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Section 7 Overview:

Section 7 is the glossary and reference chapters. The terms in this glossary are legal, medical, psychological, and practice terms commonly used by Children's Division (CD). However, some of the definitions may not reflect the meaning that the general public uses. The reference material follows the glossary. The reference chapters are on a variety of subjects that supplement the policy and procedures covered in this manual.

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1: Family Systems Theory

Chapter 1 Overview

This chapter will look at the family system theory.

Introduction

People do not exist in a vacuum. They live, play, go to school, and work with other people. Most anthropologists agree that, next to their peculiar tendency to think and use tools, one of the distinguishing characteristics of human beings is that they are social creatures. The social group that seems to be most universal and pervasive in the way it shapes human behavior is the family. For social workers, counselors, and psychologists, the growing awareness of the crucial impact of families on their clients has led to the development of family systems theory.

Family systems theory is more than a therapeutic technique. It is a philosophy that searches for the causes of behavior, not in the individual alone, but in the interactions among the members of a group. The basic rationale is that all parts of the family are interrelated. Further, the family has properties of its own that can be known only by looking at the relationships and interactions among all members.

The family systems approach is based on several basic assumptions:

- Each family is unique, due to the infinite variations in personal characteristics and cultural and ideological styles;
- The family is an interactional system whose component parts have constantly shifting boundaries and varying degrees of resistance to change;
- Families must fulfill a variety of functions for each member, both collectively and individually, if each member is to grow and develop; and
- Families pass through developmental and nondevelopmental changes that produce varying amounts of stress affecting all members.

These assumptions are diagramed in figure 1 (see next page). The components and their relationship to the whole system are as follows:

1. Family structure consists of the descriptive characteristics of the family. This includes the nature of its membership and its cultural and ideological style. These characteristics are the input into the interactional system. They are the resources and the perception of the world that shape the way in which the family interacts.

2. Family interaction is the hub of the system. It is the process of interaction among family members that determines the rules by which the family is governed. This is the family's level of cohesion, its adaptability, and its communication style. Finally, these interactions work together to serve individual members and collective family needs.
3. Family function is the output of the interactional system. Utilizing the resources available through its structure (input), the family interacts to produce responses that fulfill its needs.
4. The family life cycle introduces the element of change into the family system. As the family moves through time, developmental and non-developmental changes alter the family structure and/or the family's needs. These, in turn, produce change in the way the family interacts.

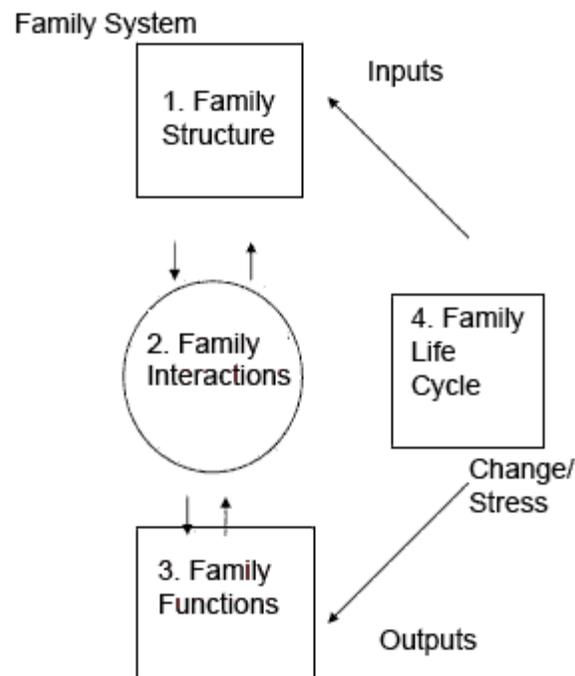


Figure 1. What is a Family System?

Understanding something as complex as a family unit is not an easy task. What does it mean to say that the family is a system? Webster (1979) defines a system as a "regularly interacting or interdependent group of items forming a unified whole." Certainly members of families are interrelated and interdependent parts of a whole.

Many writers in discussing the family as a system use the analogy of the heating system of a house. As Haley (1963) explains it, the furnace responds to the signal from the

thermostat, but the thermostat responds to the temperature of the room which responds to the heat from the furnace. Each element serves a function in the total heating system. The elements are interdependent. For example, when the air becomes "too cold" the thermostat signals the furnace to give more heat, and when the air is "warm" the thermostat signals the furnace to shut off. The temperature in the house fluctuates within a narrow range around the setting of the thermostat.

The heating system has a kind of balance, or homeostasis, and all of the elements of the system (the furnace, the thermostat, the room temperature) are involved in maintaining that balance. As long as the setting remains the same, the temperature remains stable. Even when the setting is changed the elements of the heating system still relate to each other in the same way. There are rules which govern this process, and all parts of the system work to maintain the rules, in this case, the setting.

This analogy is comparable to the family system in which the elements, the family members, are dependent upon one another. In a similar manner, families develop a kind of balance in their relationship patterns.

The family is not just a collection of individuals. It is a whole larger than the sum of its parts.

A Delicate Balance

All family members have a stake in maintaining the delicate balance in their relationship patterns. The action of one member affects all others, and that member is in turn affected by the reaction of others. This can be seen at times of change when the established balance is threatened.

Something as seemingly simple as a change in working hours can have implications for the relationships of everyone in the family. For example, a father is suddenly changed to the day shift on his job after working for years at night. What happens when he is there in the evening to interact more closely with the other family members? Will the children see his increased attention as interference in their established patterns? If they object to this change, he may interpret it as lack of respect or rejection.

On the other hand, the father may see problems that he has not noticed before because he was home during hours that the children were in school. His wife may have become involved in evening activities that she may not want to give up to be with him. She may resist his involvement with the children after enjoying a "power" position over the years. He might decide that it would be best to immerse himself in TV or outside activities as a way of avoiding some of the issues that the increased opportunity for closeness with the family present.

A change in the family situation means readjustment of the total system and can pose problems and challenges for every single member.

A Stable But Open System

When individuals live together in an intimate environment, such as a family, they begin to set limits on each other. There is a range of behavior that is acceptable and a certain amount of deviation that is tolerated. When individual behavior threatens to violate the limits that have been agreed upon, members respond by trying to reestablish the limits and to preserve the stability of the family system.

All members of the family system participate in this process of maintaining stability. For example, a child, upset after witnessing the fighting of his parents, may begin to have problems in school. He notes that when his parents focus on his problems, they spend less time fighting. In a sense, the child is able to unite them in concern over him. Even though they may eventually express anger towards him, absorbing their anger is better than having them separate. The parents, too, may take note of the fact that they get along better when the child is having problems and may begin, at some level, to reinforce the child's difficulties.

Though this sequence is dysfunctional for the child, it is functional for the continuity of the system. It keeps the family together, and all of the family members are invested in maintaining it. Typically, in such a family the child experiences a problem at times when he perceives that there is trouble between his parents. It is also possible that one of the parents, feeling anxiety over marital strife, could trigger this pattern by interpreting the child's behavior as problematic, even though that behavior might be judged quite "normal" by an outside observer. This process is not conscious. The individuals do not plan it. The pattern evolves and persists to serve the positive function of maintaining the stability of the family system over a period of time. Mother, father, and child all participate in the pattern.

When the family is viewed in this way, it becomes impossible to think of family assessment as arriving at a separate diagnosis of each individual family member at a particular moment "frozen" in time. Rather, focusing upon understanding the nature and the quality of the interactions among family members over time becomes essential. And, while family systems tend to maintain stability, they are not rigid and unchanging. A family must be prepared to respond to the changing needs of its members over time, to unpredictable events that involve family members, and to pressures that come from outside family boundaries.

Every family is faced with the test of allowing for growth and change while maintaining the integrity of the system.

Characteristics Of The Family System

A large family which includes grandparents, parents, and children whose ages range from birth to seventeen is obviously very different structurally from a family consisting of a mother and two children. Each of these families will be organized differently, too. In trying to understand more about these families, it is important to look at various

characteristics within each family. The following sections will explore five characteristics of the family system:

- External and internal family boundaries;
- Family rules;
- Family role organization;
- Power distribution among family members; and
- The communication process.

External Boundaries

Ann Hartman (1979) has defined the external boundary of a family as "that invisible line that separates what is 'inside' the family and what is 'outside' the family." This outside boundary defines the whole family in relation to other systems such as schools, churches, or other families, and outside individuals.

Although this boundary is not physical, it can be detected, to some extent, by observing the way a family uses its space. For instance, the family can describe its boundaries quite precisely with fences, walls, and hedges. Or, it can rely simply on the property line with little to separate one family's property from another. The family, too, can make it relatively easy or difficult to gain access by use of gates, doors, dogs, doorbells, or intercom systems. Families do make statements about how they perceive their boundaries with these physical statements about privacy and accessibility.

In addition to its use of space, a family has many attitudes, rules, and communication patterns which help to define its boundaries. There are rules about who is included in or given access to the family, such as extended family, in-laws, friends, and neighbors, for example. The nature of a family's boundaries might range from an extreme closed quality to an extreme open quality. Kantor and Lehr (1976) write about different structural arrangements within families and identify the following as some of the characteristics of a closed type:

- Tightly controlled access to family space - likely to have locked doors, fences and unlisted phones. Strangers are not admitted easily;
- Connections of family members to outside systems are rigidly controlled by rules and implemented by those in authority - many rules exist about permitted activities and who can associate with whom;
- New and different links to outside are difficult for members to develop - they tend to have few connections, but they are usually stable;

- Privacy is valued. Members tend to be self-protective and sometimes secretive;
- Values regarding roles and rules tend to be rigid;
- Communication is tightly channeled with little expression of conflict;
- High priority given allegiance to the family;
- Can be affectionate, but controlled in expression;
- Discipline and traditions are valued. There is low tolerance of differences; and
- Change is difficult and threatening.

At the other end of the continuum is the family with very open physical boundaries. Some of the characteristics of this type of family are:

- Family members, friends and strangers enter and exit with relative ease;
- There is little privacy - space is not well regulated internally or externally;
- Members develop individual connections to external environment, do their own thing;
- Planning is not valued so much as spontaneity;
- There is a great deal of energy flowing out of family;
- There is no clear-cut decision making process - rules tend to be fluid;
- Uniqueness is prized and often encouraged;
- Emotion and affection is expressed, but not in a consistent fashion; and
- Change can lead to chaotic situations, family has a tendency to "fly apart."

Somewhere along the middle of the continuum would be the family with well-defined and moderately open boundaries. They would tend to look like this:

- There is easy access to family space, frequent guests, unlocked doors, freedom to exchange with outside;
- Members can explore outside community and groups - tend to have numerous and strong connections;

- Communication is relatively open, opinions and ideas exchanged openly, conflict can be openly expressed;
- Rules are well-defined, but flexible;
- Growth is encouraged, intimacy and nurturing patterns are adaptive, and uniqueness is tolerated within limits;
- Closeness is encouraged. There is a balance between energy flow into and out of the system; and
- Change can be somewhat stressful but the family has resources to adapt.

The degree of openness and closeness may vary with family style, preference, culture and circumstances. It would be extremely rare to find a family who fits neatly into any of these categories, though most families tend toward one type or another. Most families have a mixture of open and closed boundaries which can change depending on circumstances. As an example, a family who is actively engaged in various community activities, a characteristic of a family with open boundaries, may designate the dinner hour as their time to be together and take the phone off the hook to deliberately limit their accessibility.

Considering the implications of family boundaries is important primarily so that the child and family can come together with the least stress possible. The most important thing to remember about the external boundary is that it must be flexible enough to permit the family access to resources from the world outside the family to meet their needs in a satisfactory way.

A family has an invisible boundary that helps to define it as separate and different from other systems.

There is a wide range of boundary styles ranging from open to closed.

Internal Boundaries

In addition to its external boundaries, a family system contains a number of subsystems which create internal boundaries. The subsystems could consist, for instance, of those members who belong to the same generation (such as the children) or the same sex (the men of the family) or those who have the same interests or functions. Obviously, one individual might belong to more than one subsystem. Over a period of time, rules develop about how the subsystems interact with each other, who is included in the subsystems, and how each member participates. In other words, a kind of boundary exists that defines the relationship between and among the subsystems.

For example, in most families the parental subsystem, be it two parents or one, will establish itself as being "in charge" of the sibling subsystem. The boundaries and rules are distinct and clear. The parent or parents may interact frequently and informally with the children, or they may be somewhat remote and formal. In some families, the interaction can be so free and open that the boundaries become blurred, and roles become confusing. In some families, the rules of interaction can tend to be so rigid that people become distant and alienated. They are not there to support each other.

People in family groups arrange themselves according to closeness and distance patterns. Aponte (1976) has written that "a family that has developed successfully will have a dependable, differentiated, and flexible system of structural alignments. Each family member will have other members on whom he or she can count to carry out family-related operations." Alignments develop between and among the individuals in a family in order to carry out tasks, developmental or otherwise, and to meet emotional needs. These alignments can shift over time, but in most families there are predictable, reliable patterns of relationships. This provides the members with dependable sources of support and nurturance. Again, there can be wide variations from family to family as to the nature and quality of these patterns. They depend in large part on such things as cultural or ethnic background, family traditions, and values.

Who is included in the subsystems can be an important issue. Sometimes a child, or perhaps a grandparent, is included in the parenting subsystem. This may be the result of circumstances - such as both parents working, or a single parent who works or needs help with parenting. It could be the cultural norm. There is nothing inherently problematic about this kind of subsystem, so long as expectations and arrangements are clear to everyone in the family.

A family has internal boundaries that define how family members relate to each other. These are subsystems based on generation, sex, interests, etc.

Role Organization

In addition to external and internal boundaries, a family is organized in terms of roles. Every family has to work out such things as who cares for the children, who does what work around the house, who makes what decisions, and who handles the money. To function well, a family must have some clarity and agreement about these roles. However, roles need not be so rigid and narrowly defined that there cannot be changes.

Role organization and expectations in any family are influenced by many factors - culture, ethnic background, experience in the family in which one grew up, life style, and family size and composition. It is possible, for example, to find a child fulfilling parental responsibilities in certain families. In some cultures, children are given responsibility as part of their training.

The way in which a family organizes itself in terms of roles is not necessarily a statement of how well or how poorly that family is functioning. Suspending value

judgements and avoiding applying one's own version of the ideal type of role arrangement is sometimes very difficult. In reality, there are a variety of role arrangements, and any of them can be functional in a given family.

Although families devise many variations of workable role arrangements, it is also true that deficits can exist in some families. The family has tasks to carry out in relation to its members and to society, and it must contain enough members with the abilities to perform those tasks adequately. In the case of a single-parent family, for example, the parenting can be carried by a single adult individual or shared with an older child, a grandparent, other relative, a friend or neighbor. Any of these arrangements can be satisfactory. However, in the event that a parent experiences the stresses of the total responsibility as an overload and does not have others to call upon, a serious deficit exists.

Role organization varies greatly among families.

Ideally, roles within the family are both clear and flexible.

Family Rules

Over a period of time, family members develop rules about how they relate to each other and to the external environment. Many of these rules are "silent contracts," not openly recognized. There are rules about communication, such as "parents never argue in front of the children." There are rules about how decisions are made, how problems are solved, and about how people are supposed to think, feel, and behave. The rules are repetitive, predictable, and stable, although, like many traditions, how and why certain rules were established may be lost or forgotten. To understand families it is important to learn about the operating rules and the behavioral patterns that maintain them. The rules that are developed by the family system ensure its stability, promote cohesiveness, and help to establish the identity of a family as distinct from other families.

The way in which the rules themselves are made, whether or not they are openly recognized, and how they can be changed is also important. When the family experiences a good deal of anxiety about discussing rules or is unable to make necessary changes in rules as time and the situation require, there can be serious problems. For instance, the rules about bedtime and homework which operate in a family with young, school-aged children are no longer appropriate when the children reach high school. In one family these rules may be changed by democratic family process initiated by the children. In another the old rules may not be open for discussion and may remain rigidly in place, leaving the adolescent to choose between obeying inappropriate rules or rebelling.

Families maintain stability by developing rules about how to live together.

Families have rules about everything. Some rules are explicit and some are not. Some can be discussed and some cannot.

Families vary in the kind of rules they have, whether they can be discussed, how easily they can be changed, and how they are enforced.

Distribution of Power

All families must have ways to make decisions and to resolve conflict. In most families all members have, and need to have, a certain amount of power and influence in some areas. As Aponte (1976) has pointed out, "Family members must have enough power in the family to be able to protect their personal interests in the family at all times, while keeping the well-being of the other members, and of the family as a whole, in mind." Normally, one thinks of power and decision-making as being vested primarily in adult members of the family. However, there can be a great variation in how power is distributed and used in families.

Some families strive for equality and permit everyone to participate in decision-making. Others have a clear and rigidly defined system in which one member of the family holds most of the power. The distribution of power can shift over time as the children grow and exercise autonomy. Children come to have a voice in such matters as how the family money is spent and where the family goes on vacation.

Perhaps the most important consideration is that the family have an orderly pattern of power distribution. They need one that is reliable, permits the family group to carry out its operations in a reliable fashion, and yet is flexible enough to change as circumstances change. Overly concentrated power in one member of the family, or an arrangement that is so diffuse in distribution that members assume no responsibility, can hinder family operations, and individual growth.

Families develop characteristic ways to make decisions and to resolve conflict. Distribution of power usually shifts over time with needs of the members. It is important that there be a reliable, predictable pattern of power distribution.

Communication

The final characteristic of family systems included here is communication. It is impossible not to communicate. All behavior is communicative. Even silence is a message. A family works out its role organization, its rules of operation, all of its activities, through a process of communication. The communication system parallels the relationship system, since it is through communication that relationships are defined.

Messages have both a content and a relationship aspect. If a husband comments to his wife, "I like your blue dress," it gives her some information. Depending upon the context of the situation and the inflection of his voice, it might be a command to wear that particular dress to a party that night. This is a message that defines the relationship in

some way. He is establishing the right to express a preference and expects a positive response. She may confirm the definition and agree to wear the dress. She may also attempt to redefine the relationship by ignoring his statement or in some way convey the message that he has no control over what she wears. Conversely, the husband's comment, "I like your blue dress," may be a compliment given after she is dressed.

Communication patterns express what is going on in relationships in a family. If there is a kind of power struggle occurring between two people, it can be seen in a high level of disagreements. In an extreme situation, the competition between the participants makes decision-making almost impossible. Children in a family in which the parents are in a power struggle can often get caught in the cross-fire, getting conflicting messages from the adults. At the other extreme is a situation in which one person is always in the power position, while the other person is always "one-down." Both types of communication patterns are usually present in most relationships. The important thing is to work out an arrangement that is a satisfactory "fit" in terms of the needs, desires, and circumstances of the individuals involved, and one that permits the family to carry out its functions with respect to its members.

Families could be located on a scale ranging from "open" to "closed" kinds of communications. On one end would be those in which messages are clear and unambiguous. Individuals can reveal their needs, requests, and desires in a relatively free manner. Expectations are clear and well-defined. On the other end would be those in which messages are distorted and ambiguous. Individuals do not freely reveal their needs, and there is little congruence between what is felt, said, and done.

It cannot be emphasized too strongly that there are all sorts of workable and effective communication and relationship patterns. Culture and ethnicity are significant variables to keep in mind.

Each family works out its ways of operating through a communication system. Families have many rules about communication which can be located on a scale ranging from open to closed. There is no one "ideal" type, and different styles work for different families.

The Family Through Time - Life Cycles

The family with its varying patterns of boundary organization, rules, roles, power distribution, and communication processes, also passes through a life cycle with certain identifiable stages. Each stage presents the family as a unit with new tasks. Each stage means considerable change for the family during transition from one stage to the next. The transitions associated with moving from one stage to another have come to be considered normal and sometimes stressful parts of development. The amount of stress experienced by a specific family during these transitions varies and depends upon many factors.

The transition points experienced by most nuclear families are outlined in the following framework. This framework is primarily applicable to nuclear families. There are variants in other kinds of families. The chart on the following pages lists the transition points and some of the tasks for family members associated with each.

Family Life Cycle:

1. Commitment

Tasks:

- Assume spouse roles
- Separate from family of origin
- Establish relationship with in-laws
- Establish rules of interaction (intimacy/distance)
- Divide work

2. Developing New Parent Roles

Tasks:

- Assume parent roles, expectation, values, etc.
- Assume child-rearing responsibility
- Negotiate changes in work, recreation, housing, relationships with extended family
- Establish rules and communications regarding children (intimacy/distance)

3. Accepting The New Personality

Tasks:

- Continue development of parental roles
- Allow development of new individual

- Relate to developing personality
- Make new space arrangements

4. Introducing The Child To Institutions Outside The Family

Tasks:

- Expand parental roles
- Support child's first separation
- Accept child's developing autonomy and accept changes in family organization
- Relate to outside institutions i.e., schools, church, sports, etc.

5. Accepting Adolescence

Tasks:

- Deal with emerging sexual identity of child
- Accept increasing influence of peer group
- Promote differentiation and autonomy of child

6. Experimenting With Independence

Tasks:

- Deal with increased striving for independence
- Facilitate greater participation – child in decision making
- Participate in education and career planning
- Accept lessening of the tie to the family or origin

7. Preparing To Launch

Tasks:

- Accept independent adult role of child

- Plan for separation
- Face own middle age transition issue

8. Letting Go/Facing Each Other Again

Tasks:

- Rework spouse roles
- Face unresolved issues of the past
- Work out separation issues around children

9. Accepting Retirement/Old Age

Tasks:

- Develop role transitions and new life style
- Develop activities other than work and family responsibilities
- Face physical and emotional problems of aging
- Deal with significant losses
- Begin life review

Variations In Life Cycle

The family life cycles and the issues involved can vary a great deal depending upon cultural and ethnic differences and upon the circumstances of the individuals involved. For instance, a family in which there has been a divorce has all of the issues of separation and loss to deal with. The family essentially faces a transition from a two-parent to a one-parent family, even though there may still be involvement of both parents. The blended family, of which there are many these days, goes through a process of trying to "fit" together two family systems. The formation stages as well as latter stages can vary for these families. The couple who has never had children will face different transitions and issues than families with children.

The cultural variations in the family life cycle are great. For example, the Mexican-American life cycle is more clearly "three-generational" than the Anglo-American life cycle. Extended family members, friends, and neighbors usually play a strong role in the family life. Older members of the extended family are respected, and age is a determinant of power and control. Families tend to be protective of their members and

to prize family loyalty. Ideas about when and under what circumstances young people leave home are different from middle class Anglo-American ideas.

The life stages and tasks of the single-parent family are similar to those of any family, with the exception of those that relate to couples. The single-parent family may face problems of task overload at various stages of the life cycle unless there are adequate support systems available. Other variations would include gay and lesbian couples and the stresses they may experience in their life stages and tasks. Obviously, the family life cycle must be considered in a socio-cultural content.

Families Are Multi-Generational Systems

The family life cycle is not the only way in which the time dimension is important in understanding families. A family may seem to consist of only two or three current generations. It is actually greatly influenced by many past generations. It is important to understand the linkages, or lack of them, between the current family and extended family members. Values, expectations, myths, secrets, and unresolved issues around important events are transmitted from one generation to the next. This can be a powerful influence in the context of the present family and its individual members. There is an assumption here that all people, whether consciously or unconsciously, are deeply enmeshed in their family systems. The family system affects people's perceptions of who they are, how they think and communicate, and how they see themselves and others. It influences what they choose to do and be, whom they choose to be with, love, and marry. It influences how they choose to structure their new family.

Early in the life cycle, every family must make decisions about how it will relate to families of origin. How will a newly married couple relate to their own and to each other's family. For many families this can be an area of great conflict that persists over the years. Sometimes there are damaging cut-offs that divide families and limit opportunities for contact and support. The extended family can be a source of support, nurturance, and stimulation and an extremely important resource. It is essential for anyone trying to understand families to pay special attention to the intergenerational facet of family life and to understand that some of the most important people may not be current family.

The Single Parent Family

The need to be sensitive to the variety of family structures and life styles that are acceptable and functional in American society today was noted earlier. The assumption tends to exist that a family contains two parents. Yet, it is now estimated that nearly one half of all the children in the United States today will spend at least part of their lives in single-parent families. Currently, one family in five is headed by single parents. There is no question that, for a variety of reasons, the single-parent family has become almost commonplace.

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2: Family Communication

Chapter 2 Overview

This chapter provides guidelines for enhancing communication within the family system. Although the chapter is titled **Family Communication**, the guidelines which are included pertain to spoken communication between all individuals. The Children's Service Worker can draw upon these guidelines as he/she interacts daily with those within and outside his/her caseload.

What is it?

We all communicate, and we all have our own idea of what good communication is. The problem comes when our idea of good communication and someone else's does not agree.

For instance, we may think we are communicating well when we're allowed to talk on and on. The people on the other end of what we're saying, however, may see us as lecturing or droning on. That wide-eyed look we think is interest may really signal a mind that has tuned out and taken our listener far away.

Experts tell us that communication is the process or way we transfer information from one person to another so that it is received and understood. Received and understood are the words that are key.

You can't call it communication if one person talks and another appears to listen. It is only communication, real communication, if information is received and understood. Communication is sharing ideas, feelings, thoughts, and viewpoints.

Family communication is complex because it includes sending, receiving and interpreting information. Sometimes the interpretations are not what the speaker intended.

Communication experts tell us "You can never not communicate!" That statement stresses the role of nonverbal behavior in family conversation. Most family members learn early how to communicate verbally, with the spoken word, and nonverbally with actions.

When someone says, "You can never not communicate!" he or she means that even though we may not be saying anything with our mouths, we are probably "saying" a great deal by our actions and the way we listen. In fact, the nonverbal response may be much more than we realize. Actions often speak louder than words.

In the book Secrets of Strong Families, Nick Stinnett and John DeFrain write that "Good communication isn't something that just happens among strong families, they make it happen."

You could say that communication is a two-way street with lots of traffic signs and billboards. To really communicate you have to be able to read the signs as you drive and watch for oncoming traffic.

Why Communicate?

The advantages of positive, open communication are many.

Family members who have learned to communicate effectively with each other have learned to talk and to listen carefully, to share information and to be understood. They know and feel each other's joys and sorrows, and they can express their own joys and sorrows through the sharing of their thoughts. They have true empathy with one another.

Family members who communicate well know how to laugh together. They enjoy a sense of humor, which brings enjoyment to their lives. They are able to express their feelings, differences, likenesses, and hopes for the future. They practice positive ways of handling conflict so problems are brought out into the open, discussed, and solutions are found. They know how to be open and expressive with each other.

When family members listen carefully to each other, they communicate an unspoken but powerful message, and that is that they respect each other. Careful listening says, "I respect you enough to listen to what you have to say."

Learning and strengthening communication skills doesn't mean an end to all problems; it doesn't mean that strong families don't have conflict because they do. Family members get angry with each other, misunderstand one another's motives, and sometimes just plain disagree.

But when they can communicate, they are able to get their differences out in the open where they can talk about them, discuss the problem, and negotiate a satisfactory solution agreeable for everyone. That doesn't mean the solution will give all involved exactly what they want - it just means they will have reached a common ground upon which they can agree.

Good communication provides security and safety. People know where they stand in the family. This leads to a feeling of "wellness" which is essential for strong families. Good, effective communication doesn't stand alone. It walks hand in hand with family appreciation and time together.

What Makes Good Communication?

Good, effective communication has four essential parts:

- Listening - By listening you demonstrate concern for all aspects of the speaker's message;

- Rephrasing - This is restating the basic message in fewer words to be sure you understand the speaker;
- Probing - This is using a question or statement to direct the speaker's attention inward to examine his or her situation, feelings, thoughts or problems in more depth;
- Positive speaking - Positive speaking is a caring communion, a way of showing that the positive aspects of relationships are valued and emphasized.

All four of these skills together are powerful when used with people you care about.

Often we take family communication for granted. We may think we communicate well just because we are a family, or because we spend a good deal of time together. But each of us can learn to communicate more effectively.

Listening - What is it?

Listening is vital to good communication. It strengthens the relationships between family members by showing that you care about and respect the person speaking. It increases understanding and can lead to empathy, shared experience and affection. (We use the word empathy instead of sympathy, which can suggest pity.)

To listen with empathy means to be able to put yourself in the other person's place so that you understand his or her joy and pain. When you're a good listener it shows you're concerned about all aspects of the speaker's message. Really listening involves paying attention to what the speaker says both verbally and nonverbally. It is hearing with the heart as well as with the ears. It is considered by many to be one of the greatest gifts you can give another person.

Listening often includes some verbal response, but it is largely a nonverbal skill. Don't think of listening as something you do just for others. There are some great payoffs for those who listen. For instance:

- You gain knowledge. You can learn a great deal of new information about people and about ideas when you listen. This increases understanding of what is meant, as well as of what is said;
- Listening stimulates the speaker's expression of ideas and feelings. When this happens the speaker directs the flow of conversation and has a sense of responsibility for what takes place;
- You become a trusted person. How many times have we heard the statement "to have a friend you must be one"? This applies to families, too. When you listen well you're building trust with the speaker, who feels relaxed, comfortable and secure in your attention;

- Good listening encourages cooperation from others. When you genuinely give attention, you encourage others to react genuinely as well. Sincere interest in your family members often leads to respect and cooperation. This, in turn, can foster a sharing of ideas and a sense of mutual accomplishment;
- You can reduce tension and prevent trouble. That can benefit both you and the speaker. Your careful listening gives the other person a chance to "let off steam" before he or she reaches the boiling point. If you learn to listen carefully before you speak, you often can head off many minor problems before they become major ones;
- Listening can be fun. Active listening, or listening with your heart as well as your ears, can increase your enjoyment in everything you do. You may actually learn to hear on higher, more positive levels of communication.

Elements Of Listening

Good, effective listening has two key elements:

- Listening and observing; and
- Letting the speaker know that you are listening and observing.

For many people, learning to listen effectively is difficult. Many societies emphasize speaking, and the other end of the communication is often ignored. Yet good speaking requires good listening; communication is not a one-way street.

Sometimes we think we're listening when we're not. We may be preparing to say something when the speaker pauses, or we may be thinking about something entirely unrelated to what is being said. That is not effective, active listening. In fact, that is not listening at all!

When you give someone the gift of active listening, you are seeing as well as hearing; observing as well as listening. Such observation is a good way to learn more about what others are trying to tell you about their feelings.

Sometimes your observations will detect a difference between what a person says verbally and nonverbally. Since nonverbal behaviors, including the expressions on our faces, the way we hold our bodies, the gestures we make, are often more difficult to control than what we say, they can be a more accurate reflection of what we're feeling.

That isn't always true, however. Cultural and personal uniqueness make a difference. If there seems to be a difference between what is said and what is shown, but you're not sure what is causing that difference, don't be afraid to ask. It's better to clear up a misunderstanding at once, rather than let it mushroom.

We noted earlier that the second element of good, effective listening and observing is to let the speaker know that you are doing so. Ways to do that include using eye contact, appropriate posture, and accurate spoken and nonspoken responses.

What is Good Eye Contact?

For most of us it means looking the speaker in the eye. It doesn't mean staring at him or her; it doesn't mean never glancing away. What it means is to do what is comfortable for you; meet the other person's eyes in a direct manner that is natural, interested and concerned. Since its purpose is to put the speaker at ease, you want to make sure that your eye contact is neither so intense nor so distracted that it makes the speaker uncomfortable.

It is important to remember that direct eye contact is not always appropriate. Each person is unique, and some people are not comfortable meeting another person's eyes. Then, too, some cultures consider direct eye contact as hostile, disrespectful, or bad manners. Be sensitive and respect individual and cultural differences. If you're not sure what the speaker is comfortable with, ask!

