when the child is legally free.

level system the organization used by many residential settings to control behaviors and promote responsibility among residents. A higher level with its privileges can be attained through acceptable behaviors.

LGBTQ youth adolescents that define their sexual orientation or gender identity as lesbian, gay, bisexual, transgender, or questioning.

life book a scrapbook of pictures, letters, and narratives that helps the adopted child know more about his or her life before placement for adoption.

limbic system a complex system of structures and connections located in the center of the brain that houses many functions related to emotions, memory, implicit learning, and basic.

low birth weight baby born at less than 2,500 grams or 5.5 pounds.

low-income families families who earn less than twice of the federal poverty line.

The Lyman School a state-funded reform/training school for delinquent boys, which opened its doors in 1847 and operated until the early 1970s on the model of the German agricultural reformatory.

mandated reporters individuals who are required by law to report child maltreatment.

marginalization social exclusion, often pushing groups to the lower or outer edge of society economically, politically, culturally, and socially.

Mary Ellen Wilson the child whose story changed the future of services to abused children. Discovered to be abused in her home, Mary Ellen was removed by social worker Etta Wheeler who appealed to director of the American Society for the Prevention of Cruelty to Animals, Henry Burgh, that animals were treated better than this child. Mary Ellen was removed from the home and the case gave rise to the establishment of the Society for the Prevention of Cruelty to Children in 1875.

Maternal Care and Mental Health a United Nations report that discussed considerable research demonstrating that institutional care had a negative effect on children.

McKinney-Vento Education of Homeless Children and Youth Assistance Act legislation that provides federal funding to states to ensure immediate enrollment and educational stability for homeless children and youth.

media violence depictions and reports of violence on television shows, movies, and the Internet.

mediated adoptions when the adoption agency facilitates a limited amount of contact—usually not direct contact between birth parents, foster parents, and adoptive parents.

medical neglect denying a child adequate health care or delaying obtaining health care in serious medical situation.

meta-analysis a statistical analysis combining the results of several independent research studies, often to resolve what appear to be conflicting results in the research literature.

middle teens age grouping established by the Department of Health and Human Services to describe youth ages 15–17.

model to teach by example.

modifications changes to curriculum content, teaching strategies, or assessment techniques that are necessary for the disabled student to achieve academic success.

Mother's Pensions an entitlement for mothers in economic need that allowed them to the resources to keep their families together.

multifactor theories suggest that numerous variables account for a perpetrator's propensity to abuse.

multitiered systems of support (MTSS) a systematic approach to intervention that offers increasingly intensive and individualized services as needed.

Munchausen-by-proxy more recently termed Factitious or Fabricated Disorder by Proxy (FDP), describes a condition where a parent—usually the mother—presents the child as ill to gain attention from the medical community while contributing to keeping the child ill through a variety of means.

National Center for the Prevention of Child Abuse and Neglect established in 1972, through financial aid from the University of Colorado Medical Center, for the purpose of research and the sponsorship of training programs in the area of child abuse and neglect.

neglect the failure to meet a child's physical, medical, educational, emotional, or safety needs. Neglect also encompasses newborns who are addicted to drugs at birth.

neuroplasticity the process by which the brain can continue to change over time and with new experiences.

neuroscientist a research who studies the development and function of the nervous system, including the brain, spinal cord, and nerve cells.

No Child Left Behind Law Educational Reform Act passed in 2001 that placed high emphasis on testing.

noncommissioned officers those who have risen to the rank of enlisted officers but are still considered to be in the enlisted subculture.

nonorganic failure to thrive refers to a syndrome where a young child who has been neglected withdraws from his/her environment and wastes away.

North Carolina Family Assessment Scales for Reunification (NCFAS-R) the only empirically validated instrument designed to assess the family's potential for reunification.

notoriety the state of being well known for some bad quality.

nutritional neglect when a child is left repeatedly hungry for long periods or is undernourished, as evidenced by poor growth.

Occupy Wall Street protest in New York and other financial districts credited for spawning a movement against social and economic inequality worldwide; highlighted the fact that 1 percent of U.S. population controls the wealth of the nation.

Office for Civil Rights (OCR) a division of the U.S. Department of Education that enforces compliance with educational laws to safeguard the civil rights of protected students.

older teens age grouping established by the Department of Health and Human Services to describe youth ages 18–19.

Omnibus Budget Reconciliation Act established the Family Preservation and Support Services Program to strengthen vulnerable families.

openness refers to the amount of contact between the parties involved, especially the birth and adoptive parents.

Operation Enduring Freedom (OEF) fought in Afghanistan between 2001 and 2014.

Operation Freedom's Sentinel (OFS) the campaign to support Afghan forces beginning in 2015.

Operation Inherent Resolve (OIR) military operations were instituted in both Iraq and Syria against the Islamic state of Iraq.

Operation Iraqi Freedom (OIF) fought in Iraq from 2003 to 2010.

Operation New Dawn (OND) troops stationed in Iraq from 2010 to 2011, the purpose of which was to help with transition to Iraqi control.

organizational or corporate gangs are organized and regimented and are heavily into crime and drug sales.

orphan asylums institutions for children who had no parents or whose parents were unable to care for them.

orphanage an institution housing children with no parents or whose parents cannot care for them.

parent subsystem composed of the parents in a family no matter their genders.

parental involvement the contact that birth parents have with their children in foster care.

parole the release of a prisoner before the completion of a sentence, usually with special conditions.

party gang uses and sell drugs and engage in vandalism.

Patient Protection and Affordable Care Act although an overreaching effort to see that all citizen had health care, this Act also included provisions for child welfare, including the extension of Medicare coverage for former foster children until the age of 26, mandated case reviews for children aging out of the foster care system, and increased services for teen parents.

pederasty the practice of using young boys sexually ostensibly, to train them to prepare for manhood.

pedophile an adult who prefers and is sexually attracted to children. Usually refers to males.

permanency planning an effort on the part of child welfare agencies to move children into permanent situations as quickly as possible to reduce the level of trauma caused by being in limbo.

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 commonly known as Welfare Reform, established means of cutting back on entitlements for poor families and stipulated that teen mothers must live with an adult in order to receive benefits.

petition a formal written request, appealing to the court for help.

physical abuse of children can be defined as a non-accidental injury inflicted on a child.

physical neglect includes abandonment, expulsion, shuttling, nutritional neglect, and clothing neglect.

PL 94-142 the 1975 law that guarantees a free and appropriate public education in the least restrictive environment for all students with disabilities.

placing out the practice of sending children by train to adoptive or foster homes in the Midwest.

polyvictimization when children have been exposed to six or more forms of violence or abuse.

post term used by the Army for a military installation.

postdeployment the period after a service member returns from deployment.

postlegalization services services provided to the adoptive family after the case has been legalized by the court.

post-traumatic stress disorder (PTSD) a disorder caused by an extremely traumatic event or events such as threat of death, observing another killed or maimed or fear for physical well-being or sexual integrity, causing a variety of symptoms that persist for more than a month after the event.

Post–World War II Baby Boom increase in birth rate following the end of World War II.

powerless mother one of Johnson's categories of non-abusive mothers. This mother feels victimized, powerless, defeated, and unable to protect herself, let alone her child.

predatory gangs involve in serious crime and significant drug use and sales.

predeployment the period of time from the orders to deploy and deployment.

preferential applicants those who adopt because they are seeking a specific kind of child (e.g., a specific gender, special needs).

Preventing Sex Trafficking and Strengthening Families Act made some improvements in the provision of child welfare services in addition to building in safeguards for children at risk for sexual trafficking.

primary prevention programs aimed at preventing sexual activity and pregnancy.

private school a school that is not supported by public funds.

procedural safeguards the legal provisions in place to ensure that the processes of eligibility determination, assessment, and IEP development are conducted in a manner that protects the rights of the students, families, and schools involved.

process models suggest that understanding abusers is not just about knowing why they abuse children but also how they go about doing so.

procreation refers to giving birth to offspring.

Project Head Start established during the War on Poverty to provide daycare services to poor children.