Appropriate Posture and Gestures

Your body language says a lot about how you think and feel about the speaker. It is best to select a posture that is comfortable for you, and to use gestures that are natural and fit what is being said. Experts say open, rather than closed, postures are best to open up communication. (Closed postures include folded arms, crossed legs, and turning your body away from the speaker.)

Gestures, too, are an important part of listening, but it is important not to overuse them. The most common gestures are those of the face, arms and hands. Facial expressions can show joy, excitement, anger, sadness, and many other emotions. Often a smile is most successful in making contact between listener and speaker.

When studying body language, it is important to realize that each person has his or her own idea of personal space. We all have certain distances we like to maintain around us. Often these distances depend on the situation and the other people involved. Often they're cultural.

Sensitivity is important here. We need to watch how the speaker uses space around others, and we need to respect that space. When we do not, it can have a disastrous result on communications.

Appropriate Verbal Responses

When we're listening, our spoken responses need to be short and direct; words that show we're following what the speaker says. Such phrases as "um hmm," "I see" or "that makes sense" show we're in tune with the speaker. Another effective response is repeating words that seem to have special meaning to the speaker.

Examples of Listening

A husband has this to say about his wife: "Some people won't believe this because they think you have to be a fountain of wisdom to help people and they don't see my wife, Dottie, in those terms. She is, though, the most important advisor I have. Not because she tells me anything, but because she listens. She could teach classes on listening! She doesn't interrupt - except maybe to ask a question to clear up a point. She'll let me get it all out. So many people don't listen; they're just waiting for you to hush so they can begin talking."

And a wife has this to say about her husband: "When we first married my husband could outtalk anybody. He could go on for hours, it seemed. I'd wait for him to stop so I could say something, and he never would. I'd have to interrupt and say my piece fast to be heard at all. I began to be embarrassed by his monopolizing the conversation when we were with friends. And frankly, I needed him to respect me enough to listen to me once in a while. It took a while and some harping, but he saw my side and, with some work, he's learned not to monologue. We used a timer at home to take turns - kind of like you do with children. I'd set it for three minutes and he'd talk; then I'd get the next three - with no unnecessary interruption. As he learned to listen, we put the timer away. We also developed a secret signal - for use in public - I'd adjust my left earring to mean he needed to listen for a change. Once he was telling a good story and stopped abruptly in the middle. Then I realized I had reached up to brush my hair back and he thought I'd sent a signal. We had a good laugh about that one later."

Rephrasing

Rephrasing is restating the content of what the speaker said. It focuses on spoken messages. As the listener, you rephrase to reflect the meaning of what was said. You can do this by simply repeating what the speaker said, with specific emphasis on certain words. Or, as is more common, you can rephrase by repeating what the speaker said in fewer words than he or she used.

Remember, rephrasing focuses on the speaker's words. It is important to avoid adding meaning, which was not intended in those words.

What are the payoffs of rephrasing?

- It builds understanding. Rephrasing tells the speaker you, the listener, understand, or are trying to understand, what he/she is saying.
- Messages become clear and precise. Often it helps the speaker clarify his or her meaning when words are briefly repeated back. This can help the speaker deepen the content of the discussion.
- It avoids confusion. Often your rephrasing points confusing content out to both you and the speaker. This helps identify differences and can lead to compromise and understanding.

- The listener's ideas can be validated. When you rephrase what the speaker says, it allows you to check out your own understanding of the speaker's spoken message. This way you can clarify things, rather than assume them.
- It demonstrates caring and concern. A caring and concerned attitude on your part can produce a sense of mutual respect and trust between you and the person who is speaking.

The Parts of Rephrasing

Rephrasing has three parts. They are:

- Listening to determine the basic message;

To use rephrasing to help in communication you must make certain judgments to determine the basic message. The speaker's content may include many thoughts, and you usually must choose only one to rephrase.

Be careful not to try to make your choice too soon. With patience, a basic message will appear. As the listener, you must use judgment to rank different ideas or statements, beginning with the one you consider most important. Don't worry if your order is different from the speaker's; he or she will usually let you know! If that doesn't happen, don't be afraid to ask.

- Restating accurately without adding meaning;

It takes practice to be able to restate a message accurately so that you don't suggest a meaning the speaker did not intend. After practice you may be able to combine several basic ideas in your rephrasing. This is helpful because it focuses the content and joins similar ideas. The best way to restate a message is to use words similar to the speaker's, but fewer in number.

- Checking it out to insure accurate understanding.

Checking it out is a way to make sure you're rephrasing accurately. As listeners, we make assumptions about the speaker's statements. Our assumptions can twist what the speaker is saying. For that reason, it is important to check out our rephrases. A simple, effective way to do that is to add phrases such as "Is that correct?" or "Is that what you said?" or "Is that what you mean?"

Examples of Rephrasing

In this example, Ann checks out what is wrong with Bob: Bob has been irritable all evening. He snapped at Ann a couple of times over nothing and has been silent for

most of the time. Of course Ann is disturbed over this. Naturally she feels hurt and resentful toward Bob. However, such resentment is based upon the assumption that Bob's irritation and negative behavior are directed toward her. This may not be the case. Ann checks it out and says, "Bob, you've been acting angry and upset tonight. Is it because of something that I have done or is it something else? Do you feel ok?" Bob then shares with Ann that his budget has been cut at the office, and because of the budget cut he has to terminate a friend who works in his office. While he hates this, he has no choice and is very frustrated about it. If Ann had not clarified the meaning of his communication, she would have misinterpreted Bob's behavior.

In this example, a husband demonstrates the need for rephrasing: "My wife's family uses a good deal of indirect messages and they understand each other. My family has always been pretty direct, so you can imagine the interesting misunderstandings Sue and I had until we figured this out. She'd say, 'Are there any good movies downtown?' and she'd mean, 'I'd like to go to a movie.' I would answer the question she voiced by telling her what was playing. I was surprised when she got angry or sulked. Eventually we figured this pattern out. She's better about saying, 'I'd like to...,' instead of hinting, and I'm better about checking to be sure I understand what she really means."

Probing

Probing is the use of a question or statement to direct the speaker's attention inward to examine his or her situation in greater depth. It also can highlight the way the listener and speaker relate.

Probing questions require more than simple "yes" or "no" answers. They are open-ended, encouraging the speaker to respond with more awareness and intensity. It is important to remember that probing questions center on the other person (the speaker, when you're listening) and what is being probed. The more your probing statements or questions relate to exactly what the speaker is saying, the more effective they will be.

Like good listening and rephrasing, probing also has its payoffs. They are:

- Probing statements focus the conversation. They help focus the speaker's attention on a specific topic;
- Information sharing is increased. You, the listener, gain more information, the speaker's awareness is heightened, and this results in better understanding;
- Probing gives clear direction. Your probing statements and questions help direct the speaker to content you consider important. This can help channel a conversation and get things "unstuck" if they've become stalled;
- Probing statements open up the discussion. You can give the speaker permission to probe ideas and notions he/she thought were too risky or taboo;
- It affects the entire interaction process. This can lead to more open sharing in which each family member feels an important part of the whole.

The Parts of Probing

Probing has three basic parts:

- Identification of a subject that needs more discussion;

You, as the listener, must use some good common sense to identify an area mentioned by the speaker that requires probing. And it is important to remember that probing can only be effective after adequate listening and rephrasing. When these skills are used in order, your probing is likely to be more relationship centered and more effective.

Listener common sense involves, a certain intuition. This intuition is like a "sixth sense," and is a way of gaining information without direct observation. Intuition can be a powerful, useful skill when used with other forms of communication.

- The phrasing of open-ended questions or statements;

The second part of probing is that of phrasing open-ended questions or statements. It is best to use words like "what, where, when, how" when phrasing your questions. Be careful to avoid the word "why" - it usually begins a question that can't be answered easily by the other person, and can lead to defensive behavior and resistance to further suggestions. "Why" can be a trap, and seldom leads to anything productive.

- The reflection of feelings.

The ability to reflect the feelings of another person is a difficult but valuable skill. This skill is best used to probe for feelings. Even though you may think you are quite sure what someone else is feeling, it is often inappropriate or unwise to assume it. A simple, but caring probe might be, "You seem upset, is there something I can do to help?"

An Example of Probing

Rod was just starting out in his business. His income was unpredictable, and getting established as a successful salesman demanded a great deal of time and energy, both physical and emotional. "I would sometimes wake up at night," Rod said, "in a cold sweat because of feeling anxious about whether I would make it as a salesman. I worried about having enough money to make ends meet. Some months I made adequate income and some months I didn't".

I was becoming an emotional wreck, but didn't share my feelings with Sally, I guess because I didn't think it was the macho thing to do. I wanted to appear strong and in control to her. But she wasn't fooled; she's very perceptive. One evening while we were walking in the park she said, "Rod, you're feeling pretty uptight about how things are going at work aren't you?" I told her I wasn't tense at all and that everything was ok.

She didn't let me off the hook. "Yes, you are worried," she insisted, "and I think it's natural. But I hate to see you feel that way. Let's talk about this and see if the situation is as bad as it seems and what action we can take to make things better."

At that point I opened up to her and shared all of my frustration and insecurity with her. I felt like a dam had been opened up inside me. I had not talked with anyone about this and it was a great relief to finally get it out. We talked about ways to cut our expenses and things we could do without and not miss too much. Then Sally asked me, "What would be the worst thing that could possibly happen?" and I answered, "The worst thing is that I would lose my job." She then reminded me that if that happened we would still be able to make it on her income and that her job was very stable. We would have to make some changes, but we could make it.

Well, that helped put things in perspective. My sales gradually increased, and today I am one of the top salesmen for the company. But that's not the most important part of the story. The most important part is that on that evening a few years ago, Sally was sensitive enough and interested in me enough to know that I was hurting and needed to talk. She cared enough to initiate the conversation. As a result of talking through that situation I felt closer to Sally than I ever had. I think that established our close bond with each other more than any other single event and it set the pattern for that type of caring, open communication.

Positive Speaking

We humans are unique among animals because of our ability to speak using the meaningful symbols we call words. Words let us communicate quickly and accurately.

However, we often take this ability to communicate for granted, especially in our families. Often we expect family members to know exactly what we want or need without having to say much, or anything, at all.

It is important for all of us to speak to those around us, telling them about our wants and needs. We may think they know what we're thinking, but they really don't. The most they can do is guess, based on their previous experience with us or with others in roles similar to ours.

Most of us don't like to be placed in the position of having to guess what someone else wants or needs. It isn't fair to ask it of others, either.

Strong families understand the importance of speaking clearly and honestly. Family members say what they mean and mean what they say. Their behavior sets the tone for continued meaningful communication, based on valuing and respecting each other. Using positive, supportive words allows you to express yourself as you develop communication skills that can bind people together.

Positive speaking is more than being honest and open; it is letting go of negative thoughts and habits that hinders relationships. Such thoughts and habits, like bullying,

blaming, dominating, and other ways of manipulating people, can destroy individuals and their ability to get close to others.

Positive speaking is being kind. It aims at building relationships by building up the other person. Honesty is part of this kindness, but it is never brutal honesty. The balance between honesty and kindness is crucial.

So what are the payoffs of positive speaking for all of us?

- You have the opportunity to express yourself. If you speak in a positive way, people will listen to you more readily. And that gives you an opportunity to exert influence.
- It helps build a positive self-image. When people listen to what you have to say and take it into consideration doesn't it make you feel better? Doing the same for others makes them feel better, too.
- It builds trust into a relationship. Positive speaking tells people you are not out to manipulate or take advantage of them.
- It encourages cooperation. Just like listening, positive speaking increases cooperation. This leads to opportunities for growth and change.
- It allows for honesty and kindness. This type of honesty is caring, never unkind. It allows love and kindness to work together to promote openness and frankness.

The Parts of Positive Speaking

Positive speaking has four basic parts:

- Focusing on the positive;

Focusing on the positive is a theme you find often in strong families. That's because it is an effective way to promote growth in family relationships.

Focusing on the positive while speaking to others helps put life and relationships in perspective, especially when things seem to be going badly. It reaffirms commitment by showing interest and caring. It says "We are in this together and we are going to win."

- Honesty and kindness;

Honesty is crucial in dealing with relationship issues, but it always must be measured with kindness. Marital therapist, Richard Stuart says uncensored, open communication may be more than any relationship can bear. We can't say hurtful, unkind things simply because we believe them to be true - at least, we can't say them without being prepared for the consequences.

Too often people use the excuse "I'm only being honest" to be brutal, overly critical, and evaluative. This is destructive to relationships and can be used to set one person up as an authority over another.

Strong families understand this and work toward a type of measured honesty that seeks intimacy through kindness. They realize honesty is a good thing, but you can get too much of a good thing. Be careful with honesty; most importantly, be kind.

- Being specific;

Being specific about what you are saying is important because, once again, you don't want to place the other person in the position of having to guess or infer what you mean. It is helpful to talk about one thing at a time, and to keep it as much in the present as you can.

Speaking about specific issues is a skill that can greatly enhance your communication. It allows you to focus on one topic at a time while sharing knowledge and information. Being specific is the best way to let others know what you want or expect of them. If you're not specific, you can't be really sure if the other person didn't understand you, or just didn't want to meet your request. Speaking in specific, concrete terms gives you a better idea of how to interpret another's actions.

- Self-disclosure.

Being willing to share personal, important aspects of yourself with others may be the most effective communication skill there is. Self-disclosure means sharing a part of you that has meaning for the relationship at hand.

Self-disclosure in families is important. Family members sometimes assume they know what others in the family are thinking and feeling. Self-disclosure is a good way to share feelings, thoughts and experiences. It lets others know about us and can keep them from jumping to conclusions.

Examples of Positive Speaking

In this example, a husband brags about his wife: "I'd like to brag about my wife just a little; she has such a wonderful attitude and manner. I haven't met very many people who are more intelligent than she; she's a physician - very respected in our community. It would be easy for her to feel just a notch or two above ordinary folks, but she doesn't. I'm sure there are people who wonder what it's like to live with her. I can tell you she never makes me feel defensive or inferior. I always feel she genuinely values me."

A mother says: "We practice our manners at home, too. 'Please' and 'thank you' are as important there as at school or work. If one of us is going to be late, we let the family

know; it's just common courtesy. It would be stupid not to be as considerate and as pleasant to family as we are to strangers."

A husband talks about being specific: "For a long time I was angry at my wife because I thought she was spending money too freely. I'd complain that she was spending too much. She'd say she couldn't cut corners any more than she was. Finally during one fight, she said, 'Just tell me how to spend less.' I began by saying that she did a good job on groceries, she didn't splurge on gifts or things for herself, but she could spend a lot less on clothes for the children. Suddenly it hit me that that was my real gripe - she spent too much on the children's clothing. I said to her, 'I believe that is what really bothers me.' She suggested she could choose less expensive shops for the kids' clothes - maybe even use the second-hand store. It was rather funny. When I could narrow it down to my real gripe, she and I could deal with it."

Setting Up a Family Council

What better way is there to practice communication skills than by setting up a family council? A family sitting down together and talking about important issues is not a new idea. However, it may never have been so needed as in our present day.

Ask Yourself These Questions:

- Do you treat family members as well as you treat your best friend?
- Does each member of your family have equal status as a valued person?
- Does everyone share in the planning and doing of family chores?
- Are decisions that affect family members shared by all concerned?
- Do you want to create feelings of trust, competency and independence in all family members?

If you answer any of the first four questions with a "no", and the last question with a "yes", you may want to consider having a regular family council.

Families need a regular time set aside for the purpose of settling disputes, making decisions and adjusting to the changes that are part of everyday family life.

A Family Council Is Not:

- A discussion meeting around the dinner table;
- A discussion while driving the car;
- A meeting called only when there is a problem.

A Family Council Is:

- A gathering of everyone in the family at a designated time and place;
- A meeting that has a chairperson and a recorder (each member takes a turn as chairperson, but only those who can read and write take turns being recorder);
- A meeting with fixed rules of procedures;
- A cooperative way of making decisions that affects all family members.

Here's How It Works:

A meeting is called, the issues are faced, and all the members have a chance to say what they think and/or feel. All possible solutions are considered and the discussion continues until a solution emerges that is acceptable to each family member. This doesn't mean they each like it, but each is willing to live with it for a period of time to see if it works. Each person is expected to support the decision and work for its success.

The Fringe Benefits Of Holding A Family Council Are:

- Parents get to be leaders not "bosses" - children also learn to lead;
- When conflicts come, the best possible solution is close at hand;
- Family members learn to listen with open ears and also with an "open" heart;
- Agreement is reached by consensus, a solution that all can feel good about;
- Everyone gets to hear the facts - this makes shared decisions possible;
- Family members help each other keep a balance between reason and emotion.

Guidelines For The Family Council:

1. Meet at a regularly scheduled time and begin on time. Give this time a high priority.
2. Share the responsibilities of chairperson and recorder whenever possible. Let everyone be heard.
3. Keep an accurate record of the meeting.
4. Set a specific time for the meeting to last. Thirty to sixty minutes depending on the age of the children. Stop on time!

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5. Encourage all members to participate in positive, constructive ways; don't just let them gripe. Focus on real issues.
6. Family decisions and problem solving are important, but plan for some fun and recreation, too.
7. Record all agreements and put them into action as soon as possible. Post agreements as a reminder.
8. End each council with something that is fun and affirms family members like a family hug, a short game, a favorite television program or anything that leaves a positive experience with members.

Hang in there!

The family council takes time and hard work to establish. Don't get too discouraged if it's hard going at first. Hang in there - it will pay off in time.

Adapted from Herb Lingren and Eileen Curry's Building a Family Council (1985)

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3: Parenting And Discipline

Chapter 3 Overview

This chapter discusses various discipline methods that parent(s) may use to discipline their child(ren). The methods represented in this chapter stress active listening and logical consequences. Most importantly, they stress respect for each other.

Introduction

The nature/nurture conflict gives parents and child development specialists cause for much discussion. A child's temperament and, therefore, his actions are indeed greatly affected by his gene pool. How a parent is able to deal with that child and his actions will considerably affect the outcome of his upbringing.

It is widely accepted that a child whose needs are attended with reasonable speed will learn that the world is a dependable place. This trust in others gives him the base he needs to develop trust in the most important person in the world - himself.

Some parents believe they will spoil a child if they give too much attention to the child as an infant. They do not hold the child frequently, do not believe in rocking a child, and allow the child to cry for long periods of time instead of picking him/her up. Children cannot be spoiled by parents who provide loving care. But the parents must respect themselves enough, not to allow the child to become a tyrant over them.

Parents who are realistic and consistent in their expectations of their children will raise children with firm foundations for independence. Independence for their children should be the goal of parents. What do parents need to do for their children, to show they are realistic and consistent, and to pass along the love and respect children need?

Infants' needs must be met reasonably. If a child cries, he/she is signaling he/she is either hungry, wet, or uncomfortable. A parent must attend to an infant in a reasonable time to teach the infant trust. Infants need verbal and tactile stimulation from the parent. A parent's talking, cooing, or singing to an infant increases the child's learning process. Tactile stimulation of holding and rocking are necessary for the infant's emotional health and growth.

On the practical side, infants should live in clean, safe surroundings. This includes regular baths and diaper changes, being fed regularly as directed by a physician, and receiving regular checkups and immunizations.

What a parent does for and with an infant is expanded, as the child grows older and more independent.

The older child continues to need verbal and tactile stimulation. This can be provided in the way a parent shows affection and teaches his/her child about life. The older child

needs consistent care, which includes encouragement to learn by being allowed to explore his/her surroundings. When the child is school age, the parent must express encouragement of learning by being interested in his/her school attendance and progress.

As a child becomes an adolescent the parenting task becomes different, yet the same. The older child is preparing to become independent of the parent. It is at this time that realistic and consistent parenting will pay off. A child raised with respect will generally respond with respect to his/her parent.

A parent should never relax in his/her role as a parent. A parent must always be on the job to provide nurture, love, acceptance, guidance, discipline, and the many other needs of his/her children. Unfortunately, many parents do not have this knowledge. Or if they have the knowledge, do not or cannot put it to use.

The Children's Service Worker's job with his/her clients is to retrain them in their parenting task. The younger the child they parent, the easier is our task. The workers must teach the parent about child development, parenting techniques, alternative discipline methods, and self-respect. The worker does not have to wait until self-esteem is in place to begin the other lessons. It is essential for the parents to realize self respect is the most important thing they can provide the child.

A Children's Service Worker can provide the personal counseling for self-esteem building and can provide the parenting information needed. Also available are CTS providers, such as parent aides, therapists, and referrals to Parents as First Teachers.

The earlier a parent learns how to nurture their child, the better chance that child and family has in succeeding.

Parenting Techniques For Four Stages Of Child Development

Clear parent/child interaction is the result of a wide variety of factors whose effects begin even before the child is born. How a person was reared, what type of family values, societal values, etc. a person brings with him to the parenting field, play a major role. The sex and temperament of the child also are important components. There is the chance of a mis-fit between child and parent on many different levels. There are also many avenues to adjustment. That is why understanding parenting techniques and child development help parents with this difficult job.

Parenting techniques abound. Many are excellent, but **none are practical for all children under all circumstances**. Parenting techniques can be divided into four stages: Infancy, toddler, school age, and adolescence.

1. Parenting Techniques In Infancy

The parents' objectives in relation to the infant are to develop a mutually satisfactory, reciprocal relationship and to actively help the baby learn to trust a

dependable adult. Note the words "mutually satisfactory." It is as important for the parent as for the child to feel good about the relationship. Two obstacles to parental satisfaction are 1) it may be some time before the baby can respond in a recognizable way, as by smiling or laughing, and 2) the baby doesn't talk, which means he/she is pretty hard to understand. It is easy to get frustrated by the one-sided conversation. Several important parenting techniques follow.

- **Learn to read your baby.** This can be summarized by the old railroad sign, "Stop, Look, and Listen."

Stop: Pay attention.

Look: Facial expressions and body movements like back arching (distress) or turning toward someone (usually pleasure). Among other cues, there are signs of tension or relaxation that can guide the parent.

Listen: To sounds such as vocalizations, crying, gurgling.

Taken together, "look" and "listen" can help the parent figure out the puzzle and can help the parent learn how to respond. If one thing does not work, try something else. Guessing is part of the game with infants.

- **Don't be afraid of spoiling.** Babies cannot be spoiled. They do have needs and try their best to express them - often by crying. When the parent attends to the distressed baby, he/she is helping to instill trust - trust that mom or dad will take care of the infant.

Because some parents have little knowledge of child development, their expectations in the area of infant care may be inappropriate. Many infants are in serious danger because a parent cannot understand why a child cries. A child's crying is extremely frustrating to a parent when they cannot calm or hush their child. In Dr. Benjamin Spock's book "Baby and Child Care" he devotes several pages to this subject. He discusses several types of infants who cry. The infant with colic (pain, distension, gas), periodic irritable crying (no distension), fretful baby (fretful spells during early weeks) and hypertonic baby (tense and restless during early weeks). Dr. Spock recommends various methods of dealing with children's crying from limited walking and rocking to looking for medical reasons.

- **Talk and read to the baby.** A parent can sing or hum, even recite the traffic regulations. What a parent says is less important than the parent saying it. Even newborns move in rhythm to the sound of a human voice. For older babies, the parent's voice establishes the possibility of communication and also helps the baby to begin to understand language.

- **Deal with undesirable behavior appropriately.** Being full grown means that a parent can easily alter most baby behaviors that bothers the parent. For example, a parent can:
 - Change the baby's environment by turning him or her around or taking the baby to another room;
 - Distract the baby with a different object;
 - Use motion to change the scene by walking the baby or lifting him/her to the shoulder.
- **Don't hit, slap, or shake.** The baby is still too young to understand social requirements. Sadly, from physical punishment the baby learns that the people one loves can cause pain and that aggression is an acceptable way to express feelings.

2. Parenting Techniques For Toddlers

Formerly horizontal (laying down), the child can now stand/walk and is full of energy as he/she strikes out to explore the world. As motor skills improve, nothing is too bizarre to try - for example, climbing up on dresser drawers or hopping out the window. The child's energy seems inexhaustible, especially to the caretaker, who must be on the lookout for possible dangers.

Also inexhaustible is the child's curiosity. Each new experience is received with a burst of delight. The toddler can absorb all kinds of stimuli, which will be grist for his/her developing cognitive processes.

During this period, the child begins to give up the infantile needs of the first year. The child leaves the parents to explore new situations and new people, but continues to need to come back to them as a place of safety.

At this time the child may also show a need to overreact, to be overly negative in speech and behavior, to defy, to do whatever is forbidden. This is another way of separating from the parents and asserting independence. It is also a response to the parents' insistence on curbing dangerous or antisocial behavior.

The goals of the parent are to define the toddler's area of functioning and keep him or her out of danger, to help the child begin to differentiate acceptable from unacceptable behavior, to support the budding sense of identity, and to help the child separate as comfortably as possible. Basic to these goals, of course, is the sense of trust that was fostered in the infant. In addition, the alert parent will provide a range of experiences to satisfy the child's boundless curiosity. Some useful techniques follow:

- **Let the toddler go.** Let him or her move away from the parent, then back, over and over. Toddlers need to practice repeatedly in order to get the feel of the new experience, to try out their abilities, and to test his/her parent's reactions. The repeated nature of the performance may be annoying to parents, so it helps to view this period as a learning time, a step toward the separation that will be signified by school attendance. In adult life, too, hours of drill are necessary for a finished performance, be it typing, drafting, or playing the piano.
- **Be ready with affection, but don't press it.** Some of the time it's essential for the toddler to be the bold explorer. Eventually, the toddler will return to have his or her "motor" charged with the kind of affection enjoyed before.
- **Continue to read to the toddler.** The time spent reading to the infant should continue into the toddler phase. It provides excellent parent-child interaction and stimulates the child's desire to learn new things.
- **Stay away from a tangled mass of rules.** Like all children, the toddler needs structure, continuity, and firmness, but these should arise from the way the family is organized rather than from rules. For the toddler to remember and obey them, the few rules should be important and basic, such as do not turn on the stove, or no playing in the driveway.
- **The parent makes the decisions.** Tell the toddler what will happen next and assume that he or she will go along. Major decisions are hard for a child in this stage, which is characterized by ambivalence. Take, for example, the situation where a toddler is to be examined by a doctor. The child may choose which ear will be examined first, but he or she should not have the say as to whether the examination occurs at all.
- **Realize that a toddler's ability to understand a rule does not imply ability to act on it.** Toddlers have an amazing comprehension of language and can understand most simple communications. At this age, however, they have not acquired the inner control we call conscience. One can sometimes observe a child in the midst of a forbidden act, while he or she murmurs, "No, don't do it." Understanding and acting on the understanding are two separate things with many months of maturing in between.
- **Recognize and deal with your frustrations.** To handle the toddler's no's and negative behavior, a parent needs a saving sense of humor plus the realization of what the child's behavior means - the beginning of independence.

As with most individuals, adults and children alike, a boost for good behavior is more effective than criticism for unwanted behavior. The

boost might be a pat on the back, an arm over the shoulder, a word of praise, a smile, or a kiss. But what do you do when the toddler has exhausted all patience, humor, and tolerance - especially when a crucial safety rule has been broken endangering the child? This is a good time for what Thomas Gordon, founder and president of Effectiveness Training Inc. calls an "I" message - verbally expressing how you feel and why. For example, "I get awfully upset when you pinch the baby, because she may get hurt." And then a parent has to follow the "I message" with something to impress the child with the seriousness of the act - keep him or her seated for five minutes, hold in abeyance a special treat, or something similar. But in addition to talking to the child, a parent needs a way to work out their feelings. Kids can make parents angry. There is nothing wrong with that. But, a parent has to find his or her own way to handle the anger so that he/she feels better but doesn't take it out on the toddler.

- **Toilet Training:** In his book "Baby and Child Care", Dr. Benjamin Spock goes into a lengthy discussion of toilet training. He discusses looking for signs of a child's readiness to train, parental attitudes, type of chair, and time frames. He concludes by recommending training is best done when a child is between 18 and 24 months. By knowing this kind of information about their infants, parents can be helped by knowing their child is not crying on purpose to harass the parent or the child's refusal to use the potty chair is not because he is enjoying seeing his parent fail. The more education parents have, the more able they are to handle the situation in a non-punitive way.

3. Parenting Techniques For School Age Children

The back and forth process of separating from and reuniting with parents has been largely settled by the time the child reaches school age, and the child is ready for the first major step away from home. The new tasks are to tackle academic subjects and learn how to get along with peers and authorities other than mom and dad. The child is curious about how things work and is willing to spend many hours on hobbies and intriguing games. The early school years are the time for laying down work attitudes that will be useful throughout the child's life.

Parents can do much to help. They can help the child interpret the new world of school. When the child has accomplished something, the parents can provide an appreciative audience. At other times they can be the refuge as he or she experiences inevitable failures. Most importantly, the parents can assist the child in understanding and beginning to take responsibility for himself or herself. Following are some ways to do these things.

- **Communicate together.** Always important, communication is vital at this stage, if the child is to adapt to the world of learning. There's school,

other people, and the child himself or herself - each new encounter crammed with surprises and interesting discoveries that need to be discussed. Sometimes the child will boast a bit, or a lot, at this stage. This is the way a child of this age continues building self-esteem.

- **Let the child go backward sometimes.** No child can win all the time. When the child makes a mistake and feels bad, he/she may want to act like a baby again for a little while. This doesn't last, but it can be a valuable source of comfort when things get tough.
- **Help the child find alternate ways of behaving.** School-age children often don't give much thought to their actions or responses. When something goes wrong and the child is hurt or in trouble as a result, the parent can use the opportunity to talk about the troublesome behavior and help the child understand. Help the child figure out other ways of acting that might have had a happier outcome. A child gains confidence as he learns of alternatives and chooses among them. Thus the child's limited repertory of behavior is expanded and at the same time his or her self-esteem is enhanced.
- **Assign appropriate responsibilities.** Children like to contribute to the family, at least they like it part of the time. Responsibilities within the child's abilities should be assigned with the expectation that they will be carried out.

4. Parenting Techniques For Children At Adolescence

This is a stage of mixtures. The adolescent reviews and repeats all the developmental stages to date as he/she struggles toward adulthood. Learning to trust another person, acquiring a solid identity, addressing the question of careers - all these and more come together for a final rerun and one hopes for settlement. Questions of intimacy, affective relationships, morality, peer associations, and life goals are tremendously important as the adolescent tries on various hats in an attempt to choose his or her life style.

A new element is the physical evidence of maturing sexuality, accompanied by strong, often conflicting feelings. All at once, it seems, there is a new kind of body, which is feeling and acting and thinking in strange and somewhat frightening ways. This means the adolescent must rework his or her self-image, still distressingly fragile. No wonder so many children are tormented by self-consciousness at this stage of life.

The adolescent goes from child to adult and back with the speed of light. Changes in a boy's voice symbolize the adolescent's status; when he opens his mouth the boy himself does not know whether he will sound like an eight year old Boy Scout or a 28 year old football hero.

The adolescent demands more privileges and freedoms than ever before (for example, concerning dating and driving) but may still have little sense of responsibility for his or her actions. At this stage much adolescent behavior is geared to peer standards because the approval of peers is far more desired than parental approval. Parents are viewed as impossibly naive, embarrassingly square, and very ancient.

The bewildering and rapid changes in the adolescent suggest that the parents' role at this stage is limited. The adolescent is again going through the separation process, this time for keeps, and must make his or her own decisions to the greatest extent possible. The wise parent does not intrude except in cases of dire need, painful as it may often be to all concerned.

What a parent can do is to maintain and uphold the values established over the long years of rearing the child, now an adolescent. The adolescent can be expected to abandon those values sometimes and to come back to them at other times. Important techniques for parents of adolescents are described below.

- **Trust the adolescent to come through to responsible adulthood.** This is a tall order, especially when a parent is worried sick about the adolescent's friends, activities, and attitudes. It is hard to represent family values, and trust that the child will eventually adopt them. Take hope in the fact that even adolescence cannot last forever, and things will settle eventually.
- **Provide structure, limits, and standards.** Important for a child of any age, these concepts are crucial for the adolescent who is subject to so much rapid change in himself or herself. Despite objections and defiance, the adolescent needs the knowledge that some things remain constant and dependable. Reasonable limits and standards also help withstand the inevitable testing. If parents fail to uphold their own commitments, the child will continue with more and more testing, he/she will become increasingly anxious if he/she perceives no boundaries, which are needed for a sense of reality.
- **Let your affection show.** When the child reaches adolescence, even formerly demonstrative parents may begin to withdraw physically just at the time when the child may need such evidence of affection.
- **Let the child go.** Letting go can be hard, especially if the adolescent is the first or the last child. Just as the adolescent must establish an identity, the parent must be willing to permit his or her own identity to change. Following this period, the parent will no longer be essential for protecting, nurturing and teaching. His or her role with the new young adult will have a flavor of colleague to colleague.

Summary

It has been said that the main job of a parent is to become dispensable.

Parenting is one of the toughest jobs a person will ever undertake. It is probably the most important job a person will ever do. Being fully informed of job expectations and trained in job skills will help with a job that is a lifetime commitment.

Discipline

Introduction

The word discipline means many things to many people. In approaching the subject of discipline with many families, what they perceive as discipline and what the Children's Service Worker believes is discipline should be considered.

As Children's Service Workers, we see discipline described and acted upon as "punishment" with many of our abusing/neglecting families. Our families generally have little understanding of child development and their expectations for their children are not realistic with their children's ability to perform.

Many of our families have been reared in homes where their parents knew little about parenting. These situations perpetuate the cycle for poor discipline/parenting techniques.

We see families where inappropriate parental expectations have been debilitating to children. Children perceive themselves as being worthless, failures, and disappointing to adults.

We see families where children's needs are ignored and children who fail to develop a basic sense of trust in self and others. Children develop a tragically low self-esteem, which does not increase their ability to successfully parent later on in life.

We work with families who think of punishment as a proper disciplinary measure and defend their right to use it. This perpetuates the abusive cycle because out of self-preservation the child grows into an adult who identifies with the punishing parent. This adult then uses punishment to manage his/her own insecurities.

In some families we see discipline/parenting is nonexistent and role reversal (the parent acting like a helpless child and expecting their child to parent them) occurs. The effect on children is destructive. They do not get the opportunity to pass through the developmental stages that bring a child to healthy adulthood.

Working with families requires the Children's Service Worker to understand their families' own ideas of discipline. They need to clarify to themselves, as well as the family, what discipline is. The worker also needs to offer alternatives to the families so parenting successes can be enjoyed by the family.

Punishment vs. Discipline

To first understand and clarify for the Children's Service Worker what discipline is, a look at punishment is in order.

First, punishment is not the same as discipline. Punishment is used to hurt. The theory of punishment is that a child will avoid pain, therefore, if an act will lead to pain, the child will not commit the act. This type of thinking perpetuates the cycle of CA/N since it is rare for intentionally inflicted pain to have any positive influence on a child. What actually motivates desirable behavior is a close, loving, emotionally meaningful relationship with the parent. We see families where the children have become "immune" to pain or have become the aggressors. Both types of children have many obstacles to overcome so as to not perpetuate this same behavior on their child; thus continuing the cycle of abuse.

Discipline on the other hand is a positive learning experience that sets behavioral limits and guidelines to lead children to and through adulthood.

The purposes of discipline are threefold. First, discipline teaches a child to achieve for himself. Secondly, it leads a child to self-discipline so he will behave without parental guidance. Thirdly, discipline helps a child develop a sense of pride and pleasure when he/she does something right.

That children need discipline is clear. Usually, however, they need to be disciplined far less than parents think.

- Discipline is not punishment.
- Discipline is not shame or guilt.
- Discipline helps the child to think.
- Discipline helps the child to learn so that his present and future behavior is changed.
- Discipline helps the child to grow intellectually and emotionally; it enhances his self-confidence and self-image.
- Discipline is best taught by example.

Discipline is designed to help the child control and change his/her behavior, thereby guiding the child into adulthood. Abuse, on the other hand, does not take the child's future needs into consideration. It is not designed to help the child learn socially acceptable ways of expressing natural desires and drives. Abuse dumps an adult's feelings on the child in a harmful or neglectful way. This satisfies the adult's needs, but it does not satisfy the child's needs.

Discipline helps the child learn a lesson that will carry over and positively affect future behavior. Abuse has the opposite effect. It affects the child's future behavior in ways that are increasingly less desirable to the parents. Abuse leads to more anger, more hatred, more deviant activity, which in later life are frequently vented against society.

Discipline enhances the child's sense of self-worth. It helps the child learn self-control, a quality he/she can take pride in. Discipline helps the child fit into the family and society in a comfortable way, which leads him/her to conclude that he/she is basically a good, strong, and effective person.

Discipline is not shame or guilt. Discipline teaches the child to use his/her own resources in the future rather than to depend on the parents. Discipline helps the child grow. It neither stunts his/her growth nor destroys his/her self-confidence. Ultimately, the reason an older child does the "right" thing is that he/she doesn't like him/herself as well if he/she does the wrong thing. Discipline helps develop a sense of self-worth, the most important ingredient necessary for a child's positive behavior in the future.

Discipline is best taught by example, but so is abuse. The vast majority of abusive parents were themselves abused as children, and abusive parenting behavior is many times handed down from one generation to the next. The examples of behavior a parent sets are the lessons the child is learning - not through parent's words, not through parent's intent, but through what the child sees the parent do.

Good discipline includes creating an atmosphere of quiet firmness, clarity, and conscientiousness while using reasoning. In order to accomplish this, parents must see their children as worthy human beings and be sincere in dealing with them.

How Discipline Works

Discipline is an essential part of parenting. Without guidance children are not well prepared for life nor are they well prepared to parent. This is our daily challenge when we work with our families. The job appears overwhelming especially if there is little parenting background available to our families. Our challenge is to stress to families the need to interact on a mutually enjoyable basis more frequently so they can come to truly like and even love each other. When families resort to physical pain, fear, and ego-deflating name calling, the potential for true love, mutual respect and constructive influence is lost in the parent/child relationship. When it is not defined or incorrectly defined we see the parent/child relationship, the family, in trouble.

It is essential to realize children can respond to their parents' behavioral desire, only when they are physically mature enough to do so.

- **Early Childhood**

Early childhood is not a time for lengthy explanations. With a preschool child, a parent should be giving their child the maximum opportunity to experience freedom within a carefully thought out space.

Early school age children need some degree of firmness, which allows the child to explore cause and effect relationships so they may learn by consequences. These children require more explanation and accentuating of the positives.

- **Later Childhood**

From ages nine or ten up to age thirteen a parent can exert subtle discipline by helping their child stay busy, keeping them away from inappropriate company, and involving them in organizations and activities. Helping children structure their lives so that their free time is used constructively will reduce the chances of them getting into trouble. If problems do develop, it is of utmost importance to work closely with the school to head them off before they become more serious.

- **Adolescence**

It is at this time that an adolescent is establishing his/her own sense of personal identity. A parent must keep in mind their "child" is trying to be his/her own person. A parent who tries to "control" his/her child at this stage of development should be prepared for rebellion. A parent must always keep in mind the child is breaking away, and trying his wings.

Respecting this child's desire to be independent, but being always cognizant of the dependency will keep lines of communication open. Listening and gently guiding the adolescent into his "own" decisions will help keep the tantrums, harsh words and sullenness at a manageable level.

Many parents who report their adolescents as the "problem" in the family have not provided a foundation upon which to build a trusting relationship based on respect and communication. The Children's Service Worker's job begins as referee. The worker starts by calming family fighting, then defines issues, and chooses a method to manage behavior. Parents need to know chronic or persistent misbehavior is a means of communicating unfulfilled and unrecognized needs.

Types of Discipline Models

This section will attempt to briefly describe some of the popular discipline programs used and taught by various professionals. The purpose of this section is to familiarize the Children's Service Worker with the existence of these programs and not to teach each program.

Foster Cline

Foster W. Cline, M.D., is a noted child psychiatrist who is director of Evergreen Consultant in Human Behavior in Evergreen, Colorado. Dr. Cline has three basic rules on discipline:

1. Avoid control battles if possible;
2. If a control battle cannot be avoided, win it if possible; and
3. If a control battle cannot be avoided, make sure you pick the right issue.

Dr. Cline teaches two fundamental issues to be handled correctly if children are going to learn to react responsibly. One, he states parents must divide all problems into two groups: 1) those that impact on the child; and 2) those that impact on the parent.

Secondly, parents must separate their own emotional needs from the needs of their children. This is called the "Whose Problem" problem.

Dr. Cline is an advocate of letting consequences follow their natural course. He thinks consequences should be enforceable, fit the "crime," and be laid down firmly and with love.

Dr. Cline has developed a "Good Neighbor Policy" in dealing with children. He says, "if parents want their children to grow up to be good neighbors, they must treat their children like good neighbors."

Dr. Cline is adamant that parents must love themselves in order to teach/model healthy self-esteem for their children. He goes on to say:

- Worried parents raise worrisome kids; insecure parents raise insecure kids.
- Authoritarian parents raise stubborn kids; helpless parents raise children who take advantage of them.
- Watchful parents raise kids who won't look.

Dr. Cline sums up what is essential to insure children have a solid foundation:

- Be aware of the importance of infancy.
- Give a child lots of cuddles, touch, stimulation and smiles.
- Make sure the child is well nourished, not fat.
- Throughout infancy and the toddler phase say "no" as little as possible but mean business when you say it.
- Remember that you must first take good care of yourself around your child.

The above material was excerpted from Foster Cline's "Parent Education Text".

PET and STEP

Dr. Thomas Gordon, a licensed clinical psychologist, developed Parent Effectiveness Training (PET). The PET method shows parents the pitfalls of being strict or lenient. In PET parents learn an alternative, the "no-lose method", for resolving family conflicts. The results of PET are in forming close, warmer relationships, and punishment is not used. In PET parents learn the skill of nonevaluative listening (active listening) and honest communication of their feelings. Active listening helps children come up with their own solutions to problems. This method stresses the use of "I messages." This skill, when learned, guides parents to the effective management of conflict in their homes.

Don Dinkmeyer, Ph.D. and Gary McRay, Ph.D developed Systematic Training for Effective Parenting (STEP). This program begins with the premise it is designed to help parents relate more effectively to their children by using a training course.

The STEP manual introduction states that our society has changed from an autocratic attitude to a democratic attitude and toward social equality. Children have recently tended to believe they should have the rights and the parents should have the responsibility. This has caused conflicts between parent and child.

The STEP model starts first with training parents to understand their children's behaviors. Behavior can best be understood by observing the consequences. Parents are taught to train themselves to look at the results of misbehavior rather than just at the misbehavior. The manual tells parents the goals of misbehavior are attention, power, revenge, and display of inadequacy.

Parents are then taught active listening and natural consequence techniques to enable a more positive relationship. The STEP manual teaches mutual respect, taking time for fun, encouragement, communicating love, and building relationships.

This model is similar to PET, but some experts say STEP is more effective with younger children and pre-teens and PET is more effective with adolescents. STEP has a more "hands on" natural and logical consequences approach than PET, which is more effective with children than adolescents who are more capable of making their own decisions.

ABC Model And Behavior Modification Techniques

The ABC model is used in teaching Children's Division (CD) behavioral foster parents to deal with the foster child's behavior as an alternative to corporal punishment.

- **The A stands for antecedents.** What is going on just before the behavior occurs?

- **The B stands for the behavior.** The focus is on behavior which is observable.
- **The C stands for consequences.** The questions are asked: What was the reaction immediately following the behavior? How was the behavior reinforced?

After analyzing troublesome behaviors by using the ABC model, a plan is developed to modify the behaviors by using positive reinforcement and logical consequences.

Behavior modification is a program where expectations/goals are structured and directed. When dealing with children who have a history of anti-social behavior and where most forms of discipline have already been used, it is recommended to use behavior modification only in the positive approach, at least until the program is fully established.

In setting up a program a parent must identify and simplify the problems they desire most to work on. They should write them down and count the number of times the behavior takes place in a given time period. They should do this more than once. The parents should look at the list again; if an item on the list does not seem to be the problem a parent had thought it was, it can be crossed off. The parent should start with only one or two of the most major problems, or the problem that "bugs" them the most.

The parent should then design a chart. There will be such items as make bed, do dishes, pick up personal belongings, take bath. Other items will need to be converted from a negative to a positive. An example would be a child that throws temper tantrums. Instead of taking something away or punishing the child, a parent will give a positive stroke for not having a tantrum for a predetermined time period. It would be written on the chart as "no tantrum" or "no screaming or cussing." For an older child who has some control over his behavior, the time period would be longer (i.e., a whole day). For a younger child that is out of control, a shorter time is needed (i.e., a timer set for 15 minutes). Whatever time period is used, it should be based on the severity of the misbehavior. This is called the base line. A parent always works with a time period in which the child can have success. The time period can be lengthened periodically as the child continues to have success meeting his/her goal.

Motivation: Before starting a behavior modification program, a parent must decide what motivates the child. This is perhaps the most difficult part of setting up a program because the results will be in direct relationship to the child's desire for the rewards.

Sometimes it is good to look at why the child misbehaves. If the behavior is attention getting, then a good reward might be a special time period alone with mother, father, or whoever's attention the child wants. Rewards do not need to be candy or toys or cost a lot of money. If material items are used, it must be something the child really wants and will not likely get any other way. With young children immediate rewards that are small such as a stick of gum, stars on the chart, stickers, pennies, glass of fruit juice, or a hug are practical rewards.

For children who can wait a day or two for their reward, they may want to do things with a parent such as reading a story together, play a game, going for a walk, or baking cookies. Some other ideas are letting the child choose the supper menu, putting money in a jar, soda pop, popcorn, stickers, ice cream sundae.

For an older child, whose desire for material items is greater and who can wait longer for rewards, a written chart or list that shows a certain number of points buys certain rewards is another practical reward system. Low cost items on the list can be toys, going out to dinner, the ball game, to the park, C D's, tapes, books, overnight guest, roller skating, bowling or new clothes.

To review the steps in setting up a behavior modification program using a chart:

1. Isolate the most disruptive behavior;
2. Count the frequency of the misbehavior (baseline measurement);
3. Decide on the rewards - use child's input when possible;
4. Make a chart;
5. Explain the program to the child;
6. Do not nag, remind, punish - let the chart do the work - not the parent;
7. Follow through with the rewards - do not delay;
8. Be consistent - no excuses.

Time-out: Time-out involves placing your child on a chair for a short period of time following the occurrence of an unacceptable behavior. This procedure has been effective in reducing problem behaviors such as tantrums, hitting, biting, failure to follow directions, leaving the yard without permission, and others. Parents have found that time-out works better than spanking, yelling, or threatening their children. It is most appropriate for children from 18 months through 10 years.

Edward R. Christophertsen, Michael A. Rapoff, and Raoul Berman, University of Kansas Medical Center, Department of Pediatrics, 1977, provide these guidelines for using time-out as discipline.

Preparations:

1. You should purchase a small portable kitchen timer.
2. A place for time-out should be selected. This could be a chair in the hallway, kitchen, or corner of a room. It needs to be a dull place (**not** your child's bedroom) where your child cannot view the TV or play with toys. It should **NOT**

be a dark, scary, or dangerous place. The aim is to remove your child to a place where not much is happening, **not** to make your child afraid.

3. You should discuss with your spouse which behaviors will result in time-out. Consistency is very important.

Practicing:

1. Before using time-out for discipline, you should practice using it with your child at a pleasant time.

2. Tell your child there are two rules when in time-out:

Rule 1: The timer will start when he is quiet. Ask your child what would happen if he talks or makes noises when in time-out. Your child should say the timer will be reset or something similar. If he does not say this, remind him of the rule.

Rule 2: If he gets off the chair before the timer rings, you will return him to the chair and reset the timer. Ask your child if he wants to get off the chair and get additional minutes added to the time-out to learn this rule. Children generally decline this offer.

3. After explaining the rules and checking out your child's understanding of the rules, go through the steps under "Procedure." Tell your child you are "pretending" this time.
4. Mention to your child you will be using this technique instead of spanking, yelling, or threatening. Most kids are pleased to learn this.

Procedure:

Step 1: Following an inappropriate behavior, say to the child, "Oh, you (describe what the child did)." For example, "You hit your sister. Go to time-out please." Say this calmly and only once. It is important not to lose your temper or begin nagging. If your child has problems getting to the chair quickly, guide him with as little effort as needed. This can range from leading the child part way by the hand to carrying the child to the chair. If you have to carry your child to the chair, be sure to hold him facing away from you so he doesn't confuse a hug with a trip to time-out.

Step 2: When your child is on the chair and quiet, set the time for a specific number of minutes. The rule of thumb is one minute for each year of age up to five minutes. A two year old would have two minutes; a three year old, three minutes; and a five year old, five minutes. For children five years and above, five minutes is the maximum amount of time. If your child makes noises, screams, or cries, reset

the timer. Do this each time the child makes any noises. If your child gets off the chair before the time is up, replace the child on the chair, and reset the timer. Do this each time the child gets off the chair.

Step 3: After your child has been quiet and seated for the required amount of time, the timer will ring. Go to the time-out chair and ask your child if he would like to get up. Do not speak from across the room. A nod of the head or a positive or neutral answer is required. Answering in an angry tone of voice or refusing to answer is not acceptable. If your child is still mad, he will probably get into trouble again in a short period of time. Should your child answer in an angry tone or refuse to answer, reset the timer. Your child may then answer appropriately, but once the time is reset it must go to the full amount of time. You are the one who should decide when your child gets off the time-out chair, not your child.

Step 4: As soon as your child is off the time-out chair, you should ask if he wishes to repeat the behavior which led him there in the first place. For example, "Would you like to hit your sister again so I can put you in time-out and then you will learn the rule?" Generally, children say no or shake their head. You can then say, "I'm happy you don't want to hit your sister." If your child should take you up on this offer and repeat the unacceptable behavior, calmly place him in time-out. Although this may sound like you are daring your child to misbehave, it is better if he repeats the behavior in your presence. That way, your child will have several opportunities to learn that unacceptable behaviors result in time-out.

Step 5: After your child finishes a time-out period, he should start with a "clean slate." It is not necessary to discuss, remind, or nag about what the child did wrong. Within five minutes after time-out, look for and praise good behavior. It would be wise to take your child to a different part of the house and start him in a new activity. Remember, catch 'em being good.

Briefly, the following is a summary of time-out rules:

For Parents:

- Decide which behaviors you will use time-out for ahead of time. Discuss these with your child.
- Don't leave your child in time-out and forget about him.
- Don't nag, scold, or talk to your child when he is in time-out. **All family members should follow this rule!**
- Remain calm, particularly when your child is being testy.

For Children:

- Go immediately to time-out when you're asked to. Don't argue.
- Remain quiet and stay on the time-out chair until you're asked to get down. You'll spend less time that way.
- The timer is not to be touched by any child in the house. If you do touch it, you will be placed in time-out.

For Brothers and Sisters:

- If you tease, laugh at, or talk with your brother or sister while they are in time-out, you will be placed on the chair and your brother or sister will get down.

Things To Check When Time-Out Doesn't Work:

1. Be sure you are not warning your child one (or more) time before sending him/her to the time-out chair. Warnings only teach your child that he/she can misbehave at least once (or more) before you'll use time-out. Warnings only make things worse, not better.
2. All adults who are responsible for disciplining the child at home should be using the time-out chair. You should agree when and for what behaviors to send your child to time-out. (You will want new sitters, visiting friends, and relatives to read and discuss the time-out guidelines.)
3. In order to maximize the effectiveness of time-out, you must make the rest of the day ("time-in") pleasant for your child. Remember to let your child know when he/she is well behaved ("Catch 'em being good") rather than taking good behavior for granted. Most children would prefer to have you put them in time-out than ignore them completely.
4. Your child may say "Going to the chair doesn't bother me," or "I like time-out." Don't fall for this trick. Many children try to convince their parents that time-out is fun and, therefore, not working. You should notice over time that the problem behaviors for which you use time-out occur less often. (Time-out is not supposed to be a miserable experience.)
5. When you first begin using time-out, your child may act like time-out is a "game." He/She may put him/herself in time-out or ask to go to time-out. If this happens, give your child what he/she wants; that is, put him/her in time-out and require your child to sit quietly for the required amount of time. Your child will soon learn that time-out is not a game. Your child may also laugh or giggle when being placed in time-out or while in time-out. Although this may aggravate you, it is important for you to completely ignore your child when he/she is in time-out.

6. You may feel the need to punish your child for doing something inappropriate in the chair (i.e., cursing, spitting). However, it is very important to ignore your child when he/she behaves badly in time-out. This will teach your child that such "attention-getting" strategies will NOT work. If your child curses when out of the chair (and it bothers you), be sure to put the child in time-out.
7. TV, radio, or a nice view out the window can make time-out more tolerable and prolong the length of time your child must stay in the chair by encouraging him/her to talk. Try to minimize such distractions.
8. You must use time-out for major as well as minor behavior problems. Parents have a tendency to feel that time-out is not enough of a punishment for big things and thereby discipline inconsistently. Consistency is most important for time-out to work for big and small problems.
9. Be certain that your child is aware of the rules, that if broken, result in time-out. Frequently, parents will establish a new rule (i.e., "Don't touch the new stereo") without telling their children. When their children break the rule they don't understand why they are being put in time-out.
10. Review the time-out guidelines to make certain you are following the recommendations. If your child is getting off the chair frequently, be sure to place your child back on the chair and reset the timer.
11. When your child is in time-out:
 - Don't: Look at him/her;
Talk to him/her;
Talk about him/her;
Talk/act angry;
Stay in the room, if possible.
 - Do: Remain calm;
Follow the written guidelines;
Find something to do (read a magazine, watch TV, listen to the stereo, or phone someone) when your child is crying and talking loudly while in time-out.

Acknowledgments

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4: Developmental Milestone

Chapter 4 Overview

This chapter provides information on physical, mental and emotional growth and development in children and teenagers. The information will assist the Children's Service Worker and parent to know what to expect from a child as he matures. Child development information can help parents know when they are expecting too much, as well as become aware of lags in development that may need professional help.

Normal Stages Of Human Development (Birth To 5 Years)

PHYSICAL AND LANGUAGE	EMOTIONAL	SOCIAL
Birth to 1 month: Feedings: 5-8 per day Sleep: 20 hrs per day Sensory Capacities: Makes basic distinctions in vision, hearing, smelling, tasting, touch temperature, and perception of pain	Generalized Tension	Helplessness Asocial Fed by mother
2 to 3 months: Sensory Capacities: Color perception, visual exploration, & oral exploration. Sound: Cries, coos, grunts Motor Ability: Control of eye muscles, lifts head when on stomach	Delight Distress Smiles at a Face	Visually fixates at a face Smiles at a face May be soothed by rocking
4 to 6 months: Sensory Capacities: Localizes sounds Sounds: Babbling, makes most vowels and about half of the consonants Feedings: 3-5 per day Motor Ability: Control of head and arm movements, purposive grasping, and rolls over.	Enjoys being cuddled	Recognizes his mother Distinguishes between familiar persons and strangers No longer smiles indiscriminately Expects feeding, dressing and bathing

PHYSICAL AND LANGUAGE	EMOTIONAL	SOCIAL
7 to 9 months: Motor Ability: Control of trunk and hands, sits without support, crawls about.	Specific emotional attachment to mother Protests separation from mother	Enjoys "peek-a-boo"
10 to 12 months: Motor Ability: Control of legs and feet, stands, creeps, apposition of thumb & forefinger. Language: Says 1 or 2 words, imitates sounds, & responds to simple commands. Feedings: 3 meals, 2 snacks Sleep: 12 hrs, 2 naps	Anger Affection Fear of Strangers Curiosity, exploration	Responsive to own name Waves bye-bye Plays pat-a-cake Understands no-no Gives and takes objects
12 to 18 months: Motor Ability: Creeps up stairs, walks (10 to 20 minutes), makes lines on paper with crayon	Dependent Behavior Very upset when separated from mother Fear of Bath	Obeys limited commands Repeats a few words Interested in his mirror image Feeds himself
18 months to 2 years: Motor Ability: Runs, kicks a ball, builds 6-cube tower (2 years), capable of bowel and bladder control. Language: Vocabulary of more than 200 words. Sleep: 12 hours a night, 1 2-hour nap	Temper tantrums (1–3 years) Resentment of new baby	Does opposite of what he is told (18 months)

PHYSICAL AND LANGUAGE	EMOTIONAL	SOCIAL
<p>2 to 3 years: Motor Ability: Jumps off a step, rides a tricycle, uses crayons, builds a 9-10 cube tower. Language: Starts to use short sentences, controls and explores world with language, stuttering may appear briefly.</p>	<p>Fear of separation Negativistic (2 years) Violent emotions Anger Differentiates facial expressions of anger, sorrow, and joy Sense of humor (plays tricks)</p>	<p>Talks, uses 'I' 'you' 'me' Copies parents' actions Dependent, clinging Possessive about toys Enjoys playing alongside other child Negativism Resists parental demands Gives orders Rigid insistence on sameness of routine Inability to make decisions</p>
<p>3 to 4 years: Motor Ability: Stands on one leg, jumps up and down, draws a circle and a cross (4 years) Self-sufficient in many routines of home life</p>	<p>Affectionate toward parents Pleasure in genital manipulation Romantic attachment to parent of opposite sex Jealousy of parent of same sex Imaginary fears of dark, injury, etc.</p>	<p>Likes to share, uses "we" Cooperative play with other children, nursery school Imitates parents Beginning of identification with same sex parent, practices sex role activities Intense curiosity and interest in other children's bodies Imaginary friends</p>
<p>4 to 5 years: Motor Ability: Mature motor control, skips, broad jumps, dresses self, copies a square and a triangle. Language: Talks clearly, mastered basic grammar, relates a story, knows over 2,000 words by age 5</p>	<p>Responsibility and guilt Feels pride in accomplishment</p>	<p>Prefers to play with other children Becomes competitive Prefers sex-appropriate activities</p>

General Developmental Sequence

Toddler Through Preschool

This information presents typical activities and achievements for children from two to five years of age. It is important to keep in mind that the time frames presented are averages and some children may achieve various developmental milestones earlier or later than the average but still be within the normal range. This information is presented to help parents understand what to expect from their child.

Age 2

Physical Development - Walks well, goes up and down steps alone, runs, seats self on chair, becoming independent in toileting, uses spoon and fork, imitates circular stroke, turns pages singly, kicks ball, attempts to dress self, builds tower of six cubes.

Emotional Development - Very self-centered, just beginning a sense of personal identity and belongings, possessive, often negative, often frustrated, no ability to choose between alternatives, enjoys physical affection, resistive to change, becoming independent, more responsive to humor and distraction than discipline or reason.

Social Development - Solitary play, dependent on adult guidance, plays with dolls, refers to self by name, socially very immature, little concept of others as "people." May respond to simple direction.

Intellectual Development - Says words, phrases and simple sentences, 272 words, understands simple directions, identifies simple pictures, likes to look at books, short attention span, avoids simple hazards, can do simple form board.

Age 3

Physical Development - Runs well, marches, stands on one foot briefly, rides tricycle, imitates cross, feeds self well, puts on shoes and stockings, unbuttons and buttons, build tower of 10 cubes. Pours from pitcher.

Emotional Development - Likes to conform, easygoing attitude, not so resistive to change, more secure, greater sense of personal identity, beginning to be adventuresome, enjoys music.

Social Development - Parallel play, enjoys being by others, takes turns, knows if he is a boy or girl, enjoys brief group activities requiring no skill, likes to "help" in small ways-responds to verbal guidance.

Intellectual Development - Says short sentences, 896 words, great growth in communication, tells simple stories, uses words as tools of thought, wants to understand environment, answers questions, imaginative, may recite few nursery rhymes.

Age 4

Physical Development - Skips on one foot, draws "man," cuts with scissors (not well), can wash and dry face, dress self except ties, standing broad jump, throws ball overhand, high motor drive.

Emotional Development - Seems sure of himself, out-of bounds behavior, often negative, may be defiant, seems to be testing himself out, and needs controlled freedom.

Social Development - Cooperative play, enjoys other children's company, highly social, may play loosely organized group games - tag, duck-duck-goose, talkative, versatile.

Intellectual Development - Uses complete sentences, 1540 words, asks endless questions, learning to generalize, highly imaginative, dramatic, can draw recognizable simple objects.

Age 5

Physical Development - Hops and skips, dresses without help, good balance and smoother muscle action, skates, rides wagon and scooter, prints simple letters, handedness established, ties shoes, girls small muscle development about one year ahead of boys.

Emotional Development - Self-assured, stable, well-adjusted, home-centered, likes to associate with mother, capable, of some self-criticism, enjoys responsibility. Likes to follow the rules.

Social Development - Highly cooperative play, has special "friends", highly organized, enjoys simple table games requiring turns and observing rules, "school," takes pride in their clothes and accomplishments, eager to carry out some responsibility.

Intellectual Development - 2,072 words, tells long tales, carries out direction well, reads own name, counts to 10, asks meaning of words, knows colors. Beginning to know difference between fact and fiction or lying, interested in environment, city, stores, etc.

Developmental Characteristics And Problems In Development For Older Children

Middle Childhood (6 TO 12)

- Rapid physical growth

- Increases in physical strength and motor skills
- Develops perception and memory (short-term, long-term, and sensory)
- Uses strategies to help in remembering
- Engages in problem solving (creative solutions)
- Becomes reflective
- Tells how he or she feels
- Understands how to form relationships
- Learns that shape does not determine quantity
- Learns and understands relative terms (darker, taller, smaller)
- Continues to develop sex typing
- May develop phobias
- Represses wrongdoing
- May experience tics if troubled
- May acquire obsessions and compulsive behaviors
- Conduct disorder problems may become more apparent
- Peers become primary socializers
- Learning problems or disabilities may become more pronounced
- Uses media in attempts to socialize (imitates dress and behaviors of favorite characters)

Adolescence (13 TO 18 YEARS)

- Onset of puberty and sexual maturation (testes and scrotum enlarge, uterus increasing size)
- Growth spurts
- Conforms to peer group
- Follows complex instructions (though may appear to be forgetful)
- Separates reality from possibilities
- Predicts ramification of actions
- Engages in more complex and abstract reasoning
- Criticizes parents, formulates own opinions and views
- Establishes independence from parents
- Dresses for peer approval
- Seeks sense of identity and self-worth
- Fears failure
- Develops moral principles

Stages Of Social-Emotional Development In Children And Teenagers

Erikson's Eight Stages Of Development

1. Learning Basic Trust Versus Basic Mistrust (Hope)

Chronologically, this is the period of infancy through the first one or two years of life. The child, well - handled, nurtured, and loved, develops trust and security and a basic optimism. Badly handled, he becomes insecure and mistrustful.

2. Learning Autonomy Versus Shame (Will)

The second psychosocial crisis, Erikson believes, occurs during early childhood, probably between about 18 months or 2 years and 3½ to 4 years of age. The "well parented" child emerges from this stage sure of himself, elated with his newfound control, and proud rather than ashamed. Autonomy is not, however, entirely synonymous with assured self-possession, initiative, and independence, but at least

for children in the early part of this psychosocial crisis, includes stormy self-will tantrums, stubbornness, and negativism. For example, one sees many two year olds resolutely folding their arms to prevent their mothers from holding their hands as they cross the street. Also, "the sound of NO rings through the house, or the grocery store.