Promoting Safe and Stable Families Act addressed the needs of the children of incarcerated parents as well as improved the services for youth who were aging out of foster care.

protective factors decrease the likelihood of a negative developmental outcome.

protective mother one of Johnson's categories of non-abusive mothers. This mother provides protection once she learns of the abuse.

psychotherapeutic milieu refers to all of the aspects of a residential facility working together in the interest of helping the residents.

The Public Health Act of 1987 addressed teen pregnancy by establishing programs for pregnant and parenting teens.

rank describes the service member's status and authority in comparison to others.

rate the Coast Guard term that corresponds to rank in other branches of the service.

reactive attachment disorder a disorder characterized by an inability to form appropriate, close attachments with a caregiver that results from a history of significant neglect.

reconstituted family consists of two adults who have had previous relationships. They come together, often with children from previous relationships, in order to create a new family. These parents may then have children together.

Refuge Movement a movement in the early 1800s that sought to remove children from almshouses and place them in institutions designed for their care.

regressed offender one of Nicholas Groth's two categories of sexual offenders. This offender may be involved with age-mates but finds them too conflictual. He turns to children as substitute peers.

rehabilitation the act of restoring an offender to former capacity.

rehoming the placement of children—usually adopted internationally—by their adoptive parents in other homes without intervention of an agency.

related adoptions where there is a preexisting blood tie between the child and the adoptive parents.

relative poverty when people technically above the poverty line experience deprivation due to having less economic resources than those they consider peers.

repeat pregnancy subsequent pregnancy after an initial one.

residential component the department within a residential setting that helps and supervises residents with daily living skills in their living areas.

residential school an educational setting where the students live and attend school.

residential treatment centers specialize in the therapeutic milieu, combining therapeutic services from residential, educational, and psychological perspectives for youths whose behaviors or issues cannot be managed in a home setting.

response to intervention (RTI) a multitiered system of intervention for academic difficulties that is allowable as an assessment process for special education eligibility determinations.

reunification when a foster child is returned to the home of his or her birth parents.

reunion the period just prior to the return of a service member from deployment.

risk factors increase the likelihood of a negative developmental outcome.

ritualized abuse the abuse of children using rituals that often include unusual and sadistic sexual behaviors, the use of satanic or supernatural symbols, consumption of bodily fluids, torture or sacrifice of animals, and a variety of other rituals.

Roe v. Wade Supreme Court decision that legalized abortion and made terminating unwanted pregnancies safe and legal.

role assignment issues refer to conflicts over who performs what role in a family.

scavenger gangs engage in petty crimes for fun, often preying on the weak.

school choice the option provided to students and families seeking a publicly funded alternative to their local neighborhood school.

school psychologist an expert in assessment, learning, behavior, disabilities, and education law who works within the school setting to provide psychological testing, counseling, and consultation services.

school readiness a measure of how prepared a child is to succeed in school cognitively, socially, and emotionally.

school social worker a specialized mental health professional who works in schools.

school voucher one of many school choice options, where parents may opt to divert their student's portion of public education funding to pay for private schooling.

school-based or school-linked clinics health care centers that provide basic health care and contraception to students in their schools.

scientific philanthropy a movement in the late nineteenth century that emphasized a scientific approach to developing charitable interventions to help them in need.

search when the adoptee seeks information about his or her past and the birth parents.

Second Chance Homes residences for teen mothers who cannot live with their families.

secondary prevention targets successive unwanted pregnancies and provides supportive services to parenting teen and their children.

Section 504 the segment of the Rehabilitation Act of 1973 that prohibits discrimination against disabled students by ensuring access to educational opportunities that is equal to that of their nondisabled peers.

Self-Sufficiency Standard defines the income necessary for a working adult to achieve economic independence for one's family without public subsidies and private/informal assistance; it accounts for the varying cost of living in different geographic areas.

seminal original, groundbreaking.

serious delinquent gangs heavily involved in all types of crime but not so much in drug use.

settlement house reform institutions in the late nineteenth and early twentieth centuries where settlement workers provided services for less-advantaged neighbors and sought to remedy poverty.

sexually active having had sex within the last 3 months.

shuttling when a child is passed from one substitute caretaker to another due to the parent's unwillingness to care for the child.

sibling subsystem composed of the children in a family.

Silver Ring Thing abstinence-only education program; participants are given a silver ring and they pledge not to remove it until their wedding day.

Single-factor theories point to one characteristic as the prime motivator for sexual offenders.

single-parent adoptions when one unmarried adult is allowed to adopt a child.

single-parent family one in which one adult is raising children. Statistically, this adult tends to more often be female. Intergenerational family systems consist of multiple generations, all engaged in carrying out the roles of the family and raising children.

social learning theory examines an individual's expectations and cognitions and ways in which behavior can be changed.

Social Security Disability Insurance (SSDI) federally funded assistance program that is available to individuals who have become disabled and have paid into Social Security for multiple years.

socialization refers to helping a child learn what is expected of him or her by the society.

Society for the Prevention of Cruelty to Children (SPCC) the first agency designated to intervene in the lives of abused and neglected children.

specialized foster home homes that care for children who may have special needs or special circumstances. These foster parents may receive special training to address the needs of their foster children.

specially designed instruction modified curricular content, teaching strategies, or assessment.

State Education Agency (SEA) the state-level government agency responsible for the oversight of public education throughout the state.

status offense an offense that would not be a crime if committed by an adult.

Stern v. Whitehead-Gould a much publicized case where a surrogate mother fought to keep the child that she had contracted to bear for another couple.

strength-based model means of working with a family emphasizing the importance of self-determination and client empowerment.

subsidized adoption when the adoptive couple is given a stipend to cover the cost of a child's preexisting condition—usually a medical issue.

substance abuse the overuse or abuse of substances such as alcohol or drugs.

substantially separate day school a therapeutic school program that is separated physically from traditional schools and classrooms.

supervised independent living provides housing and supervision for up to four adolescents giving them an opportunity to try out some degree of independence.

supervision meetings with a supervisor to discuss cases and make case decisions. May also have an educational component.

Supplemental Security Income (SSI) federally funded welfare program that provides stipends to low-income people who are either 65 or older, blind, or disabled.

surrogate mothering when a woman enters into an agreement with a couple that for a fee, she will be artificially inseminated with the husband's sperm, to carry the baby, and then to relinquish the child to the sperm donor and his wife who will then adopt the child as their own.

tax credit program a refundable tax credit that increases the income of low- and moderate-income working families by providing tax reductions and cash supplements.

technophilia coined by police detective McLaughlin to describe those who use cyberspace to engage in the sexual exploitation of children.

Teen-Tot Programs provide education and services to help parents support and nurture their children.

termination when a child leaves a residential setting for home, a foster home, a less or more restrictive setting or transitions into independent living.

territorial gangs exist in a particular area or turf and expend their time maintaining their geographic ownership.

three-generational household comprised of teen parent, her parent(s), and her child.

Title IX funding mandated equivalent funding for girls' sports in public schools.

token economy a method used by some residences to encourage acceptable behaviors. Tokens are awarded for good behavior and can be redeemed in some fashion for goods or privileges.

toxic stress the cumulative effect of experiencing a stressful environment because of strong, frequent, or prolonged adversity, such as physical and emotional abuse, neglect, chronic hunger, caregiver

substance abuse or mental illness, exposure to violence, or the accumulated burdens of family poverty.

transition planning both the process and the written goals within an IEP that plan for a disabled student's exit from high school into college or the community.

transitional periods times when children in a residential setting are transitioning from one activity to another.

transracial placement the placement of a child with adoptive parents of a different race.

trauma-informed care framework that conceptualizes a person's behavior and symptoms as adaptations to trauma and considers the age, developmental level, and specific trauma history of the child in developing interventions to help provide a sense of safety and empowerment to individuals.

trauma-informed setting an environment that provides safety for residents that eliminates or diminishes barriers to healing.

trauma-informed training the process of training social workers to recognize that all parties in protective services cases may have undergone trauma and how to work with individuals who have experienced trauma.

trauma-informed treatment addresses the impact that complex trauma has had upon the individual youth while focusing on not retraumatizing him or her while providing mental health assistance.

trauma-sensitive educational setting a learning environment with systems of support integrated into its goals and programs to reduce the risks of academic and social failure.