3. Learning Initiative Versus Guilt (Purpose)

Erikson believes that this third psychosocial crisis occurs during what he calls the "play age," or the later preschool years (from about 3½ to, in the United States culture, entry into formal school). During it the healthily developing child learns to imagine; to broaden his skills through active play of all sorts, including fantasy; to cooperate with others; to lead, as well as to follow. Immobilized by guilt, he is fearful; hangs on the fringes of groups; continues to depend unduly on adults; and is restricted both in the development of play skills and in imagination.

4. Industry Versus Inferiority (Competence)

Erikson believes that the fourth psychosocial crisis is handled, for better or worse, during what he calls the "school age," presumably up to and possibly including some of junior high school. Here the child learns to master the more formal skills of life; relating with peers according to rules; progressing from free play to play that may be elaborately structured by rules and may demand formal teamwork, such as baseball; mastering social studies, reading, arithmetic. Homework is a necessity, and the need for self-discipline increases yearly. The child who, because of his successive and successful resolutions of earlier psychosocial crisis, is trusting, autonomous, and full of initiative will learn easily enough to be industrious; but the mistrusting child will doubt the future; the shame and guilt-filled child will experience defeat and inferiority.

5. Learning Identity Versus Identity Diffusion (Fidelity)

During the fifth psychosocial crisis (adolescence, from about 13 or 14 to about 20) the child, now an adolescent, learns how to answer satisfactorily and happily the question of "Who am I?" But even the best adjusted of adolescents experiences some role identity diffusion: most boys and probably most girl's experiment with minor delinquency; rebellion flourishes; self doubts flood the youngster, and so on.

Erikson believes that during successful early adolescence, mature time perspective is developed; the young person acquires self-certainty as opposed to self-consciousness and self-doubt. He comes to experiment with different - usually constructive - roles rather than adopting a "negative identity" (such as delinquency). He actually anticipates achievement, and achieves, rather than being "paralyzed" by feelings of inferiority or by an inadequate time perspective. In later adolescence, clear sexual identity - manhood or womanhood – is established. The adolescent

seeks leadership (someone to inspire him), and gradually develops a set of ideals (socially congruent and desirable, in the case of the successful adolescent). Erikson believes that, in our culture, adolescence affords a "psychosocial moratorium," particularly for middle and upper-class American children. They do not yet have to "play for keeps," but can experiment, trying various roles, and thus hopefully find the one most suitable for them.

6. Learning Intimacy Versus Isolation (Love)

The successful young adult, for the first time, can experience true intimacy, the sort of intimacy that makes possible good marriage or a genuine and enduring friendship.

7. Learning Generativity Versus Self-Absorption (Care)

In adulthood, the psychosocial crisis demands generatively, both in the sense of marriage and parenthood, and in the sense of working productively and creatively.

8. Integrity Versus Despair (Wisdom)

If the other seven psychosocial crisis have been successfully resolved, the mature adult develops the peak of adjustment; integrity. He trusts, he is independent and dares the new. He works hard, has found a well-defined role in life, and has developed a self-concept with which he is happy. He can be intimate without strain, guilt, regret, or lack of realism; and he is proud of what he creates - his children, his work, or his hobbies. If one or more of the earlier psychosocial crises have not been resolved, he may view himself and his life with disgust and despair.

These eight stages of man, or the psychosocial crises, are plausible and insightful descriptions of how personality develops but at present they are descriptions only. We possess at best rudimentary and tentative knowledge of just what sort of environment will result, for example, in traits of trust versus distrust, or clear personal identity versus diffusion. Helping the child through the various stages and the positive learning that should accompany them is a complex and difficult task, as any worried parent or teacher knows. Search for the best ways of accomplishing this task accounts for much of the research in the field of child development.

Socialization, then is a learning - teaching process that, when successful, results in the human organism's moving from its infant state of helpless but total egocentricity to its ideal adult state of sensible conformity coupled with independent creativity.

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5: Taking Care Of Baby

Chapter 5 Overview

In many areas young parents go home from the hospital with a newborn and little or no knowledge of practical infant care, such as bathing, feeding, etc. There are few resources for these young parents to turn to for help. Many do not know how to access those resources that are available. Children's Service Workers are called on in some cases to provide this information. This section is a brief guide on infant care.

The county health nurse is a valuable resource to consult for further information on infant care.

Prenatal Care

Regular prenatal care is of primary importance to assure a healthy birth. During pregnancy a woman should consult a physician immediately when she suspects she is pregnant. She should not smoke or use alcohol and/or other drugs. Any medication taken (prescription or over-the-counter) should be under the direction of the woman's physician.

Holding Baby

An infant's neck muscles are quite weak. Therefore, when holding an infant, a parent should remember to support the back and head with his/her arm and hand. The baby is usually unable to hold his or her head erect until about the third month of life. Handle the infant carefully, but try not to inhibit natural movement of arms or legs. **Never shake the baby.**

Sleep

Most newborns will sleep more than they are awake (as much as 18 to 22 hours a day). Babies who are receiving enough to eat and who do not have any problems digesting their food will more likely sleep between feedings, with only brief periods of wakefulness. Some infants, on the other hand, are awake for longer periods of time with no apparent problems. In either case, it is probably best to allow the child to determine the amount of sleep wanted and needed.

To establish some sort of routine, it may be helpful to put the child to sleep after each feeding. To prevent breathing vomitus, babies should sleep on their side after feedings in case of spit up or vomiting during sleep. Allowing a baby to sleep on their stomach had been found to increase the chance of SIDS (Sudden Infant Death Syndrome) and should be avoided. The baby's periods of wakefulness will usually occur around the same time each day, often in the late afternoon. By the end of the first year, most babies have learned to sleep through the night, although they remain early risers and take two naps per day. During the following year, they usually give up one of these daytime naps.

Most babies seem to be more comfortable on their stomachs if they are having gas pains; however, a parent should not leave a child unattended in this position due to the increased risk of SIDS. It is usually a good idea to change the baby's sleeping position from time to time to ensure the baby's comfort while preventing one side of the head from becoming flattened. A parent should check on the infant periodically as he/she sleeps, making sure that nothing interferes with breathing. Try not to disturb a sleeping child with bright lights or unnecessarily loud noises.

Exercise, Air And Sunlight

A baby should be encouraged to exercise his or her arms and legs freely. Parents will find that their baby may be particularly active during bathing and at changing time. Clothing and bed coverings should not be overly tight, so as not to restrict movement or provoke heat rash. Babies should play in large open floor space on their tummy and back to strengthen the neck, trunk, arms, and legs prior to crawling. The parent can provide a large blanket or soft rug for this purpose.

Between seven and ten months of age, the infant will begin to crawl. This is an important preliminary exercise that further strengthens back muscles while preparing for baby's first steps.

A baby will enjoy being taken outdoors. A parent should do so whenever they have the chance and the weather permits. Exposure to fresh air can be of great benefit to babies by improving their appetites and helping them adapt to temperature changes. Parents should try to spend part of each day outdoors with their child. Sunshine in moderate amounts is also healthful because it provides the baby with the essential vitamin D. Sunscreen should be applied and exposure to the sun should be gradual, since excessive amounts can cause sunburn. The baby's eyes should be shielded from direct sunlight. If the baby is exposed to the sun for any length of time, the head should be covered.

Bathing Baby

A parent may give their newborn his or her first daily sponge bath when a few days old. It is best to bathe a very young infant at a time when the baby is content; a hungry child may become overly upset during bathing. As the baby grows older and becomes more active, a parent may switch the bathtime to the late afternoon. **Never leave the baby alone in the bath.** Be sure the room in which the baby is bathed is warm and free from drafts. Hands and fingernails should be washed thoroughly before giving the baby a bath. A parent may want to have an extra towel on hand to keep themselves dry.

The following items should be ready:

- Basin of warm (not hot) water;
- Large bath towel;

- Soft washcloth;
- Mild baby soap;
- Baby shampoo (if desired);
- Sterile cotton balls or swabs;
- Baby lotion or oil;
- Clean diaper or clothing; and
- Large safety pins or diaper pins, if using cloth diapers.

Sponge Bath

A sponge bath may be preferable to tub bathing during the baby's first few weeks. This time allows for the healing of the baby's navel, which at birth may have the remains of the umbilical cord attached to it. Within the first few weeks following birth any remnant of the cord will wither and become detached. The navel will be raw and tender and should consequently be kept as dry as possible to encourage scab formation and healing. The parent can apply alcohol (with a cotton ball) onto the umbilical cord to help dry it up and promote healing. Complete healing usually takes a few weeks.

The sponge bath will also give the parent the confidence needed to handle and maneuver the baby comfortably and effectively. Place the infant on a table covered with a large towel or pad. **Never leave baby alone on a table or high surface.** Remove all clothing and diaper and cleanse the genital area carefully. If the baby boy is circumcised, his penis should be protected with petroleum jelly and a gauze bandage until the wound has completely healed (usually within a week or two).

Cover the baby with a large towel. Clean the nose and outer ears with dampened cotton balls or swabs, never inserting the tips farther than one can see. Wash the face with a soft cloth and clear water. Use separate washcloths for the face and bottom or wash the face first. Avoid using soap on a baby's face for the first three months. Wipe each eyelid with sterilized cotton, moving from the inside corner outwards. Clean the outside of the mouth thoroughly but avoid washing the inside. Pat the face dry.

With an arm under the baby's back and a hand supporting the head, a parent can wash the scalp using very mild soap and water or baby shampoo. Lather his or her head using gentle circular motions. The head should be held back to prevent soap and water from dripping down the face or into the eyes. Rinse the baby's scalp with clear water.

Tub Bath

Giving an infant a tub bath can be quite an adventure for a new parent. The doctor will advise a parent as to when they may begin tub bathing the child.

The bath can be given in a basin, tub, baby bath, or even the kitchen sink. Have available all the necessary articles that were required for a sponge bath. Fill the tub or basin with about three inches (8 cm) of warm water. Test its temperature using your elbow to make sure it is not too hot. A rubber mat or towel may be placed on the bottom of the tub to prevent the baby from slipping. **Never leave a child alone in the tub for any amount of time.**

At first, a parent may want to wash the baby's face and head as done during a sponge bath. Then lower the baby into the tub, supporting head and back with one arm and buttocks with the other. As a parent gains experience, or when the infant is old enough to sit up, it may be simpler to wash face and scalp while baby sits in the tub. Soap and rinse the front of the body thoroughly, all the while supporting the back firmly, then shifting baby's weight forward and providing support under the chin with one hand, a parent can wash and rinse baby's back. Pay special attention to the creases and folds of the skin.

When finished, lift the baby carefully onto a table, again supporting head and back with one hand and buttocks with the other. Dry the infant thoroughly and apply baby lotion to those parts of the body most subject to chafing and irritation, especially thighs and buttocks.

As the baby gets older, he/she may enjoy playful times at bath, such as gentle patting of water, bath toys, etc.

Diapering And Diapers

Diapers should be changed when wet or soiled to prevent skin rashes. You may find that changing a baby just before or after each feeding will probably be sufficient for comfort and prevention of diaper rash. Some babies have particularly sensitive skin and may require more frequent changes.

Place baby on a towel and remove the diaper. Using warm water, wash the genital area gently from front to back (especially important for girls, but also for boys around the foreskin or circumcised area), then pat dry with a towel. If the baby has had a bowel movement, fold the soiled portion of the diaper under and wipe the buttocks with cotton or toilet tissue. The baby's buttocks should then be washed with mild soap and water, rinsed and patted dry. A parent can apply lotion or oil to the area with cotton, being attentive to skin folds and creases.

Hold baby's ankles between the thumb and middle finger (with the index finger between the ankles), raise the hips and slide a clean, folded diaper underneath. Then pull the diaper between baby's legs and pin it (or tape as in the case of disposable diapers) on each side. Use plastic pants on the outside of cotton diapers.

Dressing

Dressing a baby is not the easiest job in the world. Most infants, when being changed, will attempt to roll over, twist around or put up some sort of struggle. It may be helpful to provide distraction with a favorite plaything while you dress baby, using this time as a play period. The parent may also place pictures in the dressing area for this purpose.

Body Temperature

A baby's body temperature varies with the time of day (lower in the early morning and higher in late afternoon) and with the amount of activity (higher after morning exercise). A healthy baby's rectal temperature may range between 99.5 degrees and 100.1 degrees F (37.5 degrees and 37.8 degrees C). A rectal temperature of over 100.1 degrees F (37.8 degrees C) is usually abnormal and should be reported to the doctor. Whenever a baby is extraordinarily restless or fretful, it may be an indication of illness and a parent may want to take baby's temperature.

Rectal temperature is an accurate measure of the baby's body temperature. The thermometer should always be shaken down before use so that the mercury reads well below the "normal" point. For easier insertion, coat the bulb of the thermometer with petroleum jelly or cold cream.

Perhaps the most comfortable position for both parent and baby when taking rectal temperature is to hold the infant on his or her stomach across the parent's lap, allowing the legs to hang freely. This position permits easy access to the rectum, while making it more difficult for the baby to squirm or kick. Gently insert the bulb of the thermometer about an inch (2 to 3 cm) into the baby's rectum. Do not hold the top too stiffly, since any movement by the baby may cause some discomfort. It may be better to hold the thermometer between two fingers as the parent lays the palm of their hand across the child's buttocks. Don't leave the baby alone with the thermometer inserted.

It is preferable to keep the thermometer in for two to three minutes to be sure of an accurate reading. However, one minute is usually sufficient. The mercury will stay at the maximum level unless shaken down, so a parent may place the thermometer aside to diaper the baby and then read the temperature when the hands are free. The thermometer should be cleaned with rubbing alcohol.

Crying

During a baby's early months, crying is usually a sign of hunger, discomfort or fatigue. Once baby has fallen into a fairly regular feeding schedule, the parent will be better able to know why crying occurs at any given time. Cries of hunger usually occur just before feeding time. In such instances, feeding will quiet the baby.

Often, however, the baby may fret or cry between feeding for no apparent reason. If crying is limited to one particular period of the day (most often in the late afternoon), it

probably indicates fatigue. A tired baby who has been over stimulated during the day may find it impossible to fall asleep without first experiencing a period of fussing. However, when periods of crying are irregular and occur throughout the day or night, it may be a sign of colic. Usually holding baby on his or her stomach while the parent rubs the back gently can relieve the gas pains and discomfort associated with colic.

No matter what the cause, no child should be left to cry unattended for long periods of time. Crying is the only way a small infant has of communicating that something is wrong. A crying baby is in discomfort. The answer may be as simple as changing a wet or soiled diaper or finding a safety pin that has been pricking the skin. A young infant needs a parent's love and attention. Holding a crying child provides a sense of warmth and physical closeness. Crying infants also tend to be calmed by gentle rocking motion, rhythmic sounds such as the parent's heartbeat or singing, and closer wrapping of their bedclothes. If all the parent's efforts to soothe the baby fail, crying may be a sign of illness. Take baby's temperature, and if fever is present, call the doctor. **Never shake a child.**

Weight

There is no "normal" or fixed rate at which a baby should gain weight. Weight gain varies considerably from infant to infant. Most babies regulate their weight gain by eating only what they want and no more. In this way, each child will grow at a pace that he or she chooses.

To keep track of growth, a parent may want to weigh baby each week. A healthy baby will usually gain four to seven ounces (100 to 200 grams) each week, with some fluctuation to be expected. By the fifth month, most babies will have doubled their birth weight. After this time, however, growth begins to slow. A parent may also wish to measure baby's length about once a month. Significant weight loss, along with any feeding problems, should be reported to the doctor.

Teething

A parent may notice the appearance of their child's first tooth (usually a lower front incisor) at about six months of age. However, it is quite normal for children to begin teething as early as three or four months or as late as one year. A child will experience some discomfort when teething and consequently may be cranky or restless. He or she may also have difficulty sleeping through the night or experience a temporary loss of appetite. A rubber teething ring or other suitable object to chew on may help to relieve sore gums. Parents should not assume that fever or diarrhea are merely a result of teething. Any unusual symptoms should always be reported promptly to the doctor.

Feeding Baby

Breast-feeding is the most natural way of feeding baby, and many women find it simpler and far more satisfying than bottle feeding. However, it must be learned by doing, a book or printed page can help in only few ways.

- Should a mother breast-feed? Yes, if she thinks it will be comfortable and convenient for her. No, if she has any strong objections to the idea. Modern infant formulas and bottle-feeding are convenient and safe as a substitute for breast-feeding. Human milk is probably a little better; especially if members of the family have been allergic to cow's milk. Otherwise there is really no strong medical, psychological or economic reason for choosing either breast-feeding or bottle feeding, so the choice can be made according to the mother's own preferences.
- A mother should find someone experienced and sympathetic to teach her about breast-feeding. Other mothers who have breast-fed their babies and enjoyed it can give excellent help. In some communities such mothers have organized into groups to help new mothers with breast-feeding. The hospital or public health nurse, the doctor, or other mothers may know of such groups.
- Mothers should not blame themselves, or let others blame their milk, for all the ups and downs of the breast-fed infant. Babies fuss, spit up, cry, and have unusual bowel movements no matter how they are fed.
- How often to feed: Feed the baby when he/she seems hungry. Most babies will pass into a pattern of six or seven feedings about three to five hours apart. If the baby is more irregular than this, a mother can get him on a more regular schedule by waking him a little early or by letting him be hungry a little longer. It is easier and better to get a regular schedule by working from the baby's own schedule than by just deciding he will be fed at certain times whether he is hungry or not.

After the first several weeks, most babies will begin to sleep through one of their feedings. Most parents prefer the baby to skip the night feeding rather than a daytime feeding. If baby chooses to give up the wrong feeding, wake him/her and feed at the usual time so that he/she will, hopefully, give up one of the night feedings.

- How Much to Feed: If breast-feeding, a mother does not have to worry about how much to feed, baby decides. Most mothers who are breast-feeding worry at some time about whether they have enough milk. Actually, too little milk is extremely rare. The best reassurance is the baby's normal activity and growth. Another way for mothers to reassure themselves is to offer baby a bottle of formula just after he/she has finished nursing. If baby is still hungry, he/she will take several ounces and take them in a hurry. If baby doesn't, the mother can be sure that her milk is satisfying baby.

Most babies, after the first few days, take two to three ounces of milk per day for each pound of body weight. Most babies want to have six or seven feedings per day. For a seven pound baby, this would mean 14 to 21 ounces of formula a day, or two and one-half to three and one-half ounces in each of six or seven feedings. A parent might begin by offering three ounces in each bottle. When baby begins to empty the bottle completely at two or three feedings each day, add one-half ounce to the bottle at each feeding. Stay a little ahead of baby and let baby decide how fast he wants to increase the intake of formula. If baby takes much more or less than two to three ounces per pound, per day, discuss the baby's feeding with a nurse or doctor. There is no need to worry about how much he/she has taken at a single feeding; most babies will have times when they are not hungry and other times when they take more than expected.

Spitting Up

Most babies spit up some of their milk after many of their feedings. The milk seems to overflow from the baby's mouth. It is often curdled from the normal action of the stomach. The problem is more of worry and messiness than of health. Babies who spit up a great deal grow as fast and as strong as those who do not.

There are several tricks to reduce the amount of spitting up. But none of them works all the time and most babies will continue some spitting up even when all the tricks are used.

- Burp the baby carefully mid-way through the feeding. At the end of the feeding, and a few minutes after the feeding.
- Prop the baby in an infant seat or cradle with the head a few inches above the stomach for 10 or 15 minutes after each feeding.
- Try feeding a cold formula directly from the refrigerator.

Immunizations And Health Checkups

Refer to Reference Section 7 Chapter 6 - Nutrition, Health, and Development, of this manual, for a guide to infant immunizations and a schedule for health checkups.

Protecting Baby

Birth To Six Months

The baby needs full-time protection. Accidents tend to occur more often as the ability to roll over, crawl, and grasp increases with age.

- **Burns:** Check the bath water with the elbow to prevent scalding. Do not drink hot liquids with baby in the lap, and keep them out of reach.

- **Falls:** The baby's bed and playpen are the only safe places for the baby to be alone. Be certain that the spaces between the crib bars are 2-3/8" or less and the crib sides are secure. Mesh playpens are safer. Never leave baby unattended on a changing table. Use safety strap. Have diaper in hand before changing the baby.
- **Toys:** Toys should be too large to swallow, too tough to break, and should have no sharp points or edges. Rounded toys of smooth wood or plastic are safe.
- **Small and Sharp Objects:** Keep pins, buttons, beads, and other small or sharp objects out of the baby's reach. Use diaper safety pins with plastic shields.
- **Smothering:** Plastic bags, long toy telephone cords, harnesses, looped cords on blinds or curtains, and soft pillows can smother or strangle. Do not use cribs and gates that would allow the baby to put his/her head through the "bars." A good test for this is to pass a can of soda through the bars. If the can goes through, the bars are too far apart. Remove crib gyms and bumpers when baby can get up on his/her knees to prevent strangulation and entrapment. A firm crib mattress and a loose warm covering for a sleeping baby are the safest. Keep crib and playpen away from venetian blind cords. Do not let baby chew or suck on a balloon.
- **Auto Travel:** Safe restraint in the family car is a must. Use an approved infant carrier according to the manufacturer's instructions. Do not hold baby on parent's lap in the front seat.

Seven To Twelve Months

Babies now crawl, sit, stand, and may begin to walk. They put everything in their mouths. Babies need protection so they can explore in a safe environment.

- **Drowning: Don't leave the baby alone in the bath for any reason.** It takes only seconds for an infant to risk drowning.
- **Toys:** Toys should be washable, unbreakable, and too large to swallow, and have no points or sharp edges.
- **The Kitchen - A High Risk Area:** Hot liquids, hot foods, electric cords on irons, toasters and coffeepots should be kept out of reach. Avoid using tablecloths, which can be pulled down. Keep bleach, cleaning, and polishing agents on a high shelf.
- **Poisons:** Medicines and poisons should be kept out of sight and out of reach. Do not store lye products in the house. Keep all hazardous products in their original containers. Use child-safe packaging for all medications. Keep a one-ounce bottle of Syrup of Ipecac in the medicine cabinet for use in an emergency.

- **Strangulation and Suffocation:** Do not put necklaces or pacifier cords around the baby's neck. Do not place the baby's crib near looped curtain or blind cords. Do not allow the baby to play with small objects, which can be swallowed. Do not give the baby large pieces of food which may cause strangulation or suffocation.
- **Falls:** Use gates for stairways, but be careful with folding gates as the baby's neck can get caught in the "v," causing strangulation. Lower the crib mattress as the infant begins to sit or stand. Remove crib gyms and substitute with stuffed animals and smaller toys.
- **Burns:** Place guards in front of open heaters and fireplaces, around steam radiators, hot air registers, and floor furnaces. Buy only flame-retardant sleepwear. Check water temperature with the elbow. Water faucets should be turned off when the baby is in the bath. Temperature regulator on hot water heater should be set no higher than 120 degrees Fahrenheit. Take care to keep household items such as curling irons and steam vaporizers out of baby's reach.
- **Dangerous Objects:** Use safety plugs in wall sockets. Keep scissors, knives, and breakable objects out of reach. Remove sharp-edged furniture from the infant's play area.
- **Automobile Travel:** Use a child restraint system that has been proven safe with dynamic testing. Do not hold infants or children on the lap or allow them to ride in the car unrestrained. Child safety seats are usually meant to be installed in the rear seat. **Be sure to carefully read and follow all installation directions and directions for use of the child safety seat.**

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6: Nutrition, Health, and Development

Chapter 6 Overview

This chapter will explain briefly some health problems, which may be existent in the families we serve and also provide information on keeping children healthy.

Introduction

Deficiencies in the health of children are often associated with maltreatment. This may involve neglect of standard preventive health practices, activities that are potentially harmful to the health of the child, and neglect of treatment of disease conditions.

There is a lot parents can do to keep their child healthy. A parent should provide well balanced meals, good hygiene, and opportunity for proper rest and exercise. A parent is also responsible for providing the opportunity for regular checkups, immunizations and recognizing signs of illness and special needs.

Children's Service Workers are not expected to diagnose health conditions. They should be aware of the signs of health problems so they can refer the children to proper health providers. To help workers be aware of certain health conditions in families, this section will explain briefly some health problems, which may be existent in the families we serve and also provide information on keeping children healthy.

Food Selection and Preparation

Proper nutrition is not only a function of the quantity of food available to the family but the types of foods served. Nutrition is relevant to the health of children and improper nutrition is associated with many social interaction and developmental problems. The Children's Service Worker should pay close attention to:

- The nutritional knowledge of the individual who prepares food for the family, including knowledge of basic food groups, foods supplying basic vitamins and minerals, harmful substances in excess such as salt and sugar;
- The actual food typically served in the family with special concern for patterns of foods that exclude sufficient protein and complex carbohydrates or substitute high sugar, salt and fat, "junk" foods for balanced meals;
- Dietary patterns lacking foods high in iron and calcium; this is especially important in children at high risk of lead poisoning since they are made more susceptible by iron and calcium deficiencies.
- The manner in which the food is prepared. Safe food handling practices can minimize the risk of food borne illnesses. The family may need to be taught the

importance of clean utensils and hands, proper storage, and other precautions to prevent salmonella food poisoning.

Familiarity with the amounts and types of foods consumed by the family will be a help in determining whether there are gross nutritional deficiencies in the family's diet. Such deficiencies may be a result of ignorance about purchasing and preparing foods.

More long-lasting deficiencies may result in malnutrition. In these cases the diet is seriously deficient on a regular basis and may be translated into visible health problems for the children. Signs will include stunted growth and anemia. Children with nutritional deficiencies may show other behavioral problems including: poor attention span, hyperactivity, lethargy, poor achievement in school, frequent illnesses, etc. Diagnoses of malnutrition should, of course, be left to qualified professionals.

A standard means for determining the adequacy of diet quickly is the 24-hour diet recall. Normally this should be done by someone properly trained, since the determination of the quantity of particular foods eaten can be critical. The Children's Service Worker can obtain some idea of the adequacy of the diet, however, by simply asking what was eaten at meals and at snacks and in roughly what quantity during the last 24 hours.

Good nutrition includes foods from the six basic food groups. The following information gives guidelines for each group, including number of servings, nutritional values and serving sizes. Keep in mind these are the recommended allowances for adults. Children will require lesser amounts.

- Bread, Cereal, Rice, and Pasta: 6-11 Servings

These foods provide complex carbohydrates, an important source of energy. They also provide B vitamins, minerals, and fiber. Starchy foods are not fattening if you don't add butter, cheese, or cream sauces. Select whole grain products to maximize fiber and other nutrients.

1 serving = 1 slice of bread; 1 ounce of ready-to-eat cereal; ½ cup cooked cereal, rice or pasta.

- Fruits: 2-3 Servings

Fruits are rich sources of vitamins, most notably vitamin C. They are low in fat and calories. Select fresh fruits and fruit juices, and frozen, canned, or dried fruits. Avoid fruit processed with heavy syrups and sugar-sweetened juices.

1 serving = 1 medium apple, banana, or orange (small for children); 1 melon wedge; ½ cup of chopped fruit or berries; ¾ cup fruit juice (one half cup for children).

- Vegetables: 3-5 Servings

Vegetables provide vitamins (especially A and C), are excellent sources of fiber, and are naturally low in fat. For maximum nutrients, select dark leafy greens,

deep yellow or orange vegetables, and starchy vegetables like potatoes and yams.

1 serving = 1 cup raw leafy greens; ½ cup other vegetables chopped; ¾ cup vegetable juice. Smaller portions for children.

- Meat, Poultry, Fish, Dry Beans, Eggs, and Nuts: 2-3 Servings

Animal foods are excellent sources of protein, iron, zinc, and B vitamins, as are beans, nuts, and seeds. Tofu (made from soybeans) and white beans also supply calcium. Some seeds, like almonds, are good sources of vitamin E. 1 serving = 2-3 ounces of cooked lean meat, poultry, or fish; 2 eggs; 1 cup cooked beans; ½ cup seeds and nuts. For children, 1 serving = 1 ounce.

- Milk, Yogurt, and Cheese: 2-4 Servings

Milk products are the richest sources of calcium. They also provide protein and vitamin B12. Choose low-fat varieties to keep calories, cholesterol, and saturated fat at a minimum.

1 serving = 1 cup of milk or yogurt, 1-1/2 ounces of cheese. Children should have 5 to 6 ½ cup servings, or 2½ - 3 cups per day.

- Fats, Oils, and Sweets: Use Sparingly

These foods provide calories, but little else nutritionally. Exceptions are vegetable oil, which is a rich source of vitamin E (1 tablespoon is all you need), and molasses, an excellent source of iron.

The WIC (Women, Infants, and Children) program provides nutrition education, food packages, and makes referrals to other health services as needed. Pregnant, postpartum and breastfeeding women, infants, and children under the age of five must meet two qualifying requirements: nutritional or medical risk and income guidelines. There are over 200 offices in Missouri, with at least one in each county. Any child who is eligible for MO HealthNet or Food Stamps should be referred to the WIC program for an assessment of nutritional need.

Nutritional Services

Services to assist families in obtaining and preparing nutritious meals may include:

- Education on the subject provided by the Children's Service Worker (or other resource) in the family's home. This may include teaching and role modeling good shopping practices and safe food preparation;
- Referral to the Family Support Division (FSD) for food stamp eligibility determination and to other community food resources, such as the Community Action Agencies and local food banks;

- Homemaker or parent-aide services if the problem is basically one of ignorance of nutrition and food preparation. Many Extension offices provide in-home education through the Food Nutrition Education Program (FNEP);
- Head Start, day care or day treatment can also be used as a means of obtaining at least one good meal for the child during the day;
- Home-based family-centered services if there are other problems present that endanger the child;
- Referral to the county health department for dietary assessment and education in counties where available;
- Referral to the WIC program for food and nutritional education.

Rest and Personal Hygiene

Good personal and home hygiene habits help fight disease-causing germs. Children should begin brushing their teeth by age 2 1/2 - 3 years and should begin regular dental checkups. Children should learn to keep their bodies clean on a regular basis and later learn to use deodorants. Homes should be clean to eliminate pests, which carry diseases. A regimen of cleaning the home, washing dirty dishes, doing laundry, should be established to provide for a healthy environment.

Parents should establish regular bed times for children. Naps are necessary for pre-school children. Children who do not get outside and play regularly are not getting the exercise they need to help build muscle and improve coordination.

Physician Visits or Well-Child Conferences

Children should receive regular medical check-ups. The Children's Service Worker should inquire whether the child has regular well-baby or well-child checkups by a physician or other health care provider (i.e., nurse, nurse practitioner, physician assistant, etc.).

Normally, a physician or other qualified health care provider should see infants every three to four months.

Children between the age of one and two should be seen at least twice. This frequency will be required for standard immunizations.

Children between the ages of two and six years of age should have a well-child check at least once per year.

Recommended **medical screening** during each of the following ages:

0-4 weeks (at birth)	3 years
2-3 months	4 years

4-5 months	5 years
6-8 months	6-7 years
9-11 months	8-9 years
12-14 months	10-11 years
15-17 months	12-13 years
18-23 months	14-15 years
2 years	16-21 years

In addition, Section 210.110, RSMo requires **all** children from birth to age 10 in the custody of the Children's Division receive a physical, developmental, and mental health screening every six months following the initial examination, as long as the child remains in care. Children, ten (10) years and older, who enter custody should have continued follow up as needed following the initial examination.

Dental Screenings: Twice each year, starting by age three.

Immunizations

Regular checkups provide an opportunity for the child to receive his/her immunization on schedule.

This section should be viewed in conjunction with the previous section on physician visits. It is not identical to well-child visits, however, since immunizations may be obtained in other ways.

A family history of immunizations may be difficult or impossible to obtain. It is important, however, since 15 to 20 percent of preschool children in Missouri in any one year have not obtained their full series of immunization shots. Lack of proper immunizations may be serious when occurring in conjunction with other forms of medical neglect.

Immunizations include vaccinations for polio, diphtheria-pertussis-tetanus (DPT), measles, rubella, mumps and influenza. Immunizations are available through local health departments. A chart of immunizations is included below, as a help to the Children's Service Worker.

A physician should set the schedule, but the following may be used as a guide:

Disease	Age for Immunization
Polio	2, 4, 18* months; booster ages 4-6
Measles Mumps Rubella (German Measles)	Usually given together: 15 months
Diphtheria Pertussis (Whooping Cough) Tetanus (Lockjaw)	Usually given together: 2, 4, 6, 18* months

Boosters:	
Pertussis	Between ages 4-6
Tetanus	Every 10 years throughout life
Diphtheria	Between 14-16
Hemophilus b Poly-saccharide Vaccine	24 months (can be given at 18-23 months for children in groups who are thought to be at risk of disease, i.e., day care center attendees)

* = The most current schedule published by the Centers for Disease Control recommends that the third Polio dose and the fourth DPT dose be given at age 15 months.

Services for Immunizations

Immunizations are available through many sources:

- Private physicians and clinics;
- Community health centers. (Such centers utilize a sliding scale fee for the medically indigent and accept MO HealthNet patients);
- The Child Health Screenings in local health departments;
- The state's high-risk infant follow-up program conducted through the local health departments; and
- The high-risk follow-up programs in St. Louis (Regional Maternal-Child Health Council) and in Kansas City.

Observed Symptoms of Health Problems in Children

This section is reserved for observed symptoms of health problems in children that might indicate dietary deficiencies, environmental poisons or diseases.

It is important to remember that the Children's Division (CD) Children's Service Worker is not expected to diagnose medical conditions, but to be aware of signs and symptoms that might indicate a medical problem.

The primary service for suspicion of any of the below (or other) serious medical conditions is referral to a competent medical specialist for further screening or diagnosis of the child. This may range from a county or private public health nurse to physicians available at public agencies or in private practice.

Qualified medical personnel should conduct diagnoses. Several sets of observable symptoms that the Children's Service Worker might be alerted to are presented.

Anemia

This is a blood disorder characterized by a lower than normal hemoglobin concentration or volume of red blood cells. Nutritional anemia is most common and is characterized by inadequate intake of certain nutrients-iron, folacin, vitamin B-12, protein, vitamin C, vitamin E and copper. Although the Children's Service Worker is not expected to diagnose anemia in children, certain signs may lead to suspicion of anemia.

Suspicion of anemia may arise from knowledge of the family's dietary practices. Diets missing vegetables and meats high in iron, for example, can lead to anemia. Symptoms or indicative signs of anemia include:

- Pallor;
- Weakness or fatigue;
- Irritability;
- Decreased attention span;
- Delayed motor development;
- Poor muscle tone;
- Inflammation of the mouth and/or tongue;
- Inability to swallow or difficulty in swallowing;
- Jaundice or beeturia (red urine).

The primary service for suspicion of anemia is a referral to a competent medical specialist for further screening or diagnosis of the child. Other referrals that can be made for cases of anemia include:

- Mothers and children who meet income eligibility criteria may be eligible for the Women, Infants and Children (WIC). This program is offered through the county health departments throughout the state. Anemia is one of the criteria for eligibility and is discovered through a medical examination prior to entry in the program;
- Homemaker or parent-aide services that include training on food purchasing, preparation, and efficiency for families where the basic problem is one of which foods to serve;
- A referral to the FSD for food stamp eligibility determination and a referral to other community food resources, such as the Community Action Agencies.

Infections

Another health indicator immediately observable by the Children's Service Worker is infections. As in the case of anemia, Children's Service Workers are not in a position to make diagnoses of medical conditions. Visible skin infections, however, may be indicative of a number of problems associated with child abuse and neglect, including

improper infant care, poor sanitation, improper nutrition, lack of proper clothing (i.e. diapers in infants), lack of proper laundry facilities, and so on. Signs of infections will include open sores that are untreated or show evidence of infection (red or with pus) and skin rashes.

Another area of possible infection that may have serious consequences is the ear. Ear infections will often be accompanied with complaints of earaches.

Lead Poisoning

The source of lead poisoning most likely to be related and most observable is peeling and chipping paint in housing more than 30 years old. This can be observed by the Children's Service Worker during a home visit. Other sources that are less observable and less easily related are industrial sites that emit lead, lead pipes in the home, contaminated household dust and soil around the house, and lead based gasoline. An observable source, that has come to light more recently, is fumes produced by old painted wood being burned in wood burning stoves. For some inner city poor, the only free source of wood for their stove may be lumber from old houses. The ashes that result may also be highly toxic.

Symptoms and signs of lead toxicity are:

- Fatigue;
- Pallor;
- Malaise;
- Loss of appetite;
- Irritability;
- Sleep disturbance;
- Sudden behavioral change;
- Developmental regression.

Low level lead poisoning has recently been shown to be correlated with hyperactivity in children.

Acute lead encephalopathy is characterized by these symptoms along with more extreme symptoms, including: coma, seizures, bizarre behavior, ataxia, apathy, lack of coordination, vomiting, alteration in the state of consciousness, and subtle loss of recently acquired skills. These symptoms, of course, constitute a medical emergency.

Only through a medical diagnosis can lead poisoning be clearly established. The problem is most acute for preschool children. The nutritional status of the child is significant in determining the risk of lead poisoning. Deficiencies in iron, calcium and phosphorous are directly correlated with increased blood lead levels.

The primary service for suspicion of lead poisoning is a referral to a competent medical specialist for further screening or diagnosis of the child. Other referrals that can be made for cases of suspected lead poisoning include:

- A large scale screening program exists in the city of St. Louis. Screening is also conducted in Springfield of the blood samples of children applying for WIC. Diagnostic services are available in the state and can be obtained through private physicians, through the state's child health conferences and through programs offered at the children's hospitals.
- In St. Louis City a publicly funded housing abatement program is utilized to assist in removing lead sources from homes where lead poisoning has been discovered. Elsewhere in Missouri such programs are not typically found. It is imperative, however, to remove the source of lead from children who have been diagnosed to suffer from lead poisoning. This may involve renovation of housing or moving.

Fetal Alcohol Syndrome

Fetal Alcohol Syndrome (FAS) is defined as birth defects or other abnormalities that may occur in some children whose mothers drank alcohol during pregnancy. Women are urged not to drink alcohol while they are trying to become pregnant and during pregnancy. These precautions will prevent FAS.

The following are the symptoms of FAS: (Many of these can be due to causes other than alcohol)

- Facial abnormalities:
 - Droopy eyelids;
 - Short eye slits;
 - Small, squinty, widely spaced or crossed eyes;
 - Upturned nose or nostrils;
 - Flat, wide nose bridge;
 - Narrow upper lip;
 - No groove between lip and nose;

- Flat mid-face;
- Small rounded chin and jaw in infancy;
- Large, malformed ears;
- Cleft lip or palate;
- Small size.
- Hand abnormalities:
 - Fingers or toes that are small, bent or joined;
 - Abnormal creases on palms.
- Brain damage
- Mental retardation
- Poor coordination
- Other abnormalities:
 - Hip dislocation;
 - Heart or kidney defects;
 - Minor genital abnormalities;
 - Club foot;
 - Excess hair during infancy;
 - Abnormal pigmentation.

Head Lice

Head lice are bloodsucking insects that are found on people's heads. They do not ordinarily live on any other creatures, and animal lice normally do not infest humans (However, do not automatically assume that this is not the case). The head louse is one of three kinds that live and feed on people, each having a preference for a certain part of the body. Head lice usually inhabit only the hairy surface of the scalp, preferring the nape of the neck and the area behind the ears.

These insect parasites are very small (one to two millimeters long about the size of a pinhead). They vary in color, depending on the coloration of the host.

They are usually darker on someone with black skin and hair than on someone with fair skin and light hair. They have hook-like claws and thumbs at the end of each of their six legs, with which they grasp the shaft of a hair.

Adult lice and lice in their immature form (nymphs) feed on human blood by stabbing an opening through the skin. They pour in saliva to prevent clotting; they can then continue to feed for a long time, if not disturbed.

Itching is the most common symptom of louse infestation. The bloodsucking and the injection of saliva cause it. Sometimes a secondary bacterial infection results from scratching.

Adult head lice are believed to have a life span of about one month. A female will deposit about three or four eggs per day during her lifetime, for a total of about 90. She attaches them firmly with a cement-like substance on a shaft of hair close to the scalp. The grayish-white, oval eggs called nits, hatch in about a week and emerge as nymphs. They are immediately able to crawl and mature in about eight or nine days.

A person examining someone for head lice can usually see the crawling forms and nits with the naked eye, but a hand magnifying glass and flashlight may be helpful. Like the adult forms, nits and nymphs are most commonly found at the nape of the neck or behind the ears. The nits are easiest to see. Inexperienced examiners sometimes confuse a globule of hair spray or a hair cast (a bit of loosened follicle encasing a hair shaft) with a nit. If a school child is being examined, the youngster may erroneously be kept home from school and treated unnecessarily.

Because of the cement-like substance the female uses to attach her eggs to the hair, empty egg cases can remain stuck for long periods of time, getting farther from the scalp as the hair grows. The old idea that empty egg cases can be removed with vinegar has proved false. The best way to get rid of them is to use a fine-tooth comb.

How Lice are Spread: Everybody, no matter how "nice and clean", is susceptible to infestation with head lice. All one has to do is to come in contact with someone who has them. Besides person-to-person contact, lice can be transmitted by inanimate objects, such as coats, caps, scarves, hair brushes, combs, towels, bedding, upholstered furniture or carpets. The length of a person's hair does not seem to be a factor in susceptibility or in spreading these parasites.

Treatment: Infested individuals and their personal articles (caps, combs, brushes, clothing, towels and bedding) should be treated. There are several shampoos on the market that will kill head lice. Some can be bought over the counter at the local drugstore; others require prescription. Treatment should be repeated in ten days to kill newly hatched lice.

Washable clothing and bed linens that have been in contact with the infested person should be machine washed with hot water and detergent and dried at high heat for at least 20 minutes to destroy nits as well as lice. Dry cleaning will also kill lice and eggs.

To disinfect combs and brushes, soak them for an hour in a quart of water with one and one-half tablespoons of Lysol. They can also be placed in hot water (150 degrees Fahrenheit) for five to ten minutes, if articles are made of materials that are not damaged by heat. Boiling is not necessary.

Other Health Problems

Symptoms of other health problems may include cold and flu-like symptoms that persist (coughing, diarrhea, etc.), tiredness and weakness not apparently related to nutrition.

Failure to thrive is a condition in infants and very young children characterized by inadequate growth that can result from medical conditions and also from incomplete or inappropriate nurturing.

Chronic Health Problems

The general welfare of the family can be severely affected by health problems and disabilities of family members. Besides the emotional strain, the problem may cause financial strain on the family. Also, needed health care may simply not be available in the area.

Chronic health problems and disabilities requiring hospitalization are more prevalent among lower income families. Children in poor families are at greater risk of disease and disability.

Chronic health problems include diseases or disabilities that continue for long periods of time. The types of problems to be considered here are those requiring special care, special equipment, or regular medical treatment. Also included are disabilities of the provider(s) in the family that preclude work.

In providing services to these families, the Children's Service Worker's first response should determine if all means of publicly and privately funded health care have been applied for and is being utilized, including MO HealthNet, Crippled Children's Services, and private programs oriented to various handicaps.

Respite care, if available for these special cases, should also be considered for cases of chronically ill or handicapped children.

Developmental Milestones to Age 5

Parents may obtain a developmental milestone chart from their child's physician and should observe their child to see if those milestones in development are achieved. Most children will achieve these milestones before the age shown for each group of items. If

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the child does not pass the milestones listed at each level, it may signal a developmental lag or problem. To adjust the checklist for premature birth, subtract the time of prematurely from the age of the child (up to age two).

If there is substantial deviation in development from the milestones and ages shown, the parent should consult the child's physician. Early attention to developmental delays can often prevent more serious problems as the child gets older.

Although every child develops at a different rate, Section 7 Chapter 4, provides a developmental milestone chart as a general guide.

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7: Separation And Loss

Chapter 7 Overview

Loss and separation are universal human experiences. The ways in which people respond to loss share common elements. The family Children's Service Worker must prepare the child, parent and placement provider to recognize the typical behavioral and emotional responses to loss and successfully resolve the grief associated with loss. This chapter will examine loss and separation issues.

Stages Of Grieving

Parents and children both exhibit similar reactions, feelings and behaviors as they pass through the stages of grief. Adults and children will both progress through five stages as they struggle with separation: shock, guilt/self-blame, anger, despair, and adjustment.

The following describes some of the feelings and behaviors of parents.

- **Shock:** When the loss of the child first becomes evident to the parents, they exhibit shock-like behaviors. Parents may cry, feel shaky and find it difficult to hear what others are saying to them. They cannot think of anything except the child who has been removed. Parents may feel as though they are experiencing a dream and are just waiting to wake up. Parents may carry out their daily activities in a state similar to sleep walking - without really knowing what they are doing. They wonder what the child is doing, whether the foster parents are taking good care of the child, and doing things in the way to which the child is accustomed. The parents may think they see or hear the child in the child's bedroom. They try to keep busy and not think, but the last glimpse of their child keeps coming back. The shock may last from a few days to a few weeks. Even though others may try to comfort the parents, they feel distant and "outside" the rest of the world. Shock affects cognitive abilities such as being able to sort out their problems so plans can be made and actions taken. Shock affects both long-term and short-term memory. Information given may not be received correctly or may be forgotten. Sometimes people forget entire conversations and can't remember what they said to whom or who provided them with information. Parents sometimes wonder how they will manage without their children. Stress-related illnesses are likely to occur.
- Another behavior characteristic of this stage is **bargaining**. Bargains may be made with self, God, or whatever power is seen as being in control of right and wrong in the universe. Bargains may be similar to the following: "I'll never take another drink again, if only my child comes home" or "Dear God, if my child comes back, I will never hit her again."

- **Guilt/Self-Blame:** Most parents of children in foster care feel guilty for not being able to care adequately for their offspring. Placement is visible evidence of their failure as parents. Guilt is often the way they deal with their feelings of embarrassment or shame - feelings that may cause parents to avoid people who know of their actions, such as caseworkers, foster parents or family members. Sometimes parents find it easier to avoid the child than to deal with the child's questions about why he or she is no longer with the parent.

Bargaining may continue in this stage. If the parents make some positive behavior changes but the child is not returned, they may move into the anger stage.

- **Anger:** Parents may feel angry at strangers, or if they are religious, they may feel angry toward God. If their child was placed involuntarily, the parents may be furious with the caseworker, agency, court, etc. They may also be angry at themselves. Some parents lose their appetites, others eat constantly. Some parents experience sleep disturbances. Other parents may increase their cigarette, alcohol or drug use. They may find themselves fearful over nothing and afraid of what others think of them. They will keep going over what happened and what they could have done to make it different.

Parents may also be angry with their children; they may feel the children were difficult on purpose. Parents may tell themselves they are glad the children are gone and that they never want them back. They may resent the children for making them experience all the pain they are feeling.

Many parents become frightened at the level of their anger and may avoid their child or the caseworker. Some parents are unable to progress beyond this stage because anger hurts less than the next step - despair. These are the parents we may label as "hostile," "resistant" or unmotivated". They are people for whom aggressive outreach and support are especially critical to help them move through the grief process.

- **Despair:** At this point parents may not care about anybody or anything. They feel worthless and may see no point in getting up in the morning. Their world may seem barren and silent, and the parent may feel empty and hollow. Some parents may become ill; others may become suicidal. Some parents may try to escape from the despair by moving to another city, taking on a new job, or going to bars, etc. There may be a pervasive feeling of hopelessness and the parents may give up efforts to maintain a relationship with the child. Some of the behaviors expressed in the anger stage may also be expressed in despair or depression. Eating and sleeping disorders are common. Self-medication by use of drugs or alcohol may occur.

- **Adjustment:** One day things seem better. Parents begin eating and sleeping normally. They miss their children, but they have a more realistic understanding about the need for foster care. At this point, parents become invested in visiting the child and in keeping appointments with the worker or therapist. They may begin to feel better about spending time with their child now than before the child entered care. In addition, parents now have energy to deal with their problems. Usually, this adjustment comes if the parents can believe that care is temporary or will enable them to make a good plan for the child's future.

Related Subject: Chapter 19, of this section, Parental Behavior/Ambivalent

Children typically go through the same five stages of grief, and there are specific behaviors which characterize each.

- **Shock:** Often there is a honeymoon period for the first few weeks the child is in care. At this time, children in care are on their best behavior. This "honeymoon" period may stem from a combination of denial and bargaining. Children may be thinking, "if I'm really good, they will let me go home." One common behavior at this stage is rhythmic plan, where children may skip rope, or bounce, kick or throw a ball against the wall continuously. Children at this stage are often compliant and cooperative.

During this period some frightening things may be happening to the child. There may be memory loss, both short-term and long-term. They may be fearful that they will forget their parents. It may be hard for them to recall an image of their parents' faces. Children may have difficulty remembering conversations that were important or the questions that were asked. Children may repeat the same question over and over. They may hold on to items from home as though they were life-saving objects. Occasionally, an item given to the child by the parents may become a very important transitional object that signifies security and an ongoing attachment to the parents. Children may be very uncomfortable if their possessions are moved or disturbed, partly because of the confusion this might cause, but also because such children need some area in their life where they can exert control.

Children in this stage may become enuretic or encopretic, and may also develop stress-related illnesses. They may be tired or listless. They may develop fevers and aches. Upper respiratory infections are very common.

Children may enter into bargains, often silent ones, with God or the powerful forces they see controlling their world. Bargains such as "If I am good today, I know my Mom will call tonight," or "if they only let me go home, I'll never say bad things about Mom or Dad again."

- **Guilt/Self-Blame:** Most children removed from their families believe that they did something wrong. Most abused and neglected children blame themselves for the maltreatment they suffer. They often believe that there is something inherently wrong with them. Removal from their family and placement in foster care is further confirmation of that belief. Such children may be very uncomfortable around their parents and other people who know "what they did." Sometimes they do things they know will result in discipline so they can be punished for being bad. They may continue their bargaining with thoughts such as "I'll be good and then Dad won't hit me again."
- **Anger:** This phase is characterized by anxiety, hostility, helplessness, and weeping. At this point the child does everything possible to return home. These children are angry at everything and everyone. What would not normally bother a child will bother them. Consequently, their behavior may be characterized by rebellion, constant demands and serious behavior problems that may take the form of kicking, biting, screaming, fighting, cursing and many other behaviors that would be considered "acting up" or "acting out." The child may think about running away or may actually run away. He or she may exhibit self-mutilation behaviors and suicidal ideations. Children may feel angry at their birth parents and may direct anger toward them. Some children may direct their anger at foster or adoptive parents because they are available and may be a safer target than the birth parent. It is also a way of testing whether the foster or adoptive parents really care for them.
- **Despair:** At this point children feel despair, pain, hopelessness and depression. These children continue to long for the lost parent(s). Some children may be sad or cry. Others may not appear sad or cry; however, they may demonstrate their behavior by apathy, restlessness, withdrawal and their behavior may regress to an earlier age. Children may not take good physical care of themselves and may neglect their personal appearance and hygiene. They may sleep a great deal or have difficulty sleeping. They may develop eating disorders such as bulimia or anorexia. Children may also have suicidal thoughts or develop a plan for suicide.
- **Adjustment:** The primary indicator of this phase is that the child seeks new relationships and is able to become emotionally invested in them. Children may appear content, more self-confident and happy. Their behaviors may be characterized by an eagerness to please, by cooperation and by striving to become independent. They may show more interest in their physical care and appearance. The child will become more spontaneous in actions and in expressing feelings. Children at this time can talk more freely about their parents and with less pain. Children at this point are more available to take part in the activities of the foster or adoptive family.

Helping The Child Develop Attachment And Resolve Losses

There are many things that can be done to help the child develop attachments and resolve losses. A few of these are listed below:

- View behaviors as opportunities to re-parent the child and meet the child's attachment needs. In one true-life example, a foster mother did not punish her child whenever he shoplifted items. Instead, she insisted he return each item to the store and explain to the manager what had happened. In time, the child's embarrassment outweighed his desire to gain negative attention through shoplifting, and he stopped. By making him feel accountable for his actions, his foster mother had helped him begin to develop a conscience and take personal responsibility for his life.
- Make a commitment to identify the behavior that signifies the child's greatest need and develop a plan to meet that need. For example, if your child is overly aggressive, starts fights or rejects or destroys things you value, this could signal low self-worth. Reinforcing the child's self-worth can help stop the negative behaviors.
- Identify one behavior and the corresponding need that can be met within two weeks so you and the child can experience success. For example, refusal to do homework may signal a child does not understand the subject and needs a tutor. By arranging tutoring, you help the child experience short-term success in completing homework assignments and long-term success in improved grades.
- Identify something each parent can do every day with the child for 15 minutes that will be pleasurable for the child and parent. This activity may be reading together, talking quietly about the day or watching television. The key is that it should be enjoyable for you and the child.
- Identify activities and behaviors that represent your family and include the child in those activities. For example, if each member of your family has a special place at the table or seat in the family room, then help the child entering your family to have his/her special place.
- Identify a special role and responsibility for the child in your family.
- Identify some of the child's strengths and think of ways to build on them.
- Help the child to have mementos and memories of all significant people in his/her life.
- Develop a life book with the child.
- Help children talk about their families.

- Help the children express feelings of loss or missing their families.
- Help the child normalize feelings of loss by saying things such as "I would be concerned if you weren't feeling angry about being away from your folks."
- Predict the next stage of the grieving process and some of the feelings the child might have in that stage.
- Identify non-harmful ways the child can express anger, frustration or sadness.
- Be willing to share some of your loss experiences with the child and the ways you resolved them.
- Help children remain connected to and have contact with significant people from their past.
- Affirm the child's worth and value.
- Identify familiar and pleasurable things for children from their past and help them in the new environment (things such as favorite smells, people, activities, foods, etc.
- Be able to allow the time needed for attachments and trust to develop and for recovery and healing to take place.

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8: Fetal Drug Addiction

Chapter 8 Overview

This chapter will explain briefly some health issues a fetus may experience as a result of drug exposure.

Why Is Prenatal Drug Exposure A Problem?

Because of their chemical dependency and lack of information about prenatal care, pregnant substance abusers are more likely than other women to have poor nutrition before and during the time they are pregnant. Many women also smoke cigarettes; the number one cause of poor birth outcome is smoking. Physical and sexual abuse of children with parents addicted to either alcohol or opiates is as high as 22% in one study of 200 families. If neglect was included, the incidence rose to 40%. Parents who must devote a major portion of their energy and financial resources to their habit have less left over for the child. Violence, disorganization and criminality in the family are more common. All of these factors compromise maternal health and place the developing fetus at risk.

Characteristics Of Chemically Involved Pregnant Women:

- Mid to late 20's;
- Low self-esteem;
- Poor self-concept;
- Limited family support;
- Long history of violent or unhealthy relationships;
- Likely to be victims of early sexual or physical abuse;
- Limited education;
- Frequently unemployed;
- No job skills;
- Problems maintaining adequate stable housing;
- Little prenatal care and/or health problems;
- Poor parenting skills;

- Background of dysfunction/chemically dependent families;
- Need for a wide range of services;
- Poly drug use; and
- Mental health problems.

Not all infants show the same effects from prenatal exposure to alcohol and other drugs. Effects depend upon the genetic factors, maternal health, access to health care, chemicals used, patterns of use, duration of use and health care received. The following characteristics have been observed in infants exposed prenatal:

- Intrauterine growth retardation;
- Prematurity;
- Low birth weight;
- Shorter than average height;
- Smaller head circumference;
- Genito-urinary malformations;
- Bone/skeletal defects;
- Missing fingers or toes;
- Cerebral infarctions;
- Apnea;
- Upper respiratory infections;
- Asthma, allergies;
- Tremors;
- Seizures;
- Fevers;

- Sweating;
- Tearing;
- Frequent yawning;
- Hypertonic;
- Hypotonic;
- Hyperactive or hypoactive reflexes;
- Visual difficulties;
- Sleep abnormalities;
- Eating difficulties;
- Easily over-stimulated;
- Difficulty in consoling or comforting;
- Lethargy; and
- Low score on Brazelton Neonatal Behavioral Assessment.

Withdrawal can continue for weeks or months, damaging parent-infant bonding, as well as the baby's cognitive and social development. Perhaps the saddest effect is the high incidence of second generation abuse, violence, and addiction when addicted parents raise children.

What Drugs Are Harmful To The Fetus?

The drugs with the most obvious effects are alcohol, cocaine, heroin, methadone, amphetamines, PCP, marijuana, and cigarettes. Cigarette smoking increases the effects of some of these drugs. Multiple drug abuse is the rule rather than the exception.

ALCOHOL is the major drug abused in the United States. Damage to the fetus can occur any time during pregnancy. No amount of alcohol is safe. One binge of six drinks can do damage, as can lesser amounts chronically induced. The damage is lessened if drinking stops by the second trimester. The fetal alcohol syndrome occurs in one out of one thousand births in the U.S.; fetal effects are seen in one out of one hundred births.

Fetal Alcohol Syndrome (FAS) consists of growth retardation in both pre and postnatal development (3rd percentile) which may never be reversed. This includes low birth weight, short length, and small head circumference. Postnatal failure to thrive is common. Congenital anomalies, such as an absent or indistinct philtrum, a thin upper lip, flattened nasal bridge, abnormally formed ears, small lower jaw, cleft palate, limited flexibility of joints, epicanthic folds and short, upturned noses may also be present. FAS includes irreparable damage to the central nervous system causing mental retardation in varying degrees, hyperactivity, and learning disabilities. Other conditions children with FAS may face include heart problems, eye anomalies, poor vision and hearing, depressed immune system, and speech problems.

Fetal Alcohol Effects (FAE) are those signs in the infant that have been linked to alcohol use during pregnancy by the mother, but do not meet the diagnosis criteria for FAS. Indicators include:

- Poor motor skills;
- Short attention span;
- Overall performance generally below normal for age;
- Easily distracted, constantly moving;
- Unable to learn in group setting;
- Vision and/or hearing problems;
- Immature social behaviors;
- Delayed speech; and
- Difficulty with syntax, grammar, articulation.

Cocaine may be used by as many as one in ten pregnant women. It causes spasm of blood vessels and a rise in blood pressure. There is an increase in placental abruption, premature labor, still births, and babies suffering strokes and bowel infarct in utero. Cocaine has been linked to birth defects including chromosome abnormalities, and kidney and genital deformities. In a few studies, babies were growth retarded.

Postnatal effects include withdrawal symptoms that last longer and have worse tremors, crying and irritability than do opiate-addicted infants.

At two years, babies show fine motor difficulties, and problems with sensory systems such as fear of quick movements, or difficulty controlling their movements. They may also have difficulty with speech and articulation.

Heroin/Methadone use has been seen to cause growth retardation unrelated to maternal diet or prenatal care in 50% of infants born to addicted mothers. In utero violent kicking can occur if the mother withdraws. Ten percent of infants have chromosome changes. Precipitous births, meconium staining and perinatal asphyxia are more common. The infant does best if the mother is maintained on methadone and the dose is slowly tapered to less than 20mg.

Classic withdrawal symptoms are seen in 71 to 90% of infants. The symptoms are worse and more prolonged for methadone than for heroin. Hyperventilation, respiratory distress, sneezing, sweating, nasal stuffiness, vomiting and diarrhea, and convulsions may also be present. Methadone babies may have more jaundice and convulsions; heroin less.

Heroin and methadone babies have a five-fold increased risk for Sudden Infant Death Syndrome. Their withdrawal may last for two to six months, interfering with bonding and learning. They may suffer speech and language delays. For the one to two year old child, there may be hyperactivity, brief attention span, and delayed cognitive/perceptual/fine motor skills. Effects on the advanced motor skills are not known.

Marijuana is used by an estimated 28% of adults between the ages of 18 and 25. Ten percent of those users are women. One study reports that infants born to mothers smoking five joints a day, showed decreased visual response to light, and more tremors, startles, and shrill cries. Chasnoff reports several infants whose mothers used marijuana showed hypotonia and severe developmental delay, but says urine tests showed some marijuana is contaminated with PCP.

PCP/Angel Dust is inexpensive and easy to manufacture. It was used as an anaesthetic in humans, but now is restricted to veterinary use because of severe personality changes and psychosis. There are reports of three infants with symptoms of withdrawal attributed to PCP: jitteriness, increased tone, vomiting, diarrhea, irritability, fine tremors, coarse flapping movements of the extremities, roving eye movements, nystagmus, poor visual fixation, hyperreflexia, and respiratory distress. These effects are the same as are seen in adult humans, older children and mice exposed to PCP. One infant had microcephaly, and another whose mother smoked five-six PCP laced marijuana cigarettes a day, had dysmorphic features. This infant had Cerebral Palsy at two months follow-up.

The addicted parent needs treatment and the addicted infant needs protection. Most addiction treatment personnel do not evaluate the care of children in the course of their work. Protective service workers, on the other hand, are usually unfamiliar with the treatment of addiction.

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Perhaps the most important goal for the immediate future is to integrate these two areas of knowledge, so that cooperative treatment programs can be developed.

There is a need for increased public awareness of effects of drugs on the unborn child, and for uniform protocol for evaluating and treating addicted infants.

Sources: This material was adapted from:
Jan Bays, MD, Emanuel Hospital, Portland, Oregon, 1986.
McCullough, DeWoody and Anderson ACT-2 Alcohol and Other Drugs: A Competency-based Training. Training for Caregivers of AOD-Exposed Infants. CWLA, 1993.

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9: Failure To Thrive

Chapter 9 Overview

This chapter will discuss the indicators that an infant or child may experience if he/she is suffering from failure to thrive.

Current Definitions

Failure to thrive is a non-diagnostic term for an infant or child who fails to gain in weight and/or length and/or head size and/or development.

Non-organic failure to thrive is a specified medical diagnostic term for an infant or child who has a documented lag of two standard deviations in weight, as well as one standard deviation in one of the following parameters: height, head size and/or development. The lag must be related to environmental disruption and must improve when the disruption is eliminated. By definition, there must be an absence of organic disorders to explain these deviations.

Criteria for non-organic failure to thrive include:

- Normal birth weight, then
- The child falls below the third percentile in weight, or
- The child falls below two standard deviations from previous normal weight.

Failure to thrive may be classified as organic, non-organic, or mixed organic and non-organic. A diagnosis of mixed failure to thrive would apply in cases where the child had a disease with secondary organic psychological reaction.

Other terms used synonymously for non-organic failure to thrive include:

- Maltreatment syndrome
- Failure to thrive
- Rumination syndrome
- Growth retardation with maternal deprivation
- Functional hypopituitarism
- Deprivational dwarfism, psychosociogenic dwarfism
- Emotional deprivation

- Environmental deprivation

Non-organic failure to thrive is an interactional disorder in which parental expectations, parental skills, and the resulting home environment are intertwined with the child's developmental capabilities. In some instances it is related to child abuse or neglect. It can be characterized by physical and developmental retardation associated with a disturbed parent-child relationship. These children are slow to develop and learn, are physically small, and have flattened emotional responses, even to pain.