trauma-specific treatment seeks to address the complex trauma—that is trauma that results from exposure to multiple events and circumstances—experienced by an individual—in this case a child or youth—using group or individual therapies that focus on trauma recovery.

trauma- and stressor-related disorders a class of disorders caused by exposure to traumatic or stressful events, often resulting in significant levels of anxiety and fear that limit daily.

trauma theory first explored by Lenore Teri and more recently Sandra Bloom refers to the study of the impact of psychic trauma, which occurs when an individual experiences sudden, unexpected, or overwhelming emotional assaults (or one major assault) with which the psych does not have sufficient resources to cope. This often becomes internalized causing various responses that can be debilitating.

traumatic brain injury (TBI) a condition caused by severe impact to the head such as from an IED explosion, which disrupts the brain function and leads to a variety of symptoms.

treatment may refer to any service, from counseling to contracting with another agency for the provision of some service.

treatment plan an agreed upon document outlining a set of goals and measurable steps that indicate that clients are moving toward meeting these steps.

tribunal a court of justice.

truant to be absent from school without authorization or a legal excuse.

turf-ism protecting one's own territory, which prevents team work or collaboration. In social services, this refers to agencies not wishing to share expertise, information, or clientele with other agencies, often to the detriment of clients.

turnover rate the rate at which staff leave and agency and other staff are hired. Changes in staff can cause clients to feel unsafe.

U.S. Children's Bureau the federal agency established in 1912 as a result of the first White Conference on Children.

unregulated child custody transfers the accepted term for "rehoming."

unrelated adoptions when the adopting couple have no blood relationship to the child they adopt.

vicarious traumatization a form of trauma that counselors may develop as a result of repeated exposure to victims of trauma.

virtual pornography images of children in sexual acts or poses displayed on the Internet.

virtual school an online school program.

War on Poverty unofficial legislation introduced by President Kennedy and President Johnson is response to a national poverty rate around 19 percent.

warrior society the term for military life, characterized by its authoritarian structure, the isolation felt by its members, a distinct class system, a sense of mission, and the preparation for disaster or death.

wraparound services an intensive, holistic framework to address the complex needs of families struggling with multiple problems used to build support networks.

young teens age grouping established by the Department of Health and Human Services to describe youth ages 10–14.

Youth Development Programs provide experiences and skills training to youth so that they are less likely to choose behaviors leading to teen pregnancy.

youthful sex offenders children and youth under the age of 18 who sexually act out against others.

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Index

Abandonment, 4, 158, 317
Abbott, Grace, 5
Abecedarian Project, 257–258
Aberrant, 218
Abortion, 4
Absolute poverty, 55
Abstinence education, 255
Abstinence-only sex education, 240
Abuse burns, 153–154
ACA. *See* Affordable Care Act (ACA)
Academic failure, and trauma-sensitive educational settings, 130–132
Accommodations, 141
Acculturation, 212, 239
ACE. *See* Adverse Childhood Experience (ACE)
Acronyms, 221
ACT. *See* Action for Children's Television (ACT)
Action for Children's Television (ACT), 89
Acute stressor, 131
ADAAA. *See* Americans with Disabilities Act Amendments Act (ADAAA)
Adam Walsh Child Protection and Safety Act of 2006, 11
Addams, Jane, 9, 149, 189, 216
Addicted parents. *See* Substance-abusing parents
Addiction theory, 166
Adjustment disorder, 140
Adolescent Pregnancy Prevention Program, 258
Adolescents
  and substance abuse, 104–107
  and substance-abusing parents, 101
  violence in streets, 88
Adoptable children, decreased number of, 304–305
Adoptees' Liberty Movement Association, 333
Adoption, 297–336
  access to information and openness in, 309–310
  adoptive applicants, 321–324
  adoptive participants, 315–318
  adoptive process, 324–330
  agency-assisted *vs.* independent, 306–308
  agency *vs.* independent, 306–308
  assumptions, 300–301
  birth parents and, 315–318
  changes in types of children available for, 305–306
  children available for, 318–321
  closed, 309
  defined, 300
  disruption, 308, 313, 329–330
  dissolution, 329
  evolution of, 298–304
  extended family and, 324
  fully disclosed, 309
  issues and changes in, 304–314
  legislation concerning, 151
  legislation in United States, 298–299
  male heirs and, 298
  number of adoptable children, 304–305
  open, 326–327
  role of the adoption worker, 330
  search and lifelong services, 331–334
  transracial, 310–313
  types of, 301–303
  worker, 330
Adoption and Foster Care Analysis and Reporting System (AFCARS), 192
Adoption and Safe Families Act (ASFA), 11, 191, 200, 213, 268, 292, 300
Adoption Assistance and Child Welfare Act, 151, 191, 268, 286, 292
Adoption Resource Exchange of North America, 299
Adoptions Assistance and Child Welfare Reform Act, 10
Adoptive applicants, 321–324
  adoption and the extended family, 324
  adoptive siblings, 323
  profile of applicants, 322–323
  recruitment, 321–322
Adoptive participants, 315–318
Adoptive process, 324–330. *See also* Adoption
  homestudy, 325–326
  placement and legalization, 326–327
  postlegalization services, 327–329
Adverse birth outcomes, 249
Adverse Childhood Experience (ACE), 207, 242
AFDC. *See* Aid to Families with Dependent Children (AFDC)
Affordable Care Act (ACA), 69, 79
African American children and youth
  adoption of, 299–300
  children in care, 192
  comparison of problems by ethnic group, 3
  and cultural competency, 211
  in foster care, 269–270
  foster homes, 13
  orphanages and, 7
  and poverty, 61, 67, 80
  as slaves, 148, 150
  and substance abuse, 104
  and violence, 91
Agency-assisted *vs.* independent adoption, 306–308
  insufficient information, 308
  legal aspects of adoption, 308
  no assurance of confidentiality, 307–308
  no counseling for biological mother or adoptive couple, 308
  no follow-up services, 307
  no protection in adoption disruption, 308
  rights of the child, 306–307
Aging out, 286, 294–295
Aichorn, August, 338
Aid to Families with Dependent Children (AFDC), 6, 267
Airmen, 112
Alcohol. *See* Substance use and abuse
Almshouses, 7, 148, 150, 188
Almshouses, 338
Altgeld, John, 216
Ambivalence (ism), 311
American Academy of Child and Adolescent Psychiatry, 89
American Association for Organizing Family Social Work, 9
American Bar Association (ABA), 243
American Psychiatric Association, 339
American Psychological Association, 130
American Red Cross, 82
American Society for the Prevention of Cruelty to Animals (ASPCA), 150
American Society of Addiction Medicine, 229
Americans with Disabilities Act Amendments Act (ADAAA), 141
Amygdala, 131
Anger management, 350
Annie E. Casey Foundation, 199
Anterior cingulate cortex, 132
Antisocial behavior, 241
Apathetic futile mother, 161
Appeals cases, 223–224
Appellate courts, 223
Arraignment, 218
Asian children and youth
  adoption, 298
  family patterns of, 148
  in foster care, 270
  physical abuse of, 153
  and violence, 91
ASPCA. *See* American Society for the Prevention of Cruelty to Animals (ASPCA)
Assessment, 158
Association for the Protection of the Adoptive Triangle, 333
Asylums, 338
Attachment, (self-) Regulation and Competency Model (ARC), 369
Attachment disorder, 15
Attachment theory, 194
Attitudes. *See also* Family and child counseling of birth parents with children in foster care, 281–282
Authoritarian structure, warrior society, 113

Babylonian Code of Hammurabi, 298
Barriers to learning, 380
Base Realignment and Closure initiative, 118
Battered-child syndrome, 151
Bed-wetting, 154
Behavior
  antisocial, 241
  management, 355
Best interest of the child, 208
Beyond Rhetoric: A New American Agenda for Children and Families, 191
Bible, the, 148
Biological parents. *See* Birth parents