Family Dynamics Frequently Associated With Failure To Thrive:

- Marital discord
- Serious illness in the family
- Alcoholism
- Childhood deprivation in parent(s)
- Child abuse or neglect
- High-risk pregnancy and delivery
- Inexperience in parenting or caregiving
- Inadequate income
- Job instability
- Chronic unemployment
- Unplanned or unwanted pregnancy
- Illegitimacy
- Disruptive family move late in pregnancy
- Frequent pregnancies at short intervals
- Too many children
- Child of unwanted gender
- Child's appearance distasteful to caregiver

- Caregiver inadequately parented as a child
- Poor self-esteem in caregiver
- Limited perception of other's needs by caregiver
- Depression
- Lack of social supports

Indicators In The Child:

- Physical appearance:
 - Emaciated;
 - Wasted appearance;
 - Head appears abnormally large;
 - Muscle wasting.
- Physical symptoms:
 - Infection;
 - Vomiting;
 - Diarrhea.
- Developmental deficiencies:
 - Weight and height below third percentile;
 - Delayed motor development.
- Behavior:
 - Shows little interest in eating;
 - Avoids eye contact;
 - Makes few sounds;
 - Is aloof and unresponsive to nurturing;
 - Stares into space;

- Rocks back and forth;
 - Bangs head;
 - Looks at hands/waves hands;
 - Is more interested in objects than people.
- Poor hygiene:
 - “Cradle cap” on head;
 - Thinning of hair resulting from laying too long in one position;
 - Irritated skin in diaper area.

Sleep Disorders In Non-Organic Failure To Thrive

Studies of failure to thrive children show they suffer from sleep deficiencies. They are often up at night, searching for food and water or roaming around the house. Some studies suggest poor sleep may be one of the factors causing growth retardation. The children may forage for food with constant vigilance required for self-preservation. Researchers believe the tactics used by the child to avoid abuse positively reinforces poor sleep. The children may feel they have to be constantly aware of their surroundings to be safe. In sleep, they cannot be safe. When the children are removed from the existing home environment, their poor sleep habits disappear.

Physical Findings

Children with non-organic failure to thrive have failure to gain or maintain weight in first 12 months (50% in first six months). They show an inadequate weight gain starting at birth. After the first year, their primary deficit is in the long bone growth. Also present is vasomotor instability, manifested by blue and cold hand and feet, small ulcers, and early gangrene.

Evaluation Components

In evaluating a child for failure to thrive, the following components should be considered:

- The child’s history, focusing on social, nutritional, developmental, and the prenatal care received;
- Physical examination, including complete heights and weights and neurological/psychological exam;

- Medical tests to rule out organic etiology. Organic causes of failure to thrive include:
 - Unusual syndromes, chromosomal abnormalities, and skeletal disorders;
 - Intrauterine growth retardation;
 - Central nervous system disorder as in a brain-damaged infant;
 - Familial short stature, slow maturation, or primordial dwarfism;
 - Chronic infection;
 - Chronic renal (kidney) failure;
 - Congenital heart disease;
 - Chronic pulmonary disease;
 - Chronic hepatic (liver) disease; and
 - Chronic gastrointestinal disease.
- Feeding trial (10 – 14 days) in the hospital:
 - Daily calorie counts;
 - Nursing observations of child's behavior.
- Observation of caregiver's interaction with the child:
 - Eye contact;
 - Physical contact;
 - Verbal communication;
 - Feeding behavior;
 - Bathing, diapering, dressing;
 - Playing;
 - Caregiver's response to child's crying.
- Observation of child's response to strangers.

Intervention:

- Test malnutrition, dehydration and other health problems immediately;
- Focus on finding relief for the child as well as the caregiver:
 - Support positive caregiving skills; provide positive feedback to the caregiver on the child's care; assume a non-accusatory posture;
 - Attempt to diminish high expectations placed on the child;
 - A "rest cure" may be needed – temporary foster care, or a low expectation environment.
- Conduct team evaluation of the child's development. Consult physician, nurse, mental health professional, and nutritionist.
- Continue with long-term follow-up.

Sources: This chapter was adapted, with permission, from: Center for Advance Studies on Human Services, Michigan Self Instructional Orientation to Children's Protective Services, Office of Children and Youth Services, Michigan Department of Social Services. 1981.

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Memoranda History:

10: Chronic Neglect & Accumulation of Harm

Chapter 10 Overview

This chapter provides recommended practice for providing services to children and families at risk of or experiencing chronic neglect and accumulation of harm.

Chronic Neglect, as defined by American Humane, is *an ongoing, serious pattern of deprivation of a child's basic physical, developmental, and/or emotional needs by a parent or caregiver resulting in **accumulation of harm** to the child.*

Chronic neglect cases, where families are repeatedly reported with minimal sustainable change resulting from multiple interventions, are very challenging for the traditional practice of a child protection agency. A holistic approach to chronic child neglect is best practice and each child in the home must be considered regardless of which child is listed as the "victim" child. What distinguishes chronic neglect from situational neglect or sporadic neglect is the ineffectiveness of working with chronic families in a typical, problem-solving way. A lack of protective capacities in these families is often an indicator of underlying, serious parental impairments such as substance abuse, mental illness, or low cognitive functioning. There are a significant number of families for whom this approach is effective, as all neglect is not chronic neglect. However, with chronically neglectful families, this approach is not sufficient.

The primary expected outcomes for implementation of chronic neglect policy are as follows:

- This policy will help staff to better identify, assess, and provide and/or refer the family to goal-oriented, long term, supportive services for chronic neglect.

Staff will be knowledgeable of the Framework for Safety Decision-Making model considering the safety threat in the home, protective capacities of the parents and child vulnerability when making a safety decision.

- Designated staff will be knowledgeable about the dynamics of chronic neglect and accumulation of harm, including safety factors, comprehensive assessments, development and monitoring of outcome oriented (specific and individualized) treatment plans, intervention decision making and coordination of intervention techniques.
- County office staff will utilize a multi-disciplinary team approach that will provide community support in an effort to prevent, reduce, and remedy chronic neglect.
- Staff will more effectively document the need for removal of the child due to accumulation of harm, if necessary. Staff will be able to determine when to terminate Division intervention by more comprehensively assessing and

documenting a family's ability to sustain, over time, necessary behavioral changes.

Accumulation Of Harm

. Accumulation of harm can have long term effect on the child's overall physical, mental, or emotional development. The concept of accumulation of harm is important in identifying and developing treatment strategies with families who are experiencing chronic neglect, as well as any other pattern of abuse/neglect. When assessing the immediate safety and future risk of a child's condition, Division staff must be aware of the heightened risk to children when caretakers show a repeated pattern of failing to meet the child's physical, medical, educational and emotional needs.

In most Child Protective systems the criteria for identifying neglect focuses on recent, distinct, verifiable incidents. This is also called "incident based" focus. Instead of focusing on individual incidents as they occur, one should look at an "accumulation of experience", or the cumulative effect on children of repeated incidents, when determining whether neglect exists.

Indicators Of Chronic Neglect

The Children's Service Worker should be aware of the presence of chronic neglect indicators, which **may** indicate that the child(ren) is affected by an accumulation of harm. The continuous or prolonged nature of these indicators will show the chronicity of neglect in a family. The indicators listed below should aid the worker in identifying accumulation of harm and child safety issues, as they relate to the occurrence of chronic neglect.

- Prior History of Child Abuse & Neglect Reports and/or Referrals
- Type of Maltreatment—neglect, more likely
- Age of Child—younger, more likely
- Number of Children in the Home—more children, more likely
- Family Income—lower, more likely
- Parental Substance Abuse or Untreated Mental Illness
- Child Vulnerability/disability

Suggested Strategies For Assessment And Service Delivery In Chronic Neglect

- Ensure family interventions have enough time to work by engaging the family at the earliest opportunity.
- Be vigilant about racial bias.
- Parental support systems, both formal and informal, should be assessed

- Consideration should be given to the family heritage of neglect. It is important to utilize the genogram, when assessing the accumulation of harm and patterns of behavior that may have been learned from the neglectful parent's family of origin
- The Children's Service Worker should consider the family's need for long-term support. Although the traditional family-centered model is built around the principle of short-term intervention, the treatment of chronic neglect most often requires long-term support. This does *not* mean that the Division must have open Family-Centered Services. A long-term community support plan may better serve a specific family's needs.
- Children's Service Workers should use the practice of empowerment and advocacy in working with families. This involves strengthening the family's own control and involvement in their lives and their communities.
- The team approach should be utilized. This approach will focus on assessment, treatment, and evaluation of family progress so that families receive comprehensive services.
-

Reassessment In Chronic Neglect

Reassessment will be an ongoing process due to the long-term nature and intensity involved in chronic neglect. During the assessment process, the multi-disciplinary team can serve to assist the Children's Service Worker in evaluation of the family's progress and by continuing to hold staffings after the initial team meeting.

Termination Of Family-Centered Services In Chronic Neglect

There are special considerations for termination of Family-Centered Services in chronic neglect. There should be a plan in place for continued support by a designated community resource or natural helper after the Division's services to the family have been terminated. In some cases, the caretakers may make behavioral changes in a short period of time that result in a safe environment for the child. *However, these behavioral changes must be shown to be sustained over time.* The multi-disciplinary team and direct supervisor will be key in assessing the family's ability to sustain behavioral changes.

Although the Children's Service Worker and family may agree that behaviorally specific goals have been met during the first treatment period, the worker should develop, with the team's input, a system of continued support for the family.

Contact with the family by individuals or agencies actively involved in supporting the family is recommended. Contacts by CD and other supports should be routine enough to identify as soon as possible any indication that the family may be regressing. As long as CD continues to be involved, the focus should not only be "monitoring" the family, but on an active program that includes ongoing assessment, education, role modeling, support, and empowerment for the family. Utilizing a team approach to decision making

for CD closure of services should result in the most effective method of identifying that the family has the ability to sustain necessary behavioral changes.

A plan of continued support for the family at termination of Family-Centered Services is crucial. Before closure of services, the Children's Service Worker must explore with the family the family's own system of "monitoring" themselves. It is necessary that the family can identify and determine for themselves when help may again be needed. Is the family able to identify the behaviors that led to neglect/abuse and recognize when they may be slipping back into these behaviors? The family should feel comfortable in asking for assistance from CD or other resources, if their situation begins to regress.

In situations involving children that have been identified as having developmental delays, insufficient growth rate, malnourishment, or other physical problems associated with neglect, staff should continually evaluate the child's growth, weight gain, and development. This growth must be documented by a medical professional who is following the child. A medical professional involved with the family and participating as a team member is of vital importance.

If the juvenile court is involved, the court will also be a key component in the evaluation of the family's behavioral increments of change and subsequent recommendation for termination of court jurisdiction and termination of Family-Centered Services.

Staff should consider and utilize in teamwork the following factors when assessing for termination of services:

- There has been a reduction in risk that has been sustained over time;
- There has been a significant improvement in parental behaviors that have been sustained over time;
- There is clear and documentable indication that bonding and attachment is occurring between the parent and child;
- There is at least one caretaker in the home that does not exhibit any sign of depression, drug/alcohol abuse, or other disability preventing proper care of the child(ren) and has a safety plan for the child in the event another caretaker who is experiencing these problems is in the home;
- The home is free of problems such as lack of utilities, structural damage, filth/debris, and safety hazards and these conditions have been alleviated and improvement is sustained over time; and
- The family can verbalize an awareness of the behaviors that led to neglect and can recognize in themselves when these behaviors are occurring and can demonstrate a willingness to ask for help, if needed.

When Out-Of-Home Care Is The Plan

While in-home services are the preferable intervention in child protective services, removal of children from their homes must remain a viable alternative for all forms of maltreatment, including chronic neglect. The criteria involved in the decision-making process for recommending a child be removed from his/her home will require intensive information gathering based on the aforementioned indicators of chronic neglect. A referral to Intensive In-Home Services should be considered when children are at imminent risk of removal.

Related Subject: Section 2, Chapter 4.1.7.1, Protective Custody

Criteria For Referral To Juvenile Court For Protective Custody In Chronic Neglect

Existing policy in regard to recommendation to the court for protective custody of children provides factors to consider in regard to decision-making.

Related Subject: Section 7, Chapter 13, Juvenile Court/Legal Information

These factors provide detailed, relevant, and useful guidelines for assisting in the judgment for removal of a child. In addition to these guidelines, when assessing the need for removal in cases of chronic neglect, staff should consider the following factors. Taken alone, each of these factors should not be grounds for removal of a child. However, staff should be aware that the presence of two or more of these factors, persisting without improvement, may have long-term impact on the family, resulting in a need for placement of the children out of their home. Staff should also take into consideration what reasonable efforts have been accomplished in order to alleviate these factors and whether all resources, such as Intensive In-Home Services, have been provided to the family:

- Family has children that for any reason are particularly vulnerable and unable to protect self, such as very young children, children with developmental disabilities, etc.;
- No utilities and no access to essential utilities, especially when weather conditions are a determinant factor;
- Filth, debris and/or unsanitary conditions (that have resulted in or have strong potential to produce negative outcomes for the child) and can't be cleaned up in one day and no alternative housing is immediately available;
- Structural damage dangerous to children and there are no parental efforts to safeguard children from potential hazards;
- Absence of food and drink, especially sufficient fluids, and there are no resources to obtain such or no ability/effort on the part of the caretaker to access resources;

- Continued substance abuse, domestic violence, untreated depression, or any other incapacitating condition on the part of the caretaker that results in the caretaker's inability to provide for the safety of the child(ren) and the child(ren) cannot provide for or protect self;
- Child has received medical evaluation in which there is evidence of malnutrition, dehydration, lack of sleep, child is not growing normally, child is failure to thrive, child is not gaining weight, child is losing weight, etc. and this is due to lack of parenting;
- There appears to be no bonding or attachment between the parent and the child (no indication or observation that parent hugs, nurtures, holds, or comforts the child/parent views child in predominately negative way); and
- Repeated unsustained effort on the part of the caretaker to rectify any of the above factors.

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11: Munchausen Syndrome by Proxy

Chapter 11 Overview

This chapter will explore a form of child abuse known as Munchausen Syndrome by Proxy (MSBP).

Munchausen Syndrome by Proxy

Munchausen Syndrome by Proxy is a form of child abuse in which a disorder of the child is fabricated by a parent. It is characterized by repeated fabrications of physical illness, which are usually acute, dramatic and convincing. Factitious Disorder by Proxy (FDP) is the diagnostic term used by mental health licensed professionals based upon a mental health assessment of parents in conjunction with concerns of MSBP. Pediatric Condition Falsification (PCF) is the term used by non-mental health licensed professionals, such as physicians, in conjunction with concerns of MSBP.

The term “Munchausen Syndrome by Proxy” was coined around twenty years ago and hundreds of reports have appeared since then. In most cases, a mother either claims that her child is sick, or she goes even further to actually make the child sick.

This “devoted” parent then continually presents the child for medical treatment, all the while denying any knowledge of the origin of the problem – namely herself. The parent usually wanders from hospital to hospital and doctor to doctor seeking treatment for her child.

The parent falsifies the child’s history and may injure the child to simulate a disease. Often the child is seriously ill, requires frequent hospitalizations and may even die. Since it may take many years of illness for doctors to finally arrive at the truth, it should not be surprising that this form of child abuse has a mortality rate of nine percent. Even when MSBP victims survive, they may be forced to undergo painful tests, multiple medication trials, and unneeded surgical procedures.

The web of deceit the caregiver spins can be buttressed by medical signs and symptoms that mislead the most skillful of physicians. For instance, the MSBP perpetrator might induce apnea (a cessation of breathing) by suffocating the child to the point of unconsciousness, and then frantically display her limp child to the hospital or clinic staff as tears roll down her cheeks.

In other cases, mothers have been known to secretly place a drop of blood in the child’s urine specimen, and then appear aghast at lab results that alarm the unsuspecting physicians and nurses. Behind closed doors, she may scrub the child’s skin with oven cleaner to cause a baffling blistering rash that lasts for months.

The Perpetrator

In essentially every reported case, the mothers of the children have been the perpetrators. Often these women are intelligent and educated in health care fields.

The parent is on a misguided mission to feel special or heroic. The parent uses the illness of the child to garner attention from other persons – family, friends, community, and medical professionals – as the caretaker of a tragically ill child. Often perpetrators crave a perverse relationship with doctors in which they simultaneously engage and defeat them through their carefully crafted deceptions.

The parent is tireless in seeking medical care for the child and always appears to be deeply concerned and overly protective. When the children are hospitalized their mothers usually appear especially attentive to them, frequently continuously remaining at their bedsides. The mothers tend to form close relationships with hospital personnel, often praising and reassuring them.

The Victim

The children of Munchausen Syndrome by Proxy range in age from infancy to eight years. Some of the older children appear to aid in their parent's deceptions, perhaps to protect them.

Other Family Members

Little information regarding the fathers and siblings of children with MSBP has been reported. The fathers, when in the home, generally are inconspicuous or weak, perhaps not closely involved with their children and apparently unaware of the fabrications. Some of the fathers appear to have the syndrome themselves, having illnesses observed only by their wives.

Siblings of children with this disorder frequently are adversely affected. They may, also, display Munchausen Syndrome by Proxy, suffer non-accidental injuries, or die under suspicious circumstances.

Warning Signs: What to Look For

Experts say any of these warning signs may point to the possibility that Munchausen by Proxy syndrome is a factor in a child's apparent illness:

- Illness that persists in spite of traditionally effective treatments;
- The child has been to many doctors without a clear diagnosis;
- The parent (usually the mother) seems eager for the child to undergo additional tests, treatments or surgeries;
- The parent is very reluctant to have the child out of her sight;
- Another child in the same family has had an unexplained illness;
- Parent has a background in health care;

- Symptoms appear only when the parent is present.
- Symptoms that do not make medical sense;
- Persistent failure of the victim to respond to therapy;
- Mothers who have an unusually close relationship with the hospital's medical staff;
- A family history of sudden infant death syndrome;
- A parent who welcomes medical testing of the child, even if painful;
- A model family that normally would be above suspicion; and
- A caregiver with a previous history of Munchausen Syndrome.

Profile of MSBP Perpetrators

- Are most often biological mothers of the victims, but potential offenders are often upper-class, well-educated persons;
- Remain uncharacteristically calm in view of the victim's perplexing medical symptoms;
- Welcome medical tests that are painful to the child;
- Praise medical staffs excessively;
- Appear to be very knowledgeable about the victim's illness;
- Have some medical education, either formal or through self-initiated study/experience;
- Might have a history of the same illness as the victim;
- Typically shelter victim from outside activities, such as school or play with others;
- Allow only selected persons close to their children; and
- Maintain a high degree of attentiveness to the victim.

Motivational Factors

One or more of the following motivational factors might be present in MSBP cases:

- Most offenders crave the attention gleaned from hospital staffs, doctors, and family members;

- Offenders become more aggressive as time passes;
- Some offenders in theory might receive gratification as they fool the doctors;
- Some offenders may fear going home or adjusting to a normal daily routine without being the center of attention;
- A relatively minor crisis such as the fear of being left alone or of the child's being released from the hospital, could trigger an attack on a victim; and
- An offender who is praised as a hero for saving a child might elect to re-create that euphoria by fabricating subsequent incidents of abuse and revival of the victim.

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13: Juvenile Court/Legal Information

The Juvenile Court and Other Legal Considerations

Purpose and Mission of the Court

As designated by the Juvenile Code, the purpose of the Juvenile Court is to "facilitate the care, protection and discipline of children who come within the jurisdiction of the Juvenile Court." The Code also states that the law should be "liberally construed" which permits a great deal of discretionary power. Based on the law, the mission of the court is to ensure that "each child coming within the jurisdiction of the Juvenile Court shall receive such care, guidance and control, **preferably** in his own home, as will conduce to the child's welfare and the best interests of the state..." (RSMo 211.011)

Jurisdiction of the Court

The Juvenile Court has exclusive jurisdiction over children under 17 years of age. In cases where a child has been determined to be abused or neglected, jurisdiction can be extended to children under 18 years of age.

Another exception is when a child between the ages of 14 and 17 has committed an offense which would be considered a felony if committed by an adult. The child may then be certified as an adult and tried in the circuit court. (1)

Once the Juvenile Court has asserted jurisdiction, the court may retain jurisdiction until the child has reached the age of twenty-one. (2) Its authority over adults is limited to the following circumstances:

- The court may order parents to financially support their children in placement;
- The court may order physical, psychiatric, or psychological examinations of parents or guardians;
- Any person who interferes with a court order, or contributes to the delinquency of a child under the court's jurisdiction may be held in contempt;
- The termination of parental rights; and
- Adoptions.

Any other punitive action against the parents or other custodian must be taken through the circuit court.

The Hearing Process

The first step in the hearing process, after the court is informed that a child appears to be under the jurisdiction of the court, is for the court to hold a preliminary inquiry to determine the facts and whether the interests of the public or of the child require further action. Based upon that inquiry the court may make an informal adjustment or authorize the juvenile officer to file a petition. (3)

The Types of Hearings Which the Court May Hold Include:

- **Detention or protective custody hearings;**

If the juvenile has been taken into detention the juvenile court must order a detention hearing within twenty-four hours. These are held to determine if the court has grounds to hold the child until the Adjudicatory hearing. The detention hearing must be held within seventy-two hours excluding Saturdays, Sundays, and legal holidays. (4)

- **Adjudication and dispositional hearings;**

Once the juvenile officer files a petition the case enters the hearing phase. There are two phases of the initial hearing procedure. These two phases may be addressed consecutively in the same hearing or separately in two hearings.

The **Adjudicatory** phase is conducted to determine if the juvenile or his parents have committed acts alleged in the petition (juvenile; criminal offenses, status offenses-parents; abuse/neglect) which allow the court to take jurisdiction over the child.

If the allegations are found to be true, the hearing enters phase two, the **Dispositional** phase. In the dispositional phase, the court decides the most appropriate means to address the problem. This may include commitment to a public or private agency, supervision, examination by a psychiatrist or psychologist, participation in counseling, or any number of other dispositions.

- **Dispositional Review Hearing** – This hearing should be held within 90 days of the Dispositional Hearing and may be held as often as needed to determine the appropriate permanency plan for the child.

- **Permanency Hearings;**

These are judicial reviews held annually that are conducted to objectively determine the continuing appropriateness of a child's placement, a child's progress while in care toward the short and long range goals, and a child's need for continued care.

- **Permanency Review Hearing** – This hearing may be held as often as is necessary,

but must be held at least every 6 months following the permanency hearing. The purpose of this hearing is to determine if the permanency plan in place is the most appropriate option for the child and whether the Children's Division has made reasonable efforts to finalize the plan.

- **Termination of parental rights (TPR) hearings;**

This is a legal proceeding which considers the need to sever the legal ties of a child from his/her parents, adoptive parents, or guardian.

In other types of hearings, the Juvenile Code states that the law should be "liberally construed." This permits a great deal of discretionary power. However, appellate courts in Missouri have repeatedly stated that in an action for termination of parental rights the statutory requirements will be strictly and literally applied. (5)

- **Adoption hearings;**

This is a legal proceeding that considers a petition to adopt a child, determines the suitability of the prospective adoptive family, and grants temporary or final legal custody of a child for the purpose of adoption.

As with TPR proceedings, the adoption statutes will also be strictly construed in some circumstances during adoption proceedings. (6)

- **Special hearings;**

Other matters heard by the court upon a petition by the parent, guardian, legal custodian, spouse, relative or kinship.

Witnesses and Records

When the court receives a referral, at times the juvenile and/or parent will deny the report. When this occurs, a contested hearing is set and witnesses are subpoenaed. Witnesses may include school personnel, medical personnel, the police, Children's Division (CD) staff, etc. In order to introduce evidence contained in the records of these witnesses, it must be done under the Uniform Business Records Act. This is an exception to the Hearsay Rule. In order to comply with the Act it is necessary that:

- The custodian testify to the identity and mode of preparation of the record;
- The custodian testify that it was made in the regular course of business at or near the time of the act; and
- Sources, method, and time for the preparation of the record justify admission at the discretion of the court.

These records may also be admissible without the testimony of the custodian if they are filed with the proper affidavit.

The Expert Witness

CD staff may be required to testify in court to the facts of a case or in the role of an expert witness. Opinions and inferences of an expert witness are admissible when it has been established that the witness is professionally acquainted with, skilled, or trained in some field (i.e. child welfare, child custody) and therefore has knowledge or experience in matters generally not familiar to the public. For this reason, prior to testimony, CD staff may be asked to state their educational background, experience, etc. While CD staff may testify to matters which pertain to the "the best interests of the child," they are generally not qualified to testify to matters beyond their scope of expertise (medical opinions, mental condition/diagnosis of the parent, etc.)

Legal Rights

Certain legal rights in terms of the integrity of the family have been established by the Supreme Court via the process of legislative review. In general, these rights have been incorporated into state statutes. Such rights include, but are not limited to:

- **Constitutional Rights:** Applied to both parents and children. Parents have the constitutional right to rear their children as they see fit provided the child's general welfare is protected.
- In 1967, the United States Supreme court ruled that the Fourteenth Amendment to the United States Constitution and the Bill of Rights applied in juvenile cases where a minor could be committed to a state institution. (7)
- **Right to Counsel:** The parent's right to counsel may vary from state to state. However, in almost all instances, children have a right to counsel and/or a Guardian ad Litem. (Guardian ad Litem 'GAL': an adult individual appointed by a court to protect the best interests of a minor child in a specific legal action; may be, but is not necessarily, an attorney). In order to be appointed as a 'GAL' the individual must have completed a training program in permanency planning. (8)

Under Missouri laws a parent is entitled to have an attorney appointed, if they are indigent, in actions for termination of parental rights. (9) In cases of child abuse or neglect, where the parent is a minor, mentally ill, or incompetent, the parent is entitled to appointment of a 'GAL'. (10)

- **Right to an Impartial Hearing:** Before children can be removed from a home, parents and children have the right to a hearing before an impartial judge.
- **Right of family integrity:** Before removal of a child, attempts should be made to strengthen and rehabilitate the family. (This is currently a Federal regulation as

well; i.e., Efforts to Prevent Placement.) Therefore, courts will generally support a preference for the child to remain in the birth home. The Courts may set conditions such as cooperation with CD, mandated counseling, etc.

- Right to challenge, correct and expunge Child Protection Agency Records: This encompasses the destruction of unsubstantiated CA/N reports, the right to review CD records, and the right to challenge CD findings in Court.

Rights of the Child and Family

Family law, within the context of protective services and custody, is based upon the English Common Laws principle of "Parens Patriae." (11) Under the doctrine of "Parens Patriae," a court of equity exercising the Crown's paternal prerogative, could declare a child a ward of the Crown when the parents had failed to maintain the child's welfare. (12)

Modern legal interpretation focuses on the sanctity of the family. The court is empowered to protect "the best interests of the child." In this context, the court will place substantial weight on the following considerations:

- Love, affection, and emotional ties existing between parent and child;
- Presumption that birth parents have an inherent capacity and interest to best provide love, affection, and guidance, and the right to make educational, medical, disciplinary, and religious choices for the child;
- Length of time the child has resided with the parents and desirability of maintaining continuity; and
- Financial resources of parents are of secondary importance, provided basic necessities can be met with or without the assistance of outside resources.

Constitutional Rights and Child Protection Services

Fourth Amendment Rights (Search and Seizure) and Fifth Amendment Rights (Self-incrimination) are generally not viewed to be violated by Child Protection Services (CPS).

Visits to family homes are not seen as a violation of the Fourth Amendment when the visit is to:

- Ensure the welfare of the child;
- Privacy is respected;

- Neither forcible entry nor threats or false pretenses are used;
- Advance notice is given;
- Visits do not take place after normal working hours unless prearranged; and
- The visit is not aimed at criminal prosecution. Immediate entry with police assistance is allowable during serious emergencies.

Information gathered in the course of child protection services is not generally seen as self-incriminating if it is not acquired for the purpose of criminal proceedings. If the purpose of the investigation is criminal prosecution (13) or if the person being interviewed is under some sort of restraint (14), the Fifth Amendment Right against self-incrimination may come into force.

The Miranda warning, provided by police to persons under investigation, are warranted if the investigation is directed toward criminal prosecution and any element of apparent coercion or restraint of the individual exists. (15)

NOTE: CD staff shall not give Miranda warnings as this is a law enforcement responsibility.

Parental Responsibilities

The integrity of the family is protected by both legal and ethical rights. In contrast, parents have responsibilities as well as rights. When the welfare of the child is endangered, the state assumes the right to intervene. Children have a need for love, care, and protection. Within their ability and available resources, parents have a responsibility to provide:

- Food, shelter, clothing;
- Medical care;
- Educational opportunities;
- Supervision; and
- Moral and social guidance.

Invasion of Privacy

The state's obligation to protect children from harm balances the family's right to privacy. This is, however, predicated on the assumption that investigations are conducted under certain general guidelines:

- Efforts in gathering information should be made in a reasonable manner;
- There is no malicious intent involved;
- Only necessary information is gathered;
- The least intrusive means of acquiring information is preferred; and
- The public interest is served (i.e. state's obligation to protect children).

Standards for Child Protection Services

In general, the following guidelines should be encompassed in providing services to CD families. In the course of service delivery, such guidelines will serve the Children's Service Worker well in respecting the integrity of the family, maintaining a professional demeanor, and assisting the family to provide for the best interests of the child:

- Responsiveness to reports of suspected child abuse and neglect;
- Fair and competent assessment of the family's willingness and ability to protect a child;
- Reliance on the family's strengths and resources in casework planning;
- Direct and intensive efforts to enhance those strengths and to introduce families to appropriate resources;
- Recognition and assessment of personal feelings in the context of providing services. (The Children's Service Worker should seek supervisory assistance in dealing with common feelings that may interfere with effective service delivery such as anger, fear, anxiety, ambivalence, bias, prejudice, etc.);
- Ongoing assessment of the presence and level of risk to all children in the family; and
- Prompt follow-up (i.e., court referral) when the above efforts are unproductive and there is a **clear danger** to the child.

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Chapter 13: Juvenile Court/Legal Information
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Footnotes:

- (1) Section 211.071, RSMo (1986).
- (2) Section 211.041, RSMo (1986).
- (3) Section 211.081, RSMo (1986).
- (4) Rule 111.07.b Mo.S.Ct. Rules (1988).
- (5) e.g. S.K.L. v. Smith 480 SW2d 119 (Mo.App. 1972).
- (6) e.g. In re E.C.N. 517 SW2d 709 (Mo.App. 1974).
- (7) In re Galt 387 US 1, 18, L Ed2d 527, 87 S.Ct. 1428 (1967).
- (8) Section 210.160.6, RSMo (1986).
- (9) Section 210.453, RSMo (1986).
- (10) Section 210.160.1 (2), RSMo (1986).
- (11) Davis, Rights of Juveniles 2dEd, Section 1.2 at 1-2 and State v. Couch 294 SW2d 636 Mo.App. 1956).
- (12) Davis, id.
- (13) State v. Williams 522 SW2d 641 (Mo.App. 1975).
- (14) United States v. De la Cruz 420 F.2d 1093 (7th Cir. 1970).
- (15) Caulfield, Legal Aspects of Protective Services for Abused and Neglected Children at 107 (1978).

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14: Childhood Medical Disorder/Impairments

Chapter 14 Overview

This chapter provides a general description of childhood disorders/impairments and related symptoms and mode of treatment. It is provided for informational purposes only. All health problems/medical conditions should be diagnosed and treated by the appropriate medical personnel.

Hydrocephalus (hydro, water + cephalo, head) is a condition characterized by an increase of cerebrospinal fluid in the ventricles of the brain, which causes an increase in the size of the head and pressure changes in the brain. Hydrocephalus may be congenital or acquired. It is most commonly caused by an obstruction such as a tumor or improper formation of the ventricles. The classic symptom is an increase in the head size. This condition may be corrected by surgically implanting a shunt to bypass the point of obstruction.