Birth parents
abandonment, 317
adoption and, 315–317
with children in foster care, 281–283
emotional aspects of losing one's child, 317–318
foster children feelings about, 285–286
rights and responsibilities of, 282–283
services for, 318
termination of parental rights, 317
voluntary surrender for adoption, 315–316
Black children and youth. *See* African American children and youth
Black market adoption, 303
A Blueprint for Fostering Infants, Children, and Youths in the Nineties, 277
Boarding homes, 8
Borderline personality disorder (BPD), 171
Boston Medical Center, 259
Bowlby, John, 190
BPD. *See* Borderline personality disorder (BPD)
Brace, Charles Loring, 189, 266, 299
Britwell, Charles, 267
Bruises, as symptom of physical abuse, 153
Bullying, and school violence, 92–94
Burnout, 367
Burns, as symptom of physical abuse, 153–154
Burnside, Aubyn, 286
Bush, George W., 261

Caffey, John, 151
Cao gio, 153
CAPTA Reauthorization Act, 222
Care and protection cases, 221–223
Carrera, Michael, 258
Carrie Steele Orphan Home (Atlanta), 7
Case law, 224
Case management/advocacy, 9–13
Case manager, 176
Cataldi, Yvonne Barry, 290
CBT. *See* Cognitive-behavioral therapy (CBT)
CDC, 255
CDF. *See* Children's Defense Fund (CDF)
Census Bureau, 238
Centers for children with severe special needs, 344–345
Cesarean section, 249
CFSRs. *See* Child and Family Services Reviews (CFSRs)
Charitable and private organizations, 189–190
Charity Organization Society (COS), 6
Charles Loring Brace, placing out, 7
Charter for the Protection of Children and Young People, 168
Charter schools, 136
Chicago House of Corrections, 216
Chicken Soup for the Soul series, 203
Child abuse and neglect. *See also* Sexual abuse
efforts to control, 150–151
historical view of, 147–151
legislation concerning, 151
overview, 147–148
physical neglect, 148
sexual mores and, 149–150
Child Abuse Prevention and Enforcement Act, 11
Child Abuse Prevention and Treatment Act (CAPTA), 10–12, 151, 172, 190–192, 222, 292
Child Abuse Victims' Rights Act, 151
Child and Family Services Improvement and Innovation Act, 12, 192
Child and Family Services Reviews (CFSRs), 209
Childcare, 130. *See also* Social workers
assistance, 133–134
workers, 349
Child homelessness, 58
and family, 61–63
and housing problems, 67–68
Childhood experiences, and teenage pregnancy, 241–244
Child labor, 4–6, 9, 149
indenture, 5
maltreatment and, 149
Child labor laws, 5
Child maltreatment
community-based child protection, 183
and criminal court involvement, 178
customized response and necessity of training, 182–183
and emotional/psychological abuse, 170–171
informal and natural helpers, 184
and juvenile/civil court, 177–178
and labor, 149
and physical abuse, 152–158
and physical neglect, 158–162
and poverty, 68–69
and protective services worker, 179–181
reporting, 172–176
and sexual abuse, 162–170
Child placement, 198–200, 204–209
Child pornography and prostitution, 150
Child Pornography Prevention Act, 164
Child Protection Agencies, 199
Child Protection and Penalties Enhancement Act of 1990, 151
Child Protection Worker, 197
Childrearing, 246–248
Children, societal role of, 147–148
Children at risk, 377–379
Children cry, as symptom of physical abuse, 154
Children having children, 234
Children of military families
educational issues, 120–121
effects of deployment and return on, 110, 118–120
effects of domestic violence on, 121–123
living with change, 117–118
problem faced by, 117–123
Children's Aid Society, 189, 258
Children's Bureau, 216, 235
Children's Defense Fund (CDF), 10, 82, 88, 384
Children's status, 376–377
Children with special needs
additional diagnosis, 312
categories, 312
in foster care, 293–294
initial diagnosis, 312
late diagnosis, 312
and poverty, 63–64
residential care for, 344–345, 347–348
Child Saver Movement, 150–151
Child support, 59
The Child Welfare Information Gateway, 11, 208, 209
Child Welfare League Kinship Care Policy and Practice Committee, 272
Child Welfare League of America (CWLA), 9, 277, 299–300, 310
Child welfare services, 2–18
current status of, 13–14
history of, 2–13
training, 18
trends in, 228–230
in the twenty-first century, 384–385
Child Welfare Training, 18
Child Welfare Training Toolkit, 204
Child welfare workers, 16, 18
preparing, 382–383
supervision, 383
training, 383
China Center of Adoption Affairs, 312
Chronic health conditions, 70
Chronic stress, 67
and trauma, 72–73
Citizen Review Panels, 378
Civic action, and poverty, 81
Civilian counselors, 111
Clinical component, of residential care, 350
Clinical Services, 196
Clinton, Bill, 261
Closed adoptions, 309
Clothing neglect, 158
CNCS. *See* Corporation for National and Community Service (CNCS)
Cognitive-behavioral therapy (CBT), 196
Cognitive distortions, 167
Collusive mother, 169
Colonias, 64
Colored Big Sister Home for Girls (Kansas City, Missouri), 7
Community, residential care facilities and, 346–347
Community-based child protection, 183
Community-based homes, 341
Community Initiatives, 255
Community resources, 134
Compassionate accountability, 370
Complex populations, 379–380
Complex trauma, 268
Complex Trauma, 210
Comprehensive Family Assessment, 207
Comprehensive programs, 258
Concrete resources, 196
Concrete services, 74
Concurrent planning, 206
Conditioned emotional learning, 132
Conditioned fear responses, 131
Consent contracts, 333
Contraceptive access, 256–257
Corcoran, J., 367
Corollary, 227
Corporal punishment, 7, 148, 153, 157
Corporation for National and Community Service (CNCS), 81–82
COS. *See* Charity Organization Society (COS)
Counseling services, in residential care, 350
Country Walk Case in Miami, 179
CPS, 378
Crack babies, 100
Criminal court, and child maltreatment, 178
Crisis homes, 271
Crisis nursery, 206
Crittendon Children's Center, 134
Cubans. *See* Hispanic children and youth
Cultural competency, and family-based services, 211–212
Cultural membership and risk, of poverty, 59–60
Culture, 112
Culture changes, residential care and, 370
Culture of poverty, 74
Custody, 222
Cyberbullying, 94
Cycle of poverty, 61, 65

Date rape, 97
Delinquency, 218–219
child savers and, 150
residential care and, 344
Department of Food and Agriculture, 56
Department of Health and Human Services, 18, 234
Department of Labor, 261
DePaul, St. Vincent, 337
Deployment, 115
effect on child psychology, 118–120
four phases cycle, 118
Depressed neglect, 162
Designer street drugs, 104
Detoxification, 107
Developmentally Disabled Assistance and Bill of Rights Act of 1990, 11

Devereux, Helena Trafford, 339
Devereux Foundation, 339
Diagnostic service centers, 344
Direct placement, 303
Disability. *See* Children with special needs
Discipline, 153
Discretion, 222
Disorganized neglect, 162
Distinct class system, 114
Dockar-Drysdale, Barbara, 338
Domestic transracial adoption, 310–311
Domestic violence, 95–96
Donaldson Adoption Institute, 302
Drug/alcohol addiction
  and adolescents, 104–107
  and infants, 99–100
  in military families, 121–123
Drug-free treatment, 107
Drug gangs, 90
Drugs. *See* Substance use and abuse
Due process, 217

Early childhood programs, 257–258
Early Head Start, 134
Ecological systems theory, 194
Economic indicators, 61
Economic instability, teenage pregnancy and, 250–252
Edelman, Marian Wright, 10, 79, 384
Education
  children and, 380–381
  problem faced by military children, 120–121
  residential care and, 350, 365–366
  teenage pregnancy and, 250
Educational neglect, 159
Educational rights, and trauma-sensitive educational settings, 140–144
Educational services, 196
Educational settings, 130
  socialworkers in, 138–139
Elder abuse, 96
Emancipation, 287
Emergency shelter care, 343
Emotional disorders
  adoption of children with, 320–321
  residential treatment centers and, 338
Emotional maltreatment, 153
Emotional neglect, 159, 162
Emotional/psychological abuse, 170–171
  abusive parents, 171
  symptoms, 170–171
Emotional stressors, 157
Employment
  parental, 133
  and poverty, 61
Enculturation, 7, 90
English common law, 298
Enlistment, 110
  reason for, 112–113
  voluntary nature of, 110
Environmental neglect, 159
Evidence-based practice, 255
Explicit memory, 132
Exposure to hazards, 159
External inhibitors, 167
Extrafamilial abuse, 163
Extreme poverty, 57

Fabricated Disorder by Proxy (FDP), 157–158
Facebook, 94
Fair Labor Standards Act, 5
Familismo concept, 212
Family and child counseling
  residential care programs and, 361–363
  types of family treatment, 363
Family-based services
  assessing effectiveness of, 201–204
  brief history of, 188–192
  charitable and private organizations, 189–190
  children in care, 192
  Colonial America to 1875, 188–189
  and cultural competency, 211–212
  family preservation services, 195–198
  family preservation workers, 203–204
  family support services, 195
  future of, 209–213
  overview, 187–188
  permanency planning, 190–192
  preservation/child placement, 198–200, 204–209
  program design and evaluation, 212–213
  public child welfare services, 190
  theories, 193–195
  types of, 193–200
Family boarding homes, 271
Family Care Plan, 116
Family continuity, 268
Family Drug Courts (FDC), 197
Family factors, teenage pregnancy
  family function, 245–246
  socioeconomic disadvantage, 244
Family/families, 21–52. *See also* Family-based services
  communication patterns, 25–26
  concept of, 21–24
  disability or illness, 49
  emotional climate of, 29–33
  family members in incestuous, 169–170
  functions of, 28–29
  help for, 49–52
  homelessness, 61–63
  immigrant, 64–65
  impact of culture on, 34–47
  life cycle, 31–33
  low-income, 57
  of the National guard and reserves, 116–117
  observation of, 26–27
  parental/family dysfunction, 47–48
  parent–child relations, 48–49
  role definition and inequality, 48
  roles and rules, 25
  structure and poverty, 58–59
  and substance abusing, 197–198
  as system, 24–28
  teenage pregnancy and, 252–254
  types of, 28–29
  violence in, 95–96
Family Mentor, 197
Family preservation, 293
Family Preservation and Support Services Program, 11
Family preservation services, 193, 195–198
  and substance abusing families, 197–198
  types of service provision in, 196–197
Family preservation workers, 203–204
Family resource specialist, 277
Family support services, 193, 195
Family Welfare Association, 6
FAPE. *See* Free and appropriate public education (FAPE)
FAS. *See* Fetal alcohol syndrome (FAS)
FASD. *See* Fetal alcohol syndrome (FAS)
Fatherhood, Marriage and Families Innovation Fund, 261
Fatherhood Initiatives, 261
Father(s), 148–150
  incest and, 150
FDC. *See* Family Drug Courts (FDC)
FDP. *See* Fabricated Disorder by Proxy (FDP)
Federal Adoption Assistance and Child Welfare Act, 300, 303
Federal Interagency Forum on Child and Family Statistics, 21
Female gang members, 92
Fertility, teenagers make decisions about, 246–248
Fetal alcohol spectrum disorders (FASD). *See* Fetal alcohol syndrome (FAS)
Fetal alcohol syndrome (FAS), 98–99
Financial concern, military families of, 123
"Findings of Fact and Law", 223
Fisher, Florence Ladden, 331–333
Fixated offender, 166
Flower, Lucy, 216
Folks, Homer, 267
Food insecurity, and poverty, 70–71
Formal agency-based training, 383
Foster care, 206, 265–296
  attention to special populations in, 293–294
  birth parents with children in, 281–283
  children in, 284–288
  foster parents and, 275–281
  future of, 292–295
  history, 266–267
  leaving, 286–288
  life in, 286
  nature of, 268–271
  placement following residential care, 358
  reasons children enter, 272–274
  in recent years, 267–268
  social worker role in, 289–291
  types of foster homes, 271–272
Foster Care Independence Act, 11, 286, 292
Foster Care Review Boards, 378
Fostering Connections and Increasing Adoption Act, 262
Fostering Connections to Success and Increasing Adoptions Act, 12, 292
Foster parents
  follow-up, 278–279
  foster children feelings about, 286
  homestudy, 277–278
  kinship, 280–281
  as part of the team, 280
  placement, 278–279
  professionalization of, 293
  recruitment, 275–277
  stresses of being, 279–280
  training, 277–278, 293
  visit of birth parents, 280
Fractures, as symptom of physical abuse, 154
Free and appropriate public education (FAPE), 141
Free boarding home, 8
Fully disclosed adoption, 309
The Future of Children (Haskins and Sawhill), 377
Future perspective
  children and education, 380–381
  children and health, 380
  children and technology, 381
  children at risk, 377–379
  children in poverty, 377
  children's status, 376–377
  complex populations, 379–380
  family-based services, 209–213

Gang Deterrence and Community Protection Act, 92
Gangs, 90–92
  drug, 90
  hedonistic or social, 90
  instrumental, 90
  migration, 91
  organizational/corporate, 90
  predatory, 90
  role of girls in, 92
  scavenger, 90
  serious delinquent, 90
  territorial, 90
Garbarino, James, 90
Gates, Bill, 80

Geographic distribution, of poverty, 58
"Get Real" program, 256
Ghost Girl (Hayden), 165
Grade, military, 112
Gray market adoption, 303
Great Recession of 2008, 61
Grooming, 163
Groth, A. Nicholas, 166
Guardians ad litem, 179
Guns, 87, 88

Hague Convention on the Protection of Children and Cooperation in Respect of Intercountry Adoption, 312
Harris, Eric, 93, 94
Hawthorne, Nathaniel, 234
Head Start, 74, 133–134, 236, 257
Head Start Trauma Smart (HSTS), 134
Health
  children and, 380
  conditions, and poverty, 69–70
  insurance, and poverty, 69
  military personnel, 111
Hedonistic/social gangs, 90
Henry Horner, 88
Hippocampus, 131
Hispanic children and youth, 2
  children in care, 192
  comparison of problems by ethnic group, 3
  family patterns of, 148
  in foster care, 270
  physical abuse of, 153
  and poverty, 59
  and substance abuse, 104
  and violence, 91
Historical perspective
  on child abuse and neglect, 147–151
  on childcare, 8
  on child welfare services, 2–13
  on daycare, 8
  on foster care, 8
  on residential care, 148
  on sexual abuse, 150–151
HIV/AIDS
  foster care and, 274, 293, 294
  and substance-abusing parents, 102
Holt, Bertha, 302, 311
Holt, Harry, 302, 311
Holt Agency, 302
HOMEBUILDER programs, 196, 202
Homefinder, 277
Homeless and runaway youth, 62, 67
  opportunities for, 78
Homestudy
  adoption, 325–326
  defined, 326
  foster parents, 277–278
Hospitalization, 358
Households. three-generational, 252
The House of Refuge, 338
Houseparents, 350
Housing problems, and poverty, 67–68
Howly, G., 366
HSTS. *See* Head Start Trauma Smart (HSTS)
Hull House, 149, 189, 216
Humanitarianism, 311
Hurley, Timothy D., 216
Hyperarousal behavior, 140
Hypervigilance behavior, 140

IDEA. *See* Individuals with Disabilities Education Act (IDEA)
IDEIA. *See* Individuals with Disabilities Education Improvement Act (IDEIA)
Identifying aggressor, 96
IEDs. *See* Improvised explosive devices (IEDs)
IEP. *See* Individualized education program (IEP)
The Illinois Department of Children and Family Services, 207
Illinois State Board of Charities, 216
Immigrant children, and poverty, 59–60
Immigrant families. *See also specific ethnic groups*
  child abuse and neglect in, 148, 153
  and poverty, 64–65
Imminent risk of serious harm, 226
Improvised explosive devices (IEDs), 110
Impulse-ridden mother, 161
Inadequate supervision, 158
Incest, 150
Incest or intra-familial abuse, 163
Incestuous families, 163, 169–170
Indenture, 5, 149
Independent adoption, 303. *See also* Agency-assisted *vs.* independent adoption
  direct placement, 303
  intermediate placement, 303
  intermediate placement for profit, 303
Independent living, 359–360
Independent Living Initiative of 1986 (PL 99-272), 292
Independent living services (ILS), 288
Indian Child Protection and Family Violence Act, 10
Indian Child Welfare Act (PL 95-608), 10, 268, 292, 300, 302
Indians. *See* Native American children and youth
Individualized education program (IEP), 136
Individuals with Disabilities Education Act (IDEA), 142
Individuals with Disabilities Education Improvement Act (IDEIA), 142
Industrial Revolution, 5, 6, 149, 235
Infant Care, 9
Infanticide, 4
Infants. *See* Newborns and infants
Infertile couples, 322
Informal and natural helpers, 184
In re Gault, 219
Institutional abuse, 165
Instrumental gangs, 90
Intake social worker, 173
Intensive residential treatment, 343
Intensive Reunification Program, 202
Intercountry adoption (ICA), 302, 311–313, 321
Intermediate placement for profit, 303
International adoption, 302, 311–313, 321
Internet, 164
  -based adoption, 306
Interracial adoptions, 302
Intervention programs, teenage pregnancy
  primary prevention, 255–259
  secondary prevention, 259–262
  sexual antecedents, 255–259
Intimate partner violence (IPV), 62, 68
Intrusive parenting, 245
IPV. *See* Intimate partner violence (IPV)