Spina Bifida (divided spine) is a congenital embryonic neural tube defect in which there is an imperfect closure of the spinal vertebrae. Spina bifida occulta is a relatively minor variation of the disorder in which the opening is small and there is no associated protrusion of structures. Generally, treatment is not necessary unless neuromuscular symptoms appear. Spina bifida cystica consists of the development of a cystic mass in the midline of the spine. The prognosis of these conditions depends on the extent of the involvement. When warranted, surgery is usually performed within the first 24 hours of life and followed by habilitation to minimize the child's disability.

Congenital Heart Disease (CHD) is a defect in the structure of the heart and/or in one or more of the large blood vessels that lead to and from the heart. A mother who contracts German measles early in her pregnancy or who is poorly nourished may bear a child with a faulty heart. Alcoholism, advanced age of mother and genetic factors may also contribute to congenital heart disease. Children with mild cases of CHD can lead fairly normal lives under medical management. Children with more serious cases may require cardiac surgery.

Cleft Lip (Harelip) is characterized by a fissure or opening in the upper lip and is a result of the failure of the embryonic structures of the face to unite. In many cases it seems to be caused by hereditary predisposition coupled with a minor deviation of the intrauterine environment. This disorder appears more frequently in boys than girls and may occur on one or both sides of the lip. Babies with cleft lip are unable to suck and have difficulty eating. Surgery improves baby's ability to suck and his appearance.

Cleft Palate is more serious than a cleft lip. It forms a passageway between the nasopharynx and the nose which complicates feeding and leads to infections of the respiratory tract and middle ear. Cleft palate is also responsible for speech difficulties in later life. Unlike cleft lip, cleft palate is more common in females than in males.

Corrective surgery is usually performed before the child reaches the age of 18 months. A dental appliance is used to facilitate speech when surgery has been deferred or counter indicated. The dental appliance must be changed periodically as the child grows.

Musculoskeletal System

Clubfoot is one of the most common deformities of the skeletal system. It is a congenital anomaly characterized by a foot that has been twisted inward or outward. The treatment of clubfoot should be started as early as possible, otherwise the bones and muscles will continue to develop normally. Conservative treatment, consisting of manipulation and casting to hold the foot in the correct position, is carried out during infancy.

Congenital Hip Dysplasia is a common orthopedic deformity. The head of the femur is partly or completely displaced from a shallow hip socket. Both hereditary and environmental factors appear to be involved in the cause. Congenital hip dysplasia is seven times more common in females than in males. Newborn infants seldom have complete dislocation. When the baby begins to walk, the pressure exerted on the hip can cause a complete dislocation. The course of treatment depends on the age of the child at the time of diagnosis and may include traction, casting and/or surgery.

Juvenile Rheumatoid Arthritis is the most common arthritic condition of childhood. It is a systemic inflammatory disease that involves the joints, connective tissues and viscera. Juvenile rheumatoid arthritis is not a rare disease with over a quarter of million children in the United States with the disorder. This disorder has three distinct methods of onset and the symptoms vary with each. Symptoms may include fever, rash, abdominal pain, pleuritis, pericarditis, and an enlarged liver and spleen, and warm, swollen and tender joints. There are no cures for juvenile rheumatoid arthritis. Drug therapy and exercise are the mainstays of treatment.

Inborn Errors Of Metabolism

Phenylketonuria (PKU) is a genetic disorder caused by the faulty metabolism of phenylalanine, an amino acid essential to life and found in all protein foods. The hepatic enzyme phenylalanine hydroxylase, normally needed to convert phenylalanine into tyrosine is missing. PKU results in severe retardation evidenced in infancy. The baby appears normal at birth but begins to show delayed development at about four to six months of age. Early detection and treatment are paramount. Several screening tests are used in an effort to prevent or confirm the diagnosis of PKU. Treatment consists of close dietary management throughout the child's life.

Chromosomal Abnormalities

Down's Syndrome is a congenital defect of the embryo. There are three known causes of Down's syndrome, all of which involve abnormalities of the chromosomes. In

the most common type, trisomy 21 syndrome, the total chromosome count is 47 instead of the normal 46. It is the result of non-disjunction, the failure of a chromosome to follow the normal separation process into daughter cells. The physical characteristics of Down's Syndrome, which are apparent at birth, are close-set and upward slanting eyes, small head, round face, flat nose, and a protruding tongue that interferes with sucking and mouth breathing. Also, the hands of the baby are short and thick and the little finger is curved. There is a deep straight line across the palm, which is called the simian crease. There is also a wide space between the first and second toes. Physical growth and development may be slower than normal. The child is mentally retarded. Also, the child with Down's Syndrome has poor resistance to infection. However, the widespread use of antibiotics has increased the life span of these children.

The Blood

Iron Deficiency Anemia - The most common nutritional deficiency of children which is due to insufficient amounts of iron in the body. The incidence is highest during infancy and adolescence, two rapid growth periods. Anemia (an, without + emia, blood) is a condition in which there is a reduction in the amount and size of the red blood cells or in the amount of hemoglobin, or both. The critical features are related to the decrease in the oxygen-carrying capacity of the blood. The symptoms of iron deficiency anemia are pallor, irritability, anorexia and a decrease in activity. Anemia responds well to a regimen of oral iron supplements lasting from six to eight weeks.

Sickle Cell Disease is an inherited defect in the formation of hemoglobin. It occurs mainly in black populations, but is also carried by some people of Arabian, Greek, Maltese, Sicilian, and other Mediterranean races. Sickling due to decreases in blood oxygen may be triggered by dehydration, infection, physical or emotional stress or exposure to cold. Laboratory examination of the affected child's blood shows that the red blood cell has changed its shape to resemble that of a sickle blade, from which the name of the disorder is derived. Sickle cells are quickly removed from the blood and the body is left without enough red blood cells to supply the needed oxygen. Symptoms of sickle cell anemia usually appear after six months of age and include leg ulcers, swelling of hands and feet, slow growth, jaundice, painful joints and severe pain in the chest, abdomen, arms and legs. There is no cure for sickle cell anemia, however, treatment is available which includes medication for pain, antibiotics, increased fluid intake, transfusion, bed rest and surgery.

Leukemia (leuko, white + emia, blood) is a malignant disease of the blood-forming organs of the body that results in an uncontrolled growth of immature white blood cells. The most common symptoms during the initial phase of the illness are low-grade fever, pallor, tendency to bruise, leg and joint pain, listlessness and enlargement of lymph nodes. As the disease progresses the liver and spleen enlarge. Treatment includes chemotherapy, bone marrow transplants and immunotherapy.

The Lungs

Cystic fibrosis is a generalized disorder of the outward secreting or exocrine glands, in particular the mucous and sweat glands. This disease affects many parts of the body but particularly the lungs and sweat glands. The condition is believed to be inherited as a recessive trait from both parents who are carriers of the disease but do not show any symptoms. Treatment includes antibiotic control of pulmonary infection and surgery.

Nervous System

Bacterial Meningitis is an inflammation of the meninges, the covering of the brain and spinal cord. The symptoms of meningitis result mainly from intracranial irritation and may be preceded by a cold. There is severe headache, drowsiness, delirium, irritability, restlessness, fever, and vomiting. Another symptom is stiffness of the neck and spine. Convulsions are common and coma may occur fairly early in the older child. Wide spectrum antibiotics are used to treat bacterial meningitis. Vaccines are available for Types A, B and C.

Cerebral Palsy is a term used to refer to a group of non-progressive disorders that affect the motor centers of the brain. It is not fatal in itself, but at present there is no cure. The disease is caused by many factors, including birth injuries, neonatal anoxia, subdural hemorrhage, and infections such as meningitis and encephalitis. Lead poisoning, head injuries and febrile illness are sometimes responsible during the toddler period. The symptoms vary from child to child and may include mental and/or physical retardation. Stretching exercises, cast and splints are used to prevent shortening of the muscles and other deformities. The child may require braces, crutches, or a wheel chair for mobility. Also, the child may require orthopedic surgery.

Epilepsy is characterized by recurrent paroxysmal attacks of unconsciousness or impaired consciousness that may be followed by alternate contraction and relaxation of the muscles or by disturbed feelings or behavior. It is a disorder of the central nervous system in which the neurons or nerve cells discharge in an abnormal way.

Tonic-Clonic (Grand Mal) seizures are the most common and dramatic seizure. Onset is abrupt. During the tonic phase the body stiffens and the individual may simultaneously lose consciousness and drop to the floor from a standing or sitting position. This may be preceded by an aura, which is a particular sensation such as dizziness, visual images, nausea, headache, or an ascending feeling of abdominal discomfort.

Absence (Petit Mal) seizures are characterized by transient loss of consciousness. They originate from the central portion of the brain and cortex and last less than 30 seconds. They may be associated by upward rolling of the eyes, rhythmic nodding of the head, or slight quivering of the limbs. Anti-convulsive drug therapy is the normal method of treatment.

The Muscular System

Muscular Dystrophies are a group of disorders in which progressive muscle degeneration occurs. The childhood form (Duchenne Muscular Dystrophy) is the most common type. It is a sex linked inherited disorder occurring only in boys. Mothers are likely carriers for the disease. The onset is generally between two and six years of age. Symptoms include a waddling gait, slowness in running or climbing, and enlarged, rubbery muscles. Treatment is mainly supportive and consists of bracing, weight control and surgery for joint contractures.

Circulatory System

Acute Rheumatic Fever belongs to a group of disorders known as collagen diseases. Their common feature is the destruction of connective tissue. Rheumatic fever, a multi-system disease, is particularly detrimental to the heart. Symptoms range from mild to severe and may not occur for several weeks after a streptococcal infection. Classic symptoms are wandering joint pains, Sydenham's chorea (a nervous disorder and rheumatic carditis). Other symptoms may include fever, pallor, fatigue, anorexia and unexplained nosebleeds. Treatment is aimed at preventing permanent damage to the heart which is accomplished by antibacterial therapy, physical and mental rest and relief of pain and fever.

Endocrine System

Diabetes is a chronic metabolic condition in which the body is unable to utilize carbohydrates properly, owing to a deficiency of insulin, and internal secretion of the pancreas. Insulin deficiency leads to impairment of glucose transport (sugar cannot pass into the cells). The body is unable to store and utilize fats properly. There is a decrease in protein synthesis. When the blood glucose level becomes dangerously high, glucose spills into the urine and diuresis occurs. Type 1 diabetes is the most common endocrine/metabolic disorder of childhood. Untreated diabetes can lead to coma and death. The symptoms of diabetes appear more rapidly in children. The individual complains of excessive thirst, excretes large amounts of urine and is constantly hungry. Also, an insidious onset with lethargy, weakness and weight loss is common. Anorexia may be seen. Treatment for diabetes includes special diet and insulin management.

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15: Department Of Mental Health

Chapter 15 Overview

This chapter discusses a variety of mental health services available to individuals, families and children through state, private, school and community resources.

The Department of Mental Health provides a wide range of mental health services through its three divisions: Division of Mental Retardation and Developmental Disabilities, Division of Comprehensive Psychiatric Services and Division of Alcohol and Drug Abuse. The eligibility and referral process and description of services for each Division is as follows:

Department Of Mental Health - Division Of Mental Retardation And Developmental Disabilities

The treatment and habilitation of persons with mental retardation and other developmental disabilities are the responsibility of the Division of Mental Retardation and Developmental Disabilities (MRDD). A developmental disability is a long-term condition that significantly delays or limits mental or physical development and substantially interferes with life activities such as self-care, communication, learning, decision making, capacity for independent living and mobility.

Each individual eligible for MRDD services is assigned a case manager. The case manager is responsible for developing and monitoring the habilitation and treatment plan designed to meet the individual needs of the client.

Eligibility For Services

Eligibility for services is determined through an assessment process. Cost for services to the individual is based on his/her ability to pay.

An individual must have mental retardation (per state law Section 630.005, RSMo.) that occurred before age 18 or a developmental disability or a severe health problem such as autism, epilepsy, or cerebral palsy that results in a need for specialized habilitation services. They may also have been injured or brain damaged (from accidents, etc.). However, the disability should be expected to be a continuing problem rather than short-term and result in significant functional limitation in at least two areas.

Services are voluntary and may be provided from birth to death of the eligible individual.

School aged children (ages 5 to 21) receive primary services through the public school system. However, MRDD can assist with evaluation, behavior management or provide referrals at the request of the school system and the guardian.

Referral Process

The Children's Service Worker should contact the intake worker at the Department of Mental Health Regional Center which serves their county. The worker should assist the family in completing the necessary intake forms and making arrangements for a comprehensive assessment to determine eligibility for services. The assessment is completed by the DMH "Team" (professionals that do testing and evaluations). The assessment includes a psychological evaluation, health screening, sensory-motor assessment, speech assessment (children under 5) and a social assessment. A physical examination is also required prior to the time of the assessment. The assessment process takes approximately one to two months to complete.

Generally, a "Return Interpretation Conference" is held the same day the assessments are completed. The individual, his/her guardian and appropriate agency representatives, i.e., Children's Division (CD) staff are invited to the conference. Persons attending the conference are verbally informed of the test results, eligibility status and recommendations for future planning. There is no fee associated with this initial assessment.

When determined eligible for MRDD services, the individual is assigned a DMH case manager. The Children's Service Worker, DMH case manager and any other advocate meet and develop the Individual Habilitation Plan (IHP).

Placement

The need for placement is identified during the IHP process. If there is an immediate need for placement, the DMH "Team" attempts to locate a suitable DMH foster or group home. If placement is not needed immediately, the child is placed on a "tracking form" which is monitored by the DMH case manager. When an opening occurs in a suitable home, the Team reviews the appropriateness of the available home for the child and contacts the family.

Services Available:

- **Therapy** - A course of therapy is prescribed based on the individual's needs and may include occupational therapy, physical therapy, speech therapy and behavioral management therapy.
- **Training** - Training programs are designed to assist the individual be a contributing member of the community.
- **Residential Placement** - Community placement and state operated habilitation centers serve individuals who require assistance in a residential setting.

- **Family Support** - Family support services help individuals with disabilities live in the community. These services include respite, attendant and home health care, parent training and environmental adaptations.
- **Choices for Families** - This program provides funds for families to obtain services (excluding child care and baby-sitting) to meet the needs of the family that have a member with developmental disabilities at home.
- **Respite Care** - Temporary care of a child to provide relief to the caregiver. Respite care is available to both birth parents and placement providers.
- **Other services** - Individual DMH-MRDD Regional Centers may provide additional services which are limited to individuals/families residing in their catchment area.

Interagency Agreement

The Children's Division and Department of Mental Health - Mental Retardation and Developmental Disabilities have an interagency agreement to provide assistance for children with a dual diagnosis of mental retardation or other developmental disability and a behavior/conduct disorder. Before pursuing services through the interagency agreement, the Children's Service Worker must explore all appropriate resources and determine that they are unavailable. The major requirements of the interagency agreement are as follows:

- CD and DMH-MRDD will have joint case manager responsibilities and work together in permanency planning when appropriate;
- CD will retain legal custody of the child for a minimum of 12 months. At the end of the initial 12 month period CD and DMH-MRDD case managers will conduct a case review and make recommendations regarding the legal custody of the child;
- During the initial 12 months, payments for the child's care will be made by CD directly to the placement provider. Beyond the first year, payments will be dependent upon which agency has custody of the child, i.e., if custody is awarded to DMH, DMH will assume cost of child's care.

Department Of Mental Health - Division Of Comprehensive Psychiatric Services

The Department of Mental Health - Division of Comprehensive Psychiatric Services serves children with an emotional or behavioral disorder or mental illness/disorder (other than mental retardation or developmental disabilities). The program goal is to treat children as close to their home as possible and help them function at their optimal level. Children are provided a wide-range of services to meet the child's physical,

psychological, social, education, vocational and recreational needs. Services are funded through a combination of general revenue, the Social Services Block Grant, Federal Alcohol and Drug Abuse and Mental Health Block Grant, as well as Medicaid and/or private insurance payments for eligible children. The child's family pays for services based on their ability to pay as determined by a standard means test. Services may also be funded through contracts with other agencies, i.e., Children's Division.

Services provided for children are through a combination of programs at DMH CPS operated facilities and an administrative agent system. The administrative agent system is comprised of DMH CPS facilities and not-for-profit community mental health centers operating under state contracts. Families, children and referral sources (CD, courts, schools, doctors, etc.) can access the services through the DMH CPS administrative agent within their geographic area. The intake worker for the administrative agent will arrange for a child to be evaluated to determine what services may be appropriate and assist in accessing the system.

Eligibility For Services

Individuals with emotional or behavioral disorders or mental illness may be eligible for services through DMH CPS. Public Law 101-476 specifies that the individual must have a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects their performance:

- An inability to learn that cannot be explained by intellectual, sensory or health factors;
- An inability to build or maintain satisfactory interpersonal relationships with family, peers and school teachers;
- A general pervasive mood of unhappiness or depression; and
- A tendency to develop physical symptoms or fear associated with personal or school factors.

When the Children's Service Worker suspects that a child has an emotional or behavioral disorder or mental illness, he/she should contact the appropriate administrative agent to arrange for an assessment. If the assessment indicates that the child is eligible for and in need of services, a treatment plan will be developed and services offered.

Services Available:

- **Case Management** - Linking the child to needed services, i.e., school, community, other agencies, etc. and coordinating the delivery of those services.

- **Out-Patient Therapy** - Clinical intervention in the office of a therapist, psychologist, social worker, or other professional in the mental health field.
- **Families First** - Intensive crisis intervention provided by therapists and social workers to prevent out-of-home placement of children who have severe emotional disorders.
- **Extended Families First** - Intensive family reunification services for families who have children returning home from inpatient or residential facilities.
- **503 Project (St. Louis County)** - Interagency therapeutic case management for children with severe emotional disorders to keep children within their own family, school and community.
- **Caring Communities Project** - An interagency initiative to keep children in school within their own homes and communities.
- **Court-Ordered Evaluations** – Court-ordered evaluations and assessments of individuals. Evaluation results and recommendations are to be forwarded to the court within 20 days.
- **Assessment/Evaluation Services** - Systematic appraisal to determine the child's strengths and limitations to develop and individualized program for the child.

Placement

The Department of Mental Health - Comprehensive Psychiatric Services provides a variety of placement options for children who have been diagnosed with an emotional, behavioral or mental disorder by an approved psychiatrist or psychologist. When such children require out-of-home placement, but do not require in-patient care, the following placements less restrictive options are available:

- **Day Treatment** - Intensive therapy and structure for a portion of a 24 hour period.
- **Respite Care** - Temporary care for children to relieve that caregiver from continual child care responsibilities. Respite care is available to both parents and out-of-home placement providers.
- **Therapeutic Foster Care** - Intensive intervention and care provided by skilled and licensed placement providers in a family and community-based environment. Children may be placed in therapeutic foster care voluntarily through the mental health administrative agent or involuntarily through the juvenile court system.

Also, placements may be arranged through the interagency agreement as discussed above, for children in the legal custody of the Children's Division.

- **Residential Treatment** - Structured environment and protection for children who do not pose a threat to themselves or others. Children are placed voluntarily, through the juvenile court system, or by the Children's Division in accordance with the interagency agreement.

Children whose psychiatric needs cannot be addressed in a community environment and require 24 hour observation and treatment may be placed in an in-patient treatment facility. In-patient care may be appropriate for those children who, because of their mental disorder, pose a threat to themselves or others. Admittance is based on the finding of an assessment completed through a community mental health center. The child must meet **all** of the following criteria for admission:

- Child has a diagnosed mental disorder;
- Child requires in-patient care and treatment for the protection of himself and others due to the mental disorder/illness; and
- The mental health facility is the least restrictive environment in which the child can adequately function.

Child And Adolescent Service System Project

The Child and Adolescent Service System Project (CASSP) is an interagency effort to coordinate and develop policy around (Wrap-Around Services) services to children. The project has also developed a parent support and advocacy system.

A state level assistance team has been created to oversee the efforts of CASSP to coordinate and develop policy around the services. Team members include representatives of each of the three Department of Mental Health Divisions, Juvenile Justice Association, Elementary and Secondary Education, Division of Youth Services and Children's Division.

Department Of Mental Health - Division Of Alcohol And Drug Abuse

The Department of Mental Health - Division of Alcohol and Drug Abuse provides comprehensive treatment and rehabilitation services for adults and children to promote recovery from drug and alcohol abuse.

Available Services

Comprehensive Substance Treatment and Rehabilitation Program (CSTAR) is designed to promote recovery from alcohol and other drug abuse. The goal of CSTAR is to strengthen family relationships, involve family members in the treatment process and integrate community resources to meet the client's housing, education, employment, health and other needs. The program provides a continuum of care that includes three levels designed to provide varying amounts of structure and service. The levels are as follows:

- **Level 1** - Designed to simulate the structured programming offered in in-patient and residential treatment programs. This level of care can be offered on a residential or non-residential basis from 30 to 60 days.
- **Level 2** - An individually tailored program where individuals participate in nine hours per week of group education and counseling and one hour per week of individual counseling or family therapy for 45 to 90 days.
- **Level 3** - This supported recovery level allows an individual to receive ongoing supportive services and assist in sustaining therapeutic gains made in treatment and rehabilitation. The individual may receive services at level 3 for two years or longer.

NOTE: CSTAR programs are covered by Medicaid.

Programs

Adolescent Program - Treatment and rehabilitation for adolescents age 13 through 17. Services emphasize recovery and address the adolescent's development, education, and recreational needs. Adolescents participate in the program while living at home or other locations such as group homes and foster homes. The program joins with other agencies, i.e., CD, courts and schools to provide a coordinated treatment plan for adolescents.

Women/Children Program - Comprehensive systematic approach to the treatment and rehabilitation needs of women and their children. The program addresses the woman's recovery from alcohol and other drug abuse and the needs of the children and the family. Parent skills training is a key component of the treatment, to ensure appropriate child care while the mother participates in treatment. The children participate in co-dependency and family counseling. The children are also taught skills to reduce the possibility of becoming a victim of physical, sexual or emotional abuse. Pregnant women are given priority.

General Population Program - Treatment and rehabilitation for adult men, women and their family members. Program participants are served on a non-residential basis. They

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are linked with other community resources to meet their needs for housing, child care and health care.

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16: Substance Abuse

Chapter 16 Overview

There is little doubt that the presence of drug and alcohol abuse has a phenomenal impact on the stability of the family. Substance abuse alone contributes to at least one-third of all child abuse reported. This chapter will examine substance abuse and its effect on individuals.

The use of drugs and alcohol, combined with the normal living stresses, creates distorted thinking which makes relationships more complex; uncontrollable emotions and unreasonable judgement complicate the family that may already bear various levels of dysfunctioning.

Nine classes of psychoactive substance are associated with both abuse and dependence:

- Alcohol;
- Amphetamine (also known as "speed") or similarly acting drugs;
- Cannabis (also known as marijuana and hashish);
- Cocaine (and its derivative "crack");
- Hallucinogens;
- Inhalants;
- Opioids;
- Phencyclidine (also known as PCP or "angel dust"); and
- Sedatives.

Distinction is made here between dependency and abuse.

Psychoactive Substance Dependence

The essential feature of this disorder is a cluster of cognitive, behavioral, and physiological symptoms that indicate that the person has impaired control of psychoactive substance use. The person continues use of the substance despite adverse consequences. Symptoms of the dependence syndrome include, but are not limited to, the physiologic symptoms of tolerance and withdrawal.

The symptoms of the dependence syndrome are the same across all categories of psychoactive substances, but for some classes some of the symptoms are less salient,

and in a few instances do not apply (i.e., withdrawal symptoms do not occur in hallucinogen dependence).

Symptoms of Dependence

The following are the characteristic symptoms of substance dependence. It should be noted that not all nine symptoms must be present for the diagnosis of dependence, and for some classes of psychoactive substances, certain of these symptoms do not apply.

At least three of the nine characteristic symptoms of dependence are necessary to make the diagnosis. In addition, the diagnosis of the dependence syndrome requires that some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time, as in binge drinking:

1. The person finds that when he or she actually takes the psychoactive substance, it is often in larger amounts or over a longer period than originally intended. For example, the person may decide to take only one drink of alcohol, but after taking this first drink, continues to drink until severely intoxicated.
2. The person recognizes that the substance use is excessive, and has attempted to reduce or control it, but has been unable to do so as long as the substance is available. In other instances the person may want to reduce or control his or her substance use, but has never actually made an effort to do so.
3. A great deal of time is spent in activities necessary to procure the substance (including theft), taking it, or recovering from its effects. In mild cases the person may spend several hours a day taking the substance, but continue to be involved in other activities. In severe cases, virtually all of the user's daily activities revolve around obtaining, using, and recuperating from the effects of the substance.
4. The person may suffer intoxication or withdrawal symptoms when he or she is expected to fulfill major role obligations (work, school, homemaking). For example, the person may be intoxicated when working outside the home or when expected to take care of his or her children. In addition, the person may be intoxicated or have withdrawal symptoms in situations in which substance use is physically hazardous, such as driving a car or operating machinery.
5. Important social, occupational, or recreational activities are given up or reduced because of substance use. The person may withdraw from family activities and hobbies in order to spend more time with substance-using friends, or use the substance in private.
6. With heavy and prolonged substance use, a variety of social, psychological, and physical problems occur, and are exacerbated by continued use of the substance. Despite having one or more of these problems (and recognizing that use of the substance causes or exacerbates them), the person continues to use the substance.

7. Significant tolerance, a markedly diminished effect with continued use of the same amount of the substance, occurs. The person will then take greatly increased amounts of the substance in order to achieve intoxication or the desired effect. This is distinguished from the marked personal differences in initial sensitivity to the effects of a particular substance.

The degree to which tolerance develops varies greatly across classes of substances. Many heavy users of cannabis are not aware of tolerance to it, although tolerance has been demonstrated in some people. Whether there is tolerance to phencyclidine (PCP) and related substances is unclear. Heavy users of alcohol at the peak of their tolerance can consume only about 50% more than they originally needed in order to experience the effects of intoxication. In contrast, heavy users of opioids often increase the amount of opioids consumed to tenfold the amount they originally used, an amount that would be lethal to a nonuser. When the psychoactive substance used is illegal and perhaps mixed with other substances, tolerance may be difficult to determine.

NOTE: The following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP).

8. With continued use characteristic withdrawal symptoms develop when the person stops or reduces intake of the substance. The withdrawal symptoms vary greatly across classes of substances. Marked and generally easily measured physiologic signs of withdrawal are common with alcohol, opioids and sedatives. Such signs are less obvious with amphetamines, cocaine, nicotine, and cannabis, but intense subjective symptoms can occur upon withdrawal from heavy use of these substances. No significant withdrawal is seen even after repeated use of hallucinogens; withdrawal from PCP and related substance has not yet been described in humans, although it has been demonstrated in animals.
9. After developing unpleasant withdrawal symptoms the person begins taking the substance in order to relieve or avoid those symptoms. This typically involves using the substance throughout the day beginning soon after awaking. This symptom is generally not present with cannabis, hallucinogens, and PCP.

Criteria For Severity Of Psychoactive Substance Dependence

Dependence, as defined here, is conceptualized as having different degrees of severity, and guidelines for mild, moderate, and severe dependence and dependence in partial or full remission are provided:

- Mild: Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms result in no more than mild impairment in occupational functioning or in usual social activities or relationships with others.

- Moderate: Symptoms or functional impairment between "mild" and "severe."
- Severe: Many symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.
- In Partial Remission: During the past six months some use of the substance and some symptoms of dependence.
- In Full Remission: During the past six months either no use of substance, or use of the substance but no symptoms of dependence.

Psychoactive Substance Abuse

Psychoactive substance abuse is a residual category for noting maladaptive patterns of psychoactive substance use that have never met the criteria for dependence for that particular class of substance.

The maladaptive pattern of use is indicated by either:

1. The continued use of the psychoactive substance despite knowledge of having a persistent or recurrent social, occupation, psychological, or physical problem that is caused or exacerbated by use of the substance, or
2. The recurrent use of the substance in situations when use is physically hazardous (i.e., driving while intoxicated).

The diagnosis is made only if some symptoms of the disturbance have persisted for at least one month or have occurred repeatedly over a longer period of time.

The person must have never met the criteria for dependence for this substance.

This diagnosis is most likely to be applicable to people who have only recently started taking psychoactive substances and to involve substances, such as cannabis, octane, and hallucinogens, that are less likely to be associated with marked physiologic signs of withdrawal and the need to take the substance to relieve or avoid withdrawal symptoms.

Examples of situations in which this category would be appropriate are as follows:

- A college student binges on cocaine every few weekends. These periods are followed by a day or two of missing school because of "crashing." There are no other symptoms;
- A middle-aged man repeatedly drives his car when intoxicated with alcohol. There are no other symptoms;

- A woman keeps drinking alcohol even though her physician has told her that it is responsible for exacerbating the symptoms of a duodenal ulcer. There are no other symptoms.

More On Alcoholism

The alcoholic is an individual who compulsively uses alcohol even though it is destroying his/her life and who displays other symptoms, such as withdrawal, blackouts, and changing tolerance.

Alcoholism is a chronic, progressive disease, the same way that tuberculosis and diabetes are chronic progressive diseases. The disease is manifested by the compulsion to use even as the using destroys life. One can't become an alcoholic overnight anymore than one can contract any of the other progressive diseases overnight.

Effects Of Alcohol/Chemical Dependency Upon The Family

Alcoholism (and drug addiction) usually manifests itself in a way that begins to affect the individual's life. It begins to affect his/her family. It is a family disease. The following information, while describing alcoholism, is also applicable to families experiencing addiction to other drugs.

Children who grow up in alcoholic families, spouses living with an alcoholic and parents with alcoholic children are all affected by a common thread with common symptoms. One of the most common is role reversal or taking on each other's functions or responsibilities. The entire family becomes negatively emotionally involved with the alcoholic. The alcoholic's addiction is with the bottle. The family, in their distorted roles, is addicted to the alcoholic. Thus, both have a disease.

None of the family members are primarily concerned with their own feelings or needs. Rather they live in perpetual dread of the alcoholic's behavior. All of their highs and lows are reactions to the behavior of the alcoholic. The longer the family lives in the condition, the more distorted their own emotions and general reasoning becomes. Distorted emotions and reasoning are common symptoms among members of a family where the disease of alcoholism is present. Several "categories" can apply, and as always one must allow for the fact that all are individuals.

Listed below are the most frequent categories and roles present in these families:

- **Chemical Dependent:** Goes through progression of guilt, shame, and a growing fear. They deny the problem by hiding it behind a wall of defense and remaining basically an adolescent in terms of emotional growth. This false front does give others in the family the illusion that they (the alcoholic) are "OK."

It is said that it takes at least two to have an alcoholic. Examples of co-dependency include:

- **The Chief Enabler:** Person closest to, and most depended on by the alcoholic for their self worth. They are inevitably affected by the mood swings of the alcoholic. To keep a facade of normalcy, the enabler becomes more and more responsible for perpetuating the facade.
- **The Family Hero:** Usually, but not always, the oldest child. They see and hear more of what is happening in the family unit. They begin to feel responsible for the pain and turmoil in the family. They work hard to make things better, with a diligence to improve the situation. They often excel in academics, sports, or social organizations and bring favorable recognition to themselves and the family. They may appear quite mature, responsible, and healthy. However, hidden beneath the surface is loneliness, guilt, fear, and anger.
- **The Scapegoat:** Usually identified by the family as "The Problem." Usually the second child, he/she is quite often deprived of positive attention which is given to the hero and deprived of the immense energy which the parent with substance dependency may require. Quite often cute, humorous, and fragile, sometimes loud and precocious, the scapegoat gets attention in negative ways through disruptive and acting out behavior. Few see the fear and insecurity within the child. Scapegoats are often blamed for many of the family problems which are not their fault. "You would drink too, if you had a child like that," is often heard about the scapegoat. They come to act in a manner which will justify the accusations and often develop substance abuse problems themselves.
- **The Lost Child:** Tends to be withdrawn and a loner whose most valuable contribution is that he/she does not disrupt or demand attention. Because the family's attention is focused elsewhere, there is little attention available anyway. The lost child suffers loneliness even though loneliness is the most comfortable for them. As the family turmoil increases, the child often finds validation in fantasy. Without help it is almost impossible to find this validation in themselves, resulting in low self-esteem. They stand a good chance of becoming depressed and addicted to alcohol or drugs or becoming adults who are involved in co-dependency situations.
- **The Mascot:** Usually the family clown, the one who will do virtually anything to make the other members feel better. The mascot takes on the job of relieving tension and lessening crisis. They are very sensitive to the moods and needs of others. When mascots reach adulthood, they have trouble recognizing and meeting their own needs and have trouble dealing with stress.