Job Corps, 74, 78
Jurisdiction, 217
Justice. restorative, 229
Justice Department, 261
Juvenile/civil court, and child maltreatment, 177–178
Juvenile court
  challenges in, 225–226
  complexities of social work in, 226–227
  coping with trauma in, 227–228
  court services, 220–221
  described, 215
  factors influencing intervention of, 216
  jurisdiction of, 217
  legislation, 216
  origins and purpose of, 216–217
  processes and procedures of, 228
  role of social worker, 216, 226–227
  time delays in, 226
  trauma in, 224–228
  trend concerns, 228–230
Juvenile Court Act of 1899, 151
Juvenile court cases, 217–224
  acronyms, 221
  appeals cases, 223–224
  care and protection cases, 221–223
  delinquencies, 218–219
  status offenses, 220–221
Juvenile offenders, 168

Keane, Noel, 301
Kelly, Allison, 325–326
Kelly, Dan, 326
Kempe, C. Henry, 151
Kinship adoptions. *See* Adoption
Kinship care, 198
Kinship care, 271–272
Kinship Care Resource Center, 198
Kinship foster parents, 280–281
Klebold, Dylan, 93, 94
K-12 schools, 130, 134–138

Lanham Act of 1940, 8
Lanza, Adam, 92
Lathrop, Julia, 9, 216
Latino children and youth. *See* Hispanic children and youth
Least restrictive environment (LRE), 141
Leg, Bird, 88
Legalization, of adoption, 326–327
Legal-risk adoptions, 301. *See also* Adoption
Legal Services, 74
Lehr vs. Robertson, 316
Level system, and residential centers, 350–351
LGBTQ youth (lesbian/gay/bi-sexual/transgender), 62
Life books, 329
Lifelong services, 333–334
Limbic system, 131
Limon, Stephen M., 217
Living with change, military children, 117–118
Low birth weight, defined, 249
Low-income families, 57
LRE. *See* Least restrictive environment (LRE)
Lyman School, 338
Lynn-Spears, Jamie, 257

Magnet schools, 136
Maintenance, 107
Male heirs, and adoption, 298
Mandated reporters, 172
Mandatory school attendance, 6
The March of Dimes, 69
Marginalization, 65
"Massachusetts Juvenile Delinquency & Child Welfare Law" (Karp, Limon, and Wolf), 217
Masturbation, 149, 163, 165
Maternal Care and Mental Health, 338
McKinney-Vento Act, 78
Media
  teen pregnancy and, 257
  violence, 89
Mediated adoptions, 309
Medicaid, 251, 380
Medical concerns
  adoption of children with, 320–321
  teenage pregnancy and, 248–250
Medical neglect, 158
Men in Relationships Group (MIRG), 261

Mental health, and poverty, 70
Mental illness, foster care and, 274
Mentally retarded mothers, 161
Meta-analysis, 131
Mexican Americans. *See* Hispanic children and youth
Middle teens, 234
Migration, gang, 91
Military, present scenario, 109–111
Military couples, 116
Military culture, 112–114
Military family, 112. *See also* Children of military families
  development of strength, 124–126
  domestic violence in, 121–123
  effects on children, 121–123
  financial concern of, 123
  medical condition of, 111
  military culture impact on, 112–114
  strength–based approach, 124–126
  types, 115–117
Military hierarchy, 112
Military men, 115
Military parents, 111
Military women, 115–116
Miller v. Alabama, 219
Model Act for the Adoption of Children with Special Needs, 300
Model Approach to Partnerships in Parenting (MAPP), 277
Mother(s)
  apathetic futile, 161
  collusive, 169
  experiencing reactive depression, 161
  impulse-ridden, 161
  mentally retarded, 161
  pensions, 6, 190
  powerless, 169
  protective, 169
  psychotic, 161
MTSS. *See* Multitiered system of supports (MTSS)
Multiethnic Placement Act, 292
Multifactor theories, 166
Multitiered system of supports (MTSS), 137
Munchausen-by-proxy, 157

Napoleonic Code, 298
NASW. *See* National Association of Social Workers (NASW)
Natchez Indian Massacre, 338
National Association of Black Social Workers (NABSW), 299, 310
National Association of Social Workers (NASW), 80
National Campaign to Prevent Teen and Unplanned Pregnancy, 257
National Campaign to Prevent Teen Pregnancy, 237, 262
National Center for Children in Poverty, 57
National Center for the Prevention of Child Abuse and Neglect, 151
National Child Labor Committee (NCLC), 6
National Child Traumatic Stress Network, 204, 208
National Commission on Children, 191
National Commission on Family Foster Care, 270
National Committee on the Employment of Youth, 5
National Day to Prevent Teen Pregnancy, 257
National guard and reserves, families of, 116–117
National Institute of Mental Health, 89
National Median Income, 58
National Responsible Fatherhood Clearinghouse, 261
National Youth Gang Center survey, 90
Native American children and youth
  boarding schools for, 8
  comparison of problems by ethnic group, 3
  as complex population, 379
  family patterns of, 148
  in foster care, 270
  Indian Child Protection and Family Violence Act and, 10
  orphans, 7
  outside placement, 300
  and violence, 88
Natural and informal helpers, 184
Natural parents. *See* Birth parents
NCFAS-R. *See* North Carolina Family Assessment Scales for Reunification (NCFAS-R)
NCLC. *See* National Child Labor Committee (NCLC)
Neglect, 68–69, 148
  physical, 148
Neglectful parents, 160–162
Neighborhood Youth Corp., 74
Neuroplasticity, 132
Neuroscientists, 218
Newborns and infants
  adoption of, 319
  physical abuse of, 153–154
New York Children's Aid Society, 9, 266–267
No Child Left Behind Law, 240
Non-abusive parent, 169
Noncommissioned officers, 112
Nonorganic Failure to Thrive, 159
North Carolina Family Assessment Scales for Reunification (NCFAS-R), 201
Notoriety of juvenile court cases, 229
Nutritional neglect, 158

Obama, Barack, 255, 258, 261
Obamacare. *See* Affordable Care Act (ACA)
Occupy Wall Street, 81
OCR. *See* Office for Civil Rights (OCR)
OEF. *See* Operation Enduring Freedom (OEF)
Office for Civil Rights (OCR), 143–144
Office of Adolescent Health, 255
Office of Family Assistance, 262
OFS. *See* Operation Freedom's Sentinel (OFS)
OIF. *See* Operation Iraqi Freedom (OIF)
OIR. *See* Operation Inherent Resolve (OIR)
Older children
  adoption of, 319–320
  and substance-abusing parents, 101
Older teens, 234
Oliver Twist (Dickens), 5
Omnibus Budget Reconciliation Act, 11
Omnibus Reconciliation Act of 1993, 191
OND. *See* Operation New Dawn (OND)
Open adoption, 326–327
Openness
  in adoption, 309–310
  defined, 309
Operation Enduring Freedom (OEF), 109, 110
Operation Freedom's Sentinel (OFS), 110
Operation Inherent Resolve (OIR), 110
Operation Iraqi Freedom (OIF), 109, 110
Operation New Dawn (OND), 110
Ordway v. Hargraves, 236
Organizational/corporate gangs, 90
Orphanages, 7, 338
  corporal punishment, 7
Orphan asylums, 148
Orphan asylums, 7
Orphans, 7
Orphan trains, 266, 299
Orphan Voyage, 331, 333
Out-of-home care, 7–8
Overly strict supervision parenting, 245