It is important to remember that these roles are uncomfortable and confusing to anyone in them. The symptoms of one family member, while different from those of others, are all symptoms of a dysfunctional family. It is possible for

children to switch roles or for one person to assume more than one role at a time. For example, if the hero moves away, the family may respond by promoting another member as its hero.

Another trait of alcoholic or dysfunctional families is the presence of certain rules which prohibit a healthy family life and tend to perpetuate the dysfunction. These rules, while not stated, are none the less understood and enforced by all family members. These rules can be summarized as "Don't talk, don't trust, don't feel."

- "Don't talk" refers to the pattern of internalizing everything and not expressing feelings or thoughts to anyone. The family member understands that he or she should not disclose to anyone what is going on in the household - financial difficulties, drunkenness, physical/sexual abuse, or threats of divorce. If this rule is carried into adulthood, it makes honestly discussing virtually anything, of a personal nature, very difficult.
- "Don't trust" refers to the family member's learning that the only safe way to exist in an alcohol/substance distressed household is to not trust anyone. Others will prove to be unreliable. If this rule is carried into adulthood, it makes forming any sort of partnership with another person very difficult.
- "Don't feel" refers to the family member learning to deny and avoid his/her emotions. This rule is one way to avoid the emotional roller coaster of extreme highs and lows in an alcoholic household. Again, if this rule is carried as a coping skill into adulthood, it makes the individual poorly equipped to deal with life's emotional challenges. The adult child of an alcoholic is more likely to have inappropriate responses to events. For example, the person may have a rather cool or indifferent response to a personal or family tragedy but over respond to a book, television program or movie.

Why do families tolerate these conditions? It is because the conditions develop slowly, inch by inch, brick by brick. Role changes happen gradually and defenses are built slowly over a period of time.

The family's best defense against the emotional impact of alcoholism is gaining knowledge and achieving the emotional maturity and courage needed to put it into effect.

Recovery Resources

Successful recovery often requires a formal treatment program. The type of treatment program depends on the extent of the alcohol problem and the degree of impairment that has resulted. The two basic types of treatment programs are residential programs, which typically include detoxification services as needed, and outpatient programs:

- **Residential programs** provide extensive, short-term, 24-hour support to develop sobriety and encourage new patterns of social relationships, self-awareness, and personal development. Most residential programs have a length

of stay of approximately 30 days. Alcoholism is characterized by chronicity and tendency toward relapse. Consequently, most treatment programs in an attempt to counteract those two characteristics, offer a period of extended association with the facility called aftercare. Aftercare usually consists of regular, scheduled return visits to the facility for group and/or individual counseling sessions. Aftercare normally lasts from three months to one year or longer. The longer a person remains abstinent, the better are his chances to continue to do so.

- **Outpatient programs** provide individual and/or group counseling to individuals who do not require, or who no longer require a residential program. The advantages of outpatient to residential treatment are obvious; the person is able to continue with his/her job and home life with little interruption. Outpatient is usually far cheaper than residential treatment.

Two very different types of outpatient treatments are "intensive" and "supportive." In the intensive programs, the client usually attends classes, lectures, group therapy, and individual therapy sessions several times a week. Clients live and sleep at home and continue to work and maintain other responsibilities. Treatment sessions are usually in the evening. The length of the intensive outpatient program is usually longer than that of a residential program. Most programs are six to eight weeks. In a supportive outpatient program, the client attends the treatment facility on a regular basis; usually once a week for individual or group therapy sessions.

It is possible for a client to be transferred from one type of treatment program to another as his progress or lack of it determines. A person may need a combination of these types of treatment in succession or may only need outpatient services.

Although **Alcoholics Anonymous (AA)** is not a formal treatment program, it is often recommended to supplement professional treatment, and for some it may be the only recovery resource needed. AA provides ongoing fellowship and support for sobriety. AA was among the first methods to be successful in assisting large numbers of alcoholics to recovery. Part of its success is attributable to the premise that every member is a resource for every other member. In fact, the founding members discovered that helping each other remain sober was one of the best ways they had to remain abstinent themselves.

Al-Anon and **Alateen** are recovery programs for the spouse, friends and relatives of alcoholics (co-dependents). Al-Anon members say that those who love a practicing alcoholic become as sick as the drinker. The main purpose of participation in Al-Anon is not to help sober up the friend, lover, parent, child or spouse, but to free the co-dependent from their own destructive behaviors. Although it shares some of the same principles of recovery as AA, Al-Anon is a separate entity and is not affiliated with AA. While not necessarily a goal of Al-Anon, those in the program feel that if they become healthier and change how they behave, they can help the alcoholic to a new awareness of their behavior and possibly into recovery. They maintain that continued participation in the dysfunctional roles is destructive to families and the alcoholic.

Group medical insurance in Missouri is required to include coverage for treatment of alcoholism just like any other type of medical treatment. Group insurers are required to offer drug abuse coverage as an option. However, not everyone has "group" medical insurance. Those who have medical insurance could also have what are called "self-insured" policies or "individual" policies. Treatment is available even if one does not have group medical insurance. State funded programs provide services and charge on a sliding scale based upon family income and size. Often there is no charge or a very low charge.

Information regarding treatment resources and support groups can usually be found in local phone directories, through community health centers, and local ministerial alliances.

Check List For Symptoms Of Alcoholism

Does the person...

- Need a drink the "morning after"?
- Like to drink alone?
- Lose time from work due to drinking?
- Need a drink at a definite time daily?
- Have a loss of memory while or after drinking?
- Find himself/herself (or others) harder to get along with?
- Find his/her efficiency and ambition decreasing?
- Drink to relieve shyness, fear, inadequacy?
- Find his/her drinking is harming or worrying the family?
- Find himself/herself more moody, jealous, or irritable after drinking?

Parent Questionnaire

The following is a questionnaire the Children's Service Worker can share with the parents if their child is suspected of abusing drugs or alcohol. Symptoms vary, but there are common signs the parent can watch for:

1. A dramatic change in personality. Does your youngster seem giddy, depressed, irritable, hostile without reason?

2. Do his or her moods change suddenly and without provocation?
3. Is your youngster less responsible about doing chores, getting home on time or following household rules and instructions?
4. Has he or she lost interest in school, extracurricular activities, especially sports? Are grades dropping? Have there been complaints of sleeping or being inattentive in class? Problems at school are common warning signs.
5. Has there been a change in friends toward a drinking or drug taking group? A youngster having problems with alcohol or drugs will abandon old friends and seek out those with similar attitudes and behavior.
6. Are you missing money or objects that are easily convertible into cash?
7. Does your youngster "turn off" to talk about alcohol or other drugs or strongly defend his or her right to use either or both? Abusers would rather not hear anything which might interfere with their behavior. People defend that which is most important to them.
8. Does the youngster stay alone in his or her bedroom most of the time? Does he or she resent questions about activities and destinations? Some secrecy and aloofness by teenagers is normal, but when carried to extremes, these may signal problems other than just growing up.
9. Has the youngster's relationships with other family members gotten worse? Does he or she avoid family gatherings which once were enjoyed? The primary family relationships are affected first.
10. Does your son or daughter lie to you or others? Lying about one's drinking/drugging is almost an infallible sign of a problem.

If the parent sees real evidence, such as the aforementioned signs, that his/her son or daughter is having a problem, don't hesitate; the parent should take some action; the worst thing to do, is nothing. It's easy for the parent to deny there is a problem, just as it is easy for the youngster to deny he or she is having a problem or even drinking or using other drugs. The Children's Service Worker should assist the parents in recognizing the problem and locating professional assistance.

Refusal Skills

One reason that many young people (and some adults) use alcohol and drugs is that they have difficulty refusing an offer if it is presented. Many people feel pressured to use substances. Pressure occurs when someone encourages or tries to force them to do something. The following is presented to assist Children's Service Workers and parents in their prevention efforts with young people.

There are at least five types of pressures used when trying to persuade someone to use substances:

1. Pressure to try substances includes the **simple offer**.

The simple offer involves someone offering a drink, a pill, a snort, or any other substance as they might offer a soda, a stick of chewing gum, or a piece of candy. For example, "Would you like a beer?"

2. Pressure to try substances includes the **dare offer**.

The dare usually involves a challenge of the youth's courage or sense of daring with statements like "Go ahead, I dare you" or "What's the matter, are you scared to?"

3. Pressure to try substances includes the **threat offer**.

The threat implies that the youth will lose something of value if he/she does not use the substance. The loss could be anything of value, such as friendship or even the threat of harm. For example, "I won't be your friend if you don't try this."

4. Pressure to try substances includes the **indirect offer**.

The indirect offer does not directly threaten the youth, but it implies a loss of stature if he/she doesn't participate. For example, "We're having a keg party. Be there or be square."

5. Pressure to try substances includes the **internal offer**.

The internal offer appeals to the youth's internal needs rather than external or social needs. For example, "Oh, you're feeling down today. I have some pills that will take care of that." This offer implies that substances will take care of your feelings and problems in living.

Sometimes the pressure will be a simple offer and will progress to a dare, threat, etc.

There are good reasons for a young person refusing offers of alcohol or drugs. Here's a review of some of the basic ones:

1. For adolescents, all alcohol or drug use is illegal except for the use of medications as prescribed by a physician.
2. Substance abuse interferes with natural development physically, emotionally and mentally. The interference involves both short-term effects and long-term effects.

3. Substance abuse is destructive to family relationships. Substance abuse by one family member negatively effects all family members.
4. Substance use can become a preoccupation and interfere with other interests and your ability to function.

Once the young person has begun using substances it is not easy to just stop and start saying "no". Even if they know in their mind that alcohol and drugs are a negative influence on their lives and their future, it is not easy to change their behavior. However, there are certain skills and knowledge that can help them.

There are many different ways to refuse drug offers. Some of these techniques are:

1. "No thanks" Technique
"Would you like a joint?"
"No thanks."
2. Broken Record
Repeat the same phrase over & over.
"Would you like a joint?"
No, thanks."
"Come on!"
"No, thanks."
"Just try it, chicken!"
"No, thanks."
3. Giving a Reason or Excuse
"How about a beer?"
"No thanks. I don't drink" or
"No, thanks. I'm going to
play ball in a little while."
4. Walk Away
"Would you like to smoke some marijuana?"
Say "no" and walk away while you say it.
5. Cold Shoulder
"Hey! Do you want one of these pills?"
Just ignore the person.
6. Changing the Subject
Start talking about something else.
"Do you want to smoke a cigarette?"
"Come on. Let's get started with baseball
practice."
7. Reversing the Pressure
Putting the pressure back on the person
offering you the drug.
"Do you want to smoke a joint with me?"
"No, thanks. I thought you were my friend."
8. Avoiding the Situation
If you see or know of places where people

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often use drugs, stay away from those places.

9. Strength in Numbers

Hang around with non-users, especially where drug use is expected.

Related Subject: Division of Alcohol and Drug Abuse Service Provider Directory http://www.dmh.missouri.gov/ada/help/ProviderDirectory10-07.pdf

Acknowledgments: Jim Schlueter, Program Specialist, and other staff at the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse, reviewed this chapter and submitted contributions.

Sources:

Missouri Department of Mental Health, Division of Alcohol and Drug Abuse, Curriculum Guide for Alcohol and Drug Education Programs (ADEP), 1988

Missouri Department of Mental Health, Division of Alcohol and Drug Abuse, Curriculum Guide for Alcohol Related Traffic Offenders Program (ARTOP), 1988

The Koala Center, P.O. Box 90, Lonedell, Missouri 63060, "Parent Questionnaire"

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17: Relationship Building

Chapter 17 Overview

This chapter will examine the importance of developing the helping relationship and those skills needed to develop a positive working relationship between the Children's Service Worker and the family member.

The Primacy Of Relationship

Strong Children's Service Worker-family relationships are primary to the process of treating dysfunctional families in their own homes. The intensity of service and the workers' presence in the home make possible a much closer working relationship with the family than in traditional service systems.

The positive in-home helping relationship has many dimensions:

- A spirit of friendship that is facilitated by the Children's Service Worker's willingness to work with the family on their "turf";
- The family's experience of really being believed in, often for the first time. Educational research has shown that the expectations of the helper are a prime determinant of behavior. Family-Centered workers find that this principle operates in family settings as well;
- Providing support when the going is tough. Sometimes simply living through an experience with the family is the most helpful thing one can do;
- Stimulating hope, often the necessary first step in developing the motivation to change.
- The families referred for Family-Centered Service tend to be those for whom developing relationships is the most difficult. Because of their many negative experiences, they often have developed an understandable mistrust of authority, institutions and so-called "helping" professionals. But, even though developing relationships is not to be considered an end in itself, all else hinges on a positive working relationship.

Developing The Helping Relationship

A positive working relationship with the family members can be developed by the Children's Service Worker:

- Being readily available to the family;
- Interacting with them in a relaxed and natural manner;

- Showing genuine concern and really listening;
- Recognizing each member as an individual;
- Being honest; and
- Being willing to reach out and make extra efforts for the family.

In turn, the family members can learn to trust the Children's Service Worker and experience a relationship that is consistent, predictable and reliable. They can feel cared about as individuals. Through their relationship with the worker, the family can find someone that they can depend on. This may decrease the parents' need to depend upon their children in unhealthy and inappropriate ways, and demonstrate responsible adult behavior to the children.

Stages Of The Helping Relationship

After the initial stage of relationship development, many helping relationships pass through four additional stages:

- **Transition Period.** During this stage of the relationship, parents are learning to trust the Children's Service Worker and may begin to test the relationship through difficult and unproductive forms of behavior. Anger and frustration may be freed and vented and the parent may even be hostile to the helper. If the parent tests the relationship in this way, it is important for the worker to set limits and focus on helping the parent learn how to begin changing behavior patterns to ones that are appropriate;
- **Partial Dependency.** As parents learn that they are valued in spite of their difficult behavior or hostility, they may be ready to begin self-acceptance and self-nurture. This is also a time to concentrate on learning new parenting patterns and problem solving;
- **Independence.** The goal of the nurturing and re-parenting relationship is to improve self-esteem enough so that the parents can cope constructively with crisis situations, can use others in times of extreme stress, and can enjoy being with their children and use appropriate parenting and child-management techniques. The Children's Service Worker should respond to the parent's strong need to have positive growth and change recognized;
- **Termination.** The termination process is crucial. Children's Service Workers should work with their supervisors to plan and carry out the termination phase. Generally, the procedure for terminating should include:
 - Preparing for withdrawal through open discussions;

- Gradually decreasing contact between Children's Service Worker and parent;
- Helping the parent develop other supports if this has not begun earlier in the relationship;
- Continuing to recognize and highlight positive changes;
- Being sure that parents have someone they trust with whom contacts can be maintained after termination;
- Either continuing permission to contact the Children's Service Worker or by contacting an alternative friend and advocate;
- Children's Service Workers should not be surprised if the parent experiences a sudden "failing" during the termination process. It is often a normal phenomenon and should not ordinarily be permitted to forestall termination.

Developing Alternative Support Systems

Family-centered programs emphasize the need to help family members develop their own support systems which will remain in place after services are terminated. The Children's Service Worker should be planning toward the family's eventual independence from the onset of service. The possible sources of alternative support are as varied as the circumstances of the family and its members:

- Community organizations;
- Religious organizations;
- Groups at neighborhood centers;
- Parenting classes;
- Groups organized around special interests (athletics, gardening, CB radios, etc.);
- The extended family (though resolution of relationships with members of the extended family may be necessary before their involvement can be constructive);
- One-to-one relationships with volunteers recruited and supported by Children's Service Workers for special purposes;
- Support groups for persons with similar problems, such as:
 - Parents Anonymous;

- Parents Without Partners;
- Alcoholics Anonymous;
- Al-Anon family groups;
- Alateens; and
- Weight control groups. (These can be very supportive, and some maintain a policy of waiving membership fees for low income members.)

Program Support Groups

Many family-centered programs which serve multi-problem, socially isolated parents eventually develop their own support groups to meet client needs which cannot be met by the Children's Service Workers alone:

- **Mother's Groups**

Socialization: Generally the most important purpose of a mother's club is to provide opportunities for mothers to get away from the children for a time, to emphasize the mother's separateness and need for adult friendship and to make her the center of attention. In a semi-safe atmosphere, accompanied by the Children's Service Worker, she may learn to develop and maintain other relationships. Gathering for coffee, festive Christmas parties, picnics and other events are memorable occasions for workers and families alike.

Group Counseling: In group settings, parents may realize that their problems are not unique and that others are facing and coping with similar problems. Skills such as assertiveness and problem-solving, which have been learned in the counseling relationship, may be practiced in the group setting. In general, mother's club meetings give clients a chance to experience themselves in a new and different light.

Education: The agency may use the group meetings to provide a structured educational component. Club members often participate with Children's Service Workers in planning topics and activities of interest, such as how infants and children learn, parents' role in teaching children, dealing with homework, sex education and family planning, family health and safety issues, abused women, inexpensive crafts and hobbies, using community resources, and preparing inexpensive, but nutritious meals.

- **Youth Groups**

Mother's clubs are often organized to fill a vacuum in a community's existing organizational life. Such vacuums may also exist for adolescents who do not participate in the cultural or social mainstream of their communities.

Example: A family-centered agency serving an affluent farming community became aware that many of the families of adolescents referred for status offenses or delinquent behavior shared a common cultural environment. Living in small, makeshift homes on the banks of a local river, these "river people" were largely excluded from the organizational life of the school and community.

Children's Service Workers who counseled these families in their homes became aware of their special interests and talents. Existing organizations (school and 4-H clubs) neither recognized nor nurtured their exceptional strengths in hunting, forest and wildlife survival skills. Children's Service Workers organized a 4-H group which offered a channel for recognition of the skills which were important in their sub-culture. A boxing club was also formed by a volunteer worker.

- **Self-Help Networks**

Agencies have used their community organizers or resource coordinators to compile resource files of neighborhood residents with special skills that other clients can use. For instance, a family having difficulty with the Department of Social Services could be put in touch with a neighbor who knows the ins and outs of the welfare system.

- **Parent Workshops**

Agencies have organized workshops which use a parenting curriculum developed for high-risk families. The workshops meet for two hours per week for a period of eight weeks. While the opportunity to socialize with other parents is a by-product of these workshops, the essential purpose is to help parents understand themselves and their children better. Participation in such workshops can be used to document parents' efforts and progress for Children's Service Workers and the court. (Providing both child care and transportation is often essential to gaining the parents' participation).

Source: This chapter was adapted from Placement Prevention and Family Reunification: A Handbook for the Family-Centered Service Practitioner, authored by June C. Lloyd and Marvin E. Bryce with assistance from LaVonne Schulze, published by The National Resource Center on Family Based Services, Revised 1984, Chapter 8, "The Nurturing and Re-parenting Role."

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18: Investigative Interviewing

Chapter 18 Overview

This chapter will outline procedures for interviewing the subjects of a report and other persons who may have relevant information.

I. Objectives Of The Interview

The purpose of interviewing is to establish contact with the subjects of the report and other persons who may have relevant information. The worker should use the interviews to secure information to assess the need for protective services and the priority status of that need. The worker should use investigative interviews to secure information relevant to determining whether there is credible verbal evidence or physical evidence to determine a reason to suspect conclusion or whether there are indicators to determine an unsubstantiated preventive services indicated conclusion or if neither is present, and unsubstantiated conclusion.

II. Preparing For Interview

To best prepare for a child abuse and neglect response the worker should consider and resolve any personal doubts about his authority. It is critical for the worker to evaluate his own reactions to the allegations contained in each report. Despite training and expertise, a worker is not necessarily immune from negative feelings about allegations. The worker needs to recognize and resolve these feelings in the effort to maintain objectivity.

The worker must be prepared to acknowledge his/her own feelings realizing that personal biases are inappropriate in the professional setting. Biases only inhibit an objective assessment of the facts.

Some allegations of abuse and neglect will not be settled conclusively. Despite rigorous investigative efforts, the available evidence will not prove or disprove certain allegations. Workers will then have to enter an unsubstantiated conclusion. A status of reason to suspect cannot be determined if there is no physical or credible verbal evidence to support the status.

The rule of thumb for the investigation is that obtaining too much information is preferred to obtaining too little. Remembering that each piece of information is the key to additional information that reinforces the importance of the fact-finding process and the interviewing mode.

NOTE: If the case involves a current client, review case records, talk to protective service worker, but do not make preconceived decisions. Be objective.

III. Opening The Interview

The manner in which the worker begins the initial interview will set the tone and pace for the investigation/assessment. Consequently, it is important that the worker utilize techniques which will facilitate entry into the home.

The worker should introduce her/himself and show an ID card to the caretaker(s). He/She should then clearly explain the purpose of the visit. The worker should anticipate that the individual will be, at the minimum, surprised at the worker's presence. If the individual is hostile and threatening, the worker has the option of leaving the home. A situation of this sort is a judgement call, but under no circumstances should a worker feel obligated to pursue an interview with a person who constitutes a danger to his/her safety. On the other hand, many people may simply need to express their anger and frustration and may do so without actually posing an immediate threat. Before beginning a lengthy conversation, the worker should ask permission to go into the home if the caretaker has not already extended this invitation. Once inside, the worker should try to go to a comfortable private area to sit down and talk.

The worker should then state the reason for the investigation/assessment, making reference to the receipt of a hotline report. He/She should provide the alleged perpetrator and subjects of the report a written description of the investigation process (CS-24) and assessment process (CS-24A). Leading into the interview by discussing the agency's concern for the child's safety and well-being, in general terms rather than in specific terms, will encourage the caretaker's discussion of problems and will not limit the conversation by focusing exclusively on the specific allegations in the report. The worker should assume a non-accusatory manner and emphasize that the report has not been accepted as true and that determining its validity is the purpose of the fact-finding process. In addition, the worker should enlist the caretaker's assistance in identifying problems and in determining whether the child has been harmed or is at risk of future harm. The worker should consider asking the caretaker about the child in general (i.e., his/her routine, behavior, development) to ease into a more specific decision of the caretaker-child interactions and the caretaker's perception of the child's condition.

The worker should also tell the caretaker that he/she will need to interview the child, alleged perpetrator (if other than the caretaker) and perhaps others who can lead to the final case determination. The more the parent understands about the investigation/assessment process and the worker's role, the more likely he/she is to cooperate.

Things you may want to tell the caretaker, depending on your particular case situation, include:

- The agency's responsibility to secure information from other persons and facilities in order to complete a thorough investigation/assessment;

- The agency's responsibility to intervene, when necessary, initiate court petitions, and provide services;
- The agency's intent to work confidentially with them, except when it becomes necessary to inform and/or collaborate with the court systems, law enforcement officials or other relevant agencies (i.e., hospital);
- The possibility of arrest and criminal prosecution of the perpetrator;
- The fact that information concerning the report has been entered into the agency's files and the subjects have a right to access some information in the report (excluding reporter's name);
- The caretaker's rights and responsibilities; and
- The additional action to be taken by the worker, including information that will be sought. At times a written consent/release of information should be obtained to contact certain collaterals. i.e., hospitals, counselors. Statute allows investigator to obtain such information, but it may be easier with consent.

IV. Conducting The Interview

Establishing Rapport

Workers use a variety of methods to establish rapport. These methods vary significantly given the persons involved and the situation in which interviews are taking place. Workers exercise their professional judgment when formulating an approach to developing rapport and take into consideration several personal factors, including:

- The emotional and physical health of the individual;
- The apparent educational level of the individual;
- The individual's ability to understand English or the worker's fluency in the interviewee's language;
- The maturity and sophistication of the individual; and
- The individual's level of hostility.

Interviews are usually conducted in person, although telephone contacts with collateral sources are used when time and other constraints make face-to-face contact impossible. Interviews with the caretaker and child must always take place in person, although subsequent telephone contacts may be used to obtain clarifying information or to discuss a particular aspect of the agency's intervention.

The nature of the investigation and intervention in family life can create an adversary relationship between the worker and the family. The worker must be mindful that attempts to discuss problems and concerns with the family will be difficult and will be met with some resistance. Communication can only be accomplished if the worker is willing and able to discuss the nature and potential outcomes of the agency's involvement. Persons who feel that they are being deceived or manipulated will be hesitant to talk openly about child rearing difficulties that may have resulted in abuse and neglect. The worker should never lie to or deceive the interviewee or minimize the importance of the investigation. Attempts to soften the impact of the agency's involvement, through hidden agendas or by misrepresenting the process or outcome of child protective interventions to assure the child's safety, will backfire. Rather, the worker should emphasize that the agency's primary objectives are to assure the child's safety, to determine the validity of the report, and to limit its intervention in family life. Expressing the agency's child protective role and responsibility in non-threatening, non-accusatory, matter-of-fact manner will convey concern for the child's safety and the non-compromising nature of the investigation.

In summary, rapport is the positive feeling the worker seeks to establish with a client. To reach this goal remember these tips:

- Show empathy;
- Express concern;
- Be non-punitive;
- Be honest; and
- Focus on the here and now.

Maintaining Control

The potentially adversarial nature of child protective services investigations may create a difficult environment for conducting interviews. Interviewees may express anger, hostility, denial or resistance. They may do so by becoming verbally abusive, sullen, manipulative, overly compliant, and/or physically aggressive.

In order to maintain control during interviewing, the worker should utilize a variety of techniques, including:

- **Structuring Interviews:** To control the interview, workers should keep interviewees on the subject, prevent them from going into excessive or extraneous detail, and maintain a calm, emphatic and firm demeanor which will help prevent escalating emotions. The worker should not appear shocked or surprised at information given or feelings expressed during investigations.

- **Maintaining Objectivity:** The worker should not interpret an interviewee's negative remarks as a personal attack. If the remarks are taken personally, the worker may become defensive, discourteous, argumentative, or conciliatory and is likely to disrupt the course of the interview. A worker's retreat from a stated position, apology for the investigation, or inappropriate agreement with the interviewee's statements to pacify him or her may weaken the worker's authority as well as complicate and impede the interview.
- **Being Assertive:** Workers should be assertive by communicating confidence in their own role and their professional judgment. They should demonstrate acceptance of the responsibilities invested in them by state law and state and agency policies and procedures. Workers should be comfortable with their knowledge and expertise as investigators. They should not express fear, embarrassment or discomfort with their role as agency representatives. Nonetheless, they should convey the authority of the agency without appearing authoritarian. Remaining calm, composed, and attentive rather than excited, aloof, insensitive, or belligerent is important.
- **Anticipating Responses And Questions:** The worker should anticipate that the interviewee will want to know the identity of the reporter and may become hostile or antagonistic in an effort to obtain this information. The worker should inform the interviewee that the reporter's identity is confidential and cannot be shared, just as information secured in the investigation will also remain confidential. The worker should quickly redirect the interview, making it clear that the investigation must continue. In some instances it is inevitable that the interviewee will randomly name the reporter in a guessing game to determine the reporter's identity. The worker should anticipate that this will happen and be prepared, each time, to matter-of-factly redirect the interview back to the incident. Because the law protects the confidentiality of the reporter, refusing to confirm or deny the interviewee's guess is important.
- **Redirecting:** Anger and fear are typical reactions to being interviewed. To prevent escalating emotions from impeding the investigation, the worker may wish to redirect the interview to a "safe" topic. After the interviewee has regained his/her composure, the worker gently and sympathetically leads the interviewee back and redirect him/her through leading questions to a discussion of the immediate situation.
- **Discontinuing Interviews Temporarily:** A final strategy that should be considered when the interviewee's anger or hostility is hampering the investigation is to stop the interview temporarily and resume it at a later time. Before the worker uses this technique the following should be considered:
 - The effect the delay may have on the child's safety;

- The possibility that the interviewee might try to cover up the truth;
- The likelihood that the family might flee with the child; and
- The time frames for completing the investigation.

The worker should consider interviewing the child or other family and household members when it appears necessary to temporarily discontinue an interview with the caretaker. Unless physically threatened, the worker should see the child prior to leaving the home. Pausing to do so gives the worker an opportunity to carry out mandated responsibilities while providing the caretaker with time to calm down and regain composure.

If the worker decides to discontinue the interview temporarily, he/she should make another appointment immediately to resume the interview. Depending on worker's assessment of the situation, he/she may wish to return to the home later alone, return to the residence with the police, or request the interviewee to come to the worker's office.

- **Responding To Overly Compliant Interviewees:** Workers may encounter interviewees who are unable to express themselves directly and resort to behaving in what superficially appears to be a very socially acceptable manner. The worker who is not prepared to deal with the overly compliant, accepting or helpful individual may relinquish control of the interview.

The worker should not be falsely assured by overly compliant, cooperative and accommodating behavior or statements. These may be a smoke screen to diffuse the agency's concern and to manipulate the worker. In certain situations the worker should be suspicious when, despite the adversarial nature of the investigation, a caretaker graciously and warmly receives the worker in the home, taking care to be friendly and complimentary during the interview. This behavior may be coupled with attempts to engage in social conversation. While acknowledging that this behavior and attitude are facilitating the interview, the worker should realize that determining the validity of the report and assessing the child's need for protective services are the main purposes of the investigation.

- **Handling Physical And Verbal Threats:** On occasion, a worker may encounter individuals who threaten the worker's physical safety. No threat should ever be ignored, although the context and expression of the threat should influence the worker's response. Observations about behavior, communication and physical appearance are also critical to gauging the likelihood that the individual will carry out a threat of physically attacking the worker. These cues include:

- An individual experiencing a high degree of emotional arousal (i.e., feeling rage or threatened) may exhibit increased body movement, accelerated speech, or a change in the volume and tone of voice;
- An individual fearing attack or invasion of personal territory may physically distance himself or herself from the worker in an effort to defend against the perceived threat;
- An individual's facial expression (tensed muscles, dilated pupils, fixed stare, clenched teeth, reddened face) may signal potential uncontrolled anger; and
- Communications which become increasingly abbreviated during the course of the interview may signal the individual's loss of control. Noteworthy is a change from narrative explanations and answers to abrupt, abbreviated speech (i.e., yes, no, so what, etc.).

At all times, **remaining calm, composed, and in control** is important. Remembering that aggressive or hostile behavior may represent the individual's fear and self defense mechanisms is important. Reassuring the individual of concern for the child's safety while restating the worker's roles and responsibility in a non-threatening way may be comforting.

Individuals who remain enraged and diffused by discussions with the worker or who seem unaware that their behavior is threatening should be taken seriously. Under some circumstances telling the individual that police will be summoned is not advised if it could prompt the individual to attack the worker. Being prepared to assess the potential danger of a situation is critical. The worker should never ignore any cue that the worker's physical safety is in danger, nor should the worker ever hesitate to obtain assistance of law enforcement or juvenile court personnel when appropriate, to ensure the child's safety.

- **Assessing The Interviewee's Condition:** An important factor influencing the process and outcome of any interview is the condition of the person being interviewed including age, level of intellectual functioning, personality, emotional state, and influence of alcohol or other chemical intoxicants.

As a general rule, do not attempt to conduct interviews with chemically intoxicated individuals. In all but emergency situations, their interviews should be postponed. If a caretaker's functioning is so hampered