PAAP. *See* Practicing Alcoholic/Addicted Parent (PAAP) Syndrome
Padrinos (godparents), 212
Palin, Bristol, 257
Parent abuse, 96
Parental drug/alcohol addiction. *See* Substance-abusing parents
Parental drug use, 12
Parental employment, 133
Parental involvement, 283
Parental rights, termination of, 317
Parenting
  overly strict supervision or intrusive, 245
  programs, 259–260
  teenage pregnancy and, 233–264
Parent(s), 148
  anger in, 157
  education, and poverty, 62–63, 71
  munchausen-by-proxy in, 157
  profile of child abuser, 154–158
Parole, 219
Parole sentences, 219
Patient Protection and Affordable Care Act, 12
PCP (*Pneumocystis carinii* pneumonia), 102
Pederasty, 149
Pedophile, 163
Peer relationships, in residential care, 351–352
Permanency planning, 190–192
Permanency planning, 267, 293, 300
Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 236
Petition, 222
Physical abuse, of children, 152–158
  in cultural context, 153
  profile of abuser, 154–158
  symptoms, 153–154
Physical neglect, 148, 152, 158–162
  impact of, 162
  neglectful parents, 160–162
  symptoms, 159–160
PL 94-142, 141
PL 96-272, 286, 292, 300
Placing out, 266
Planned Parenthood, 256
Planned Parenthood League of Massachusetts, 256
Political factors, pornography, 150
Polyvictimization, 268
Pornography, 149–150
Postdeployment, 118
Postlegalization services, 327–329
  agency services, 327–328
  telling the child about adoption, 328–329
Post-traumatic stress disorder (PTSD), 111, 122–123, 131, 205, 210
Post–World War II baby boom, 235
Poverty
  absolute, 55
  causes of, 61–66
  child and family homelessness, 61–63
  and child maltreatment, 68–69
  children in, 377
  and civic action, 81
  cultural membership and risk of, 59–60
  culture of, 74
  cycle of, 61, 65
  defining, 55–57
  demographics, 57–58
  and disabilities, 63–64
  efforts to fight, 73–85
  and employment difficulties, 61
  extreme, 57
  and family structure, 58–59
  and food insecurity, 70–71
  geographic distribution of, 58
  Great Recession and, 61
  and health conditions, 69–70
  health insurance and, 69
  and housing problems, 67–68

and immigrant children, 59–60
and immigrant families, 64–65
impact of, 66–73
impoverished environment, 66–69
and intimate partner violence, 62, 68
and mental health, 70
and parents' education, 62–63, 71
prevention services and assistance programs, 74–78, 80–82
and public policy, 81
race/ethnicity and, 59–60
racial group children and, 2
relative, 56
runaway and homeless youth, 62
and Self-Sufficiency Standard, 56–57, 78
Social Security Act (SSA) and, 10
solutions to end, 82–84
stress and, 67, 72–73
and teen risk factors, 71–72
and volunteering, 81–82
Wraparound Services, 74, 77
Poverty line, 56–57, 59, 65, 66, 71, 78, 80
Powerless mothers, 169
Practicing Alcoholic/Addicted Parent (PAAP) Syndrome, 101–102
Precious (film), 241
Preconditions Model, 166
Predatory gangs, 90
Predeployment, 112, 119
Preferential applicants, 322
Pregnancy
repeat, 243
teenage, 233–264
Preschool children, and substance-abusing parents, 100–101
Present scenario, military of, 109–111
Preservation/child placement, 198–200, 204–209
Preventing Sex Trafficking and Strengthening Families Act of 2014, 12
Primary prevention programs, 255–259
abstinence education, revised, 255
early childhood programs, 257–258
educational programs for teens and their families, 256
media, 257
nonsexual antecedents, 257–258
programs providing contraceptive access, 256–257
sexual and nonsexual antecedents, 258–259
teen pregnancy prevention initiative, 255–256
Youth Development Programs, 258
Private schools, 136
Procedural safeguards, 144
Process models, 167
Project Head Start, 10
Promise Neighborhood grant program, 81
Promoting Safe and Stable Families Act of 2001, 11
Protective mothers, 169
Protective services worker, and child maltreatment, 179–181
Psychological abuse. *See* Emotional/psychological abuse
Psychological stress, 249
Psychotherapeutic milieu, 340
Psychotic mother, 161
PTSD. *See* Post-traumatic stress disorder (PTSD)
Public child welfare services, 190
Public Health Act of 1987, 11
Public policy, and poverty, 81
Puerto Ricans. *See* Hispanic children and youth

Race/ethnicity, and poverty, 59–60
RAD. *See* Reactive attachment disorder (RAD)
Rank, military, 112
Rate, military, 112
Rational emotive behavioral therapy (REBT), 196
Reactions, of birth parents with children in foster care, 281–282
Reactive attachment disorder (RAD), 140
REBT. *See* Rational emotive behavioral therapy (REBT)
Recidivism, 218
Recruitment
of adoptive parents, 321–322
foster parents, 275–277
Refuge houses, 150
Refuge Movement, 150
Regressed offender, 166
Rehabilitation, 218
Rehoming, 313
Relapse Prevention Model, 167
Related adoptions, 301. *See also* Adoption
Relative poverty, 56
Repeat pregnancy, 243
Reporting child maltreatment, 172–176
assessment, 174–175
case management and treatment, 176
intake, 173–174
Residential care, 337–374
adjustment in, 348
children in, 346–360
clinical component of, 366–367
components of, 348–350
educational component of, 350, 365–366
families of children in, 361–364, 371
handling crises in, 352–353
historical perspective on, 148, 337–346
life in, 348
peer culture, 351–352
phases, 338–339
problems of, 367–368
role of staff, 364–368
sexual abuse of children in, 356–357
sexually acting out in, 354–357
termination from, 357–360
token economy, 351
trends in, 368–371
types of, 340–345
Residential programs, 260–261
Residential school, 136
Residential treatment centers (RTCs), 341–343
Response to intervention (RTI), 142
Restorative justice, 229
Reunification, of children with birth family, 283
Reunion, military, 118
Rights, of birth parents, 282–283
Ritualized abuse, 165
Rivers, Lafeyette, 88
Rivers, Pharaoh, 88
Roe v. Wade, 236
Roosevelt, Franklin, 8
Roosevelt, Theodore, 235
RTI. *See* Response to intervention (RTI)
Runaway and homeless youth, 62, 67
opportunities for, 78

Safer Choices Peer Team, 256
"Safer Choices" program, 256
Sailors, 112
SAMHSA. *See* Substance Abuse and Mental Health Services Administration (SAMHSA)
Sandy Hook Elementary School, 92–93
The Scarlet Letter (Hawthorne), 234
Scavenger gangs, 90
School adjustment counselors. *See* School social workers
School-based clinics, 256
School choice, 136
School Health Promotion Council, 256
School-linked clinics, 256
School psychologists, 139
School readiness, 250
School Social Work Association of America, 138
School social workers, 138–139
School violence and bullying, 92–94
School vouchers, 136
Scientific philanthropy, 189
Screening, of residential care staff, 355
SEA. *See* State Education Agency (SEA)
Search, for birth parents, 331–334
Secondary prevention programs
keeping fathers involved, 261–262
parenting programs, 259–260
residential programs, 260–261
services for teen parents, 259–262
Second Chance Homes, 260
Seduction, 163
Self-care, of residential care staff, 369–370
Self-esteem, of child abusers, 157
Self-Sufficiency Standard, 56–57, 78
Seminal case, 219
Separation
Separation, foster care children feelings about, 284–285
Serious delinquent gangs, 90
Settlement house movement, 189–190
Settlement house movement, 9, 149
Sex education, abstinence-only, 240
Sex offenders
living space management, 356
staff protection, 356
treatment plans, 356
youthful, 355
Sex rings, 164
Sexual abuse, 149–150, 162–170
family members in incestuous families, 169–170
historical perspective on, 150–151
incest, 150
perpetrators, 165–168
in residential care, 356–357
sexually acting out and, 354–357
symptoms, 165
types of, 163–165
Sexual antecedents, 255–259
Sexuality, masturbation, 149, 163, 165
Sexually active teens, defined, 246
Sexual mores, and child abuse, 149–150
Shrine, Denise, 89
Shuttling, 158
Sibling groups, adoption of, 320
Silver Ring Thing, 255
Single-factor theories, 167
Single-parent adoptions, 302. *See also* Adoption
16 and Pregnant, 246, 257
Sixth Amendment, 219
Slavery, 148, 150
Small group home, 271
Social/hedonistic gangs, 90
Social learning theory, 194
Social Security Act (SSA), 10, 190, 292
Social Security Administration, 56
Social Security Disability Insurance (SSDI), 64
Social stressors, 157
Social work, complexities of, in juvenile court, 226–227
Social workers
in educational settings, 138–139
emergence of juvenile court
juvenile court processes and procedures
role of
role of foster care, 289–291
Society for the Prevention of Cruelty to Children (SPCC), 9, 150
Soldiers, 112

SPCC. *See* Society for the Prevention of Cruelty to Children (SPCC)
Special Education for Infants and Toddlers Act, 11
Specialized foster home, 271
"Special needs" adoptions, 299
Sports, and violence, 89–90
Spouse abuse. *See* Domestic violence
SSA. *See* Social Security Act (SSA)
SSDI. *See* Social Security Disability Insurance (SSDI)
SSI. *See* Supplemental Security Income (SSI)
Stanley vs. the State of Illinois, 316
START (Sobriety Treatment and Recovery Teams) program, 197
State Education Agency (SEA), 144
Status offenses, 220–221
Stern, William, 301
Stern v. Whitehead-Gould, 301
Strength-based approach, of military families, 124–126
Strength-based model, 193
Stress, and poverty, 67, 72–73
Structured Analysis Family Evaluation (SAFE), 277
Subabuse, 96
Subsidized adoption, 302. *See also* Adoption
Substance Abuse and Mental Health Services Administration (SAMHSA), 104
Substance-abusing parents
  effects in later life, 103
  effects of drug/alcohol addiction on infants, 99–100
  fetal alcohol spectrum disorders (FASD), 98–99
  and HIV/AIDS epidemic, 102
  and older children and adolescents, 101
  Practicing Alcoholic/Addicted Parent (PAAP) Syndrome, 101–102
  and preschool children, 100–101
  and violence, 98–103
Substance use and abuse, 98
  and adolescents, 104–107
  effects and treatment of, 106–107
  foster care and, 273
  military personnel, 121–123
  in treatment of PTSD and TBI, 122–123
  violence and, 121–123
Substantially separate day school, 136
Suicide, 87, 88
"Suitcases for Kids", 286
Supervised independent living, 341
Supervision, of residential care staff, 355
Supplemental Security Income (SSI), 64
Support, of residential care staff, 369–370
Surrogate mothering, 301. *See also* Adoption
Sybil: The Two Nations (Disraeli), 2

Taft, William, 216
Tax credit program, 377
TBI. *See* Traumatic brain injury (TBI)
Teachers, in residential settings, 365–366
Technology, children and, 381
Technophilia, 164
Teenage pregnancy
  adoptable children and, 304–305
  child, impact on, 248–254
  childhood experiences, 241–244
  defining, 234
  developmental issues and, 250
  economic instability, 250–252
  education and, 250
  family factors, 244–246
  family function and, 245–246
  family structure and dynamics, 252–254
  father, impact on, 248–254
  fluctuations in teen birth rates, 237–240
  historical perspectives, 233–241
  individual factors, 241–244
  intervention programs, 254–262
  medical concerns, 248–250
  mother, impact on, 248–254
  and parenting, 233–264
  risk and protective factors, 241–248
  shaping the future of services, 262–263
  socioeconomic disadvantage and, 244
  teens make decisions about fertility and childrearing, 246–248
  viewed as a problem, 234–237
Teenagers
  make decisions about fertility and childrearing, 246–248
  middle teens, 234
  older teens, 234
  young teens, 234
Teen birth rates, fluctuations in, 237–240
Teen Health Project, 256
Teen Health Project Leadership Council, 256
Teen Mom, 246
Teen Pregnancy Prevention Initiative, 255–256
Teen risk factors, and poverty, 71–72
Teen-tot programs, 259
Temporary Assistance to Needy Families (TANF), 251
Territorial gangs, 90
Three-generational households, 252
Time delays in juvenile court, 226
Title IV-E Foster Care and Subsidized Adoption Program, 286
Title IX, 236
  funding, 240
Token economy, 351
Toxic stress, 67, 131
Toynbee Hall, 149
Training. *See also* Education
  in child welfare, 111
  child welfare workers, 383
  foster parents, 277–278, 293
  of residential care staff, 355, 369–370
Transculturalism, 311
Transition planning, 143
Transracial adoptions, 302, 310–313
  domestic, 310–311
  international or intercountry, 311–313
Transracial placement, 299
Trauma, and chronic stress, 72–73
Trauma, in juvenile court, 224–228
  challenges in juvenile court settings, 225–226
  complexities of social work in the juvenile court, 226–227
  coping with, 227–228
  time delays in juvenile court, 226
Trauma- and stressor-related disorders, 131
Trauma-informed and skill-based protective training, 183
Trauma-informed approaches, 208, 210
Trauma-informed care, 73
Trauma-informed setting (TI), 369
Trauma-informed treatment, 369
Trauma-sensitive educational settings
  and academic failure, 130–132
  and childcare, 133–134
  creating, 133–138
  and educational rights, 140–144
  and K–12 schools, 134–138
  overview, 129–130
Trauma-specific treatment, 368–369
Traumatic brain injury (TBI), 111, 122–123
Trenchcoat Mafia, 93
Tribunals, 223
Truant children, 220
Turf-ism, 384
Turnover rate, 368
Twenty Years at Hull House (Addams), 149
Two-parent homes, 58

Uniform Adoption Act, 306
United Birth Parents, 333
United Nations, 338
United States, adoption legislation, 298–299
University of North Carolina, 257
Unregulated child custody transfers, 314
Unrelated adoptions, 301. *See also* Adoption
Unspeakable Acts (Hollingsworth), 179
Upward Bound, 74
Ursaline Convent, 7
Ursuline nuns of New Orleans, 338
U.S. Census, 64
U.S. Children's Bureau, 5, 9
U.S. Constitution, 219
U.S. District Courts, 223
U.S. Supreme Court, 219, 223

VAWA, Violence Against Women Reauthorization Act (VAWA)
Vicarious traumatization, 137
Violence
  in community, 88–95
  in families, 95–96
  gangs, 90–92
  influences on youth, 89–90
  media, 89
  peer violence in relationships, 97
  school violence and bullying, 92–94
  and sports, 89–90
  and substance-abusing parents, 98–103
  substance use and abuse, 121–123
  war in streets, 88
Violence Against Women Reauthorization Act (VAWA), 62
Virginia Polytechnic Institute massacre, 92
Virtual pornography, 164
Virtual schools, 136
Vocational Rehabilitation Act (Section 504), 141
Voluntary surrender for adoption, 315–316
Volunteering, and poverty, 81–82

Wal-Mart, 81
War on Poverty, 10, 73, 81, 133
Warrior society, 113–114
Wayward Youth (Aichorn), 338
Welfare Reform Act of 1996, 80, 236
West Side Story, 90
Whitehead-Gould, Mary Beth, 301
White House Conference on Children, 5, 9
Wilson, Mary Ellen, 9, 150
Wise Guys program, 258
Women and girls. *See also* Mother(s)
  incest and, 150
  motivations and characteristics of abuse, 167–168
  working mothers, 8
Workhouses. *See* Almshouses
Working mothers, 8
World War II, 235, 299
Wounded Warrior project, 210
Wraparound services, 74, 77, 377

Young teens, 234
Youth Development Programs, 258
Youthful sex offenders, 355

Zuckerberg, Mark, 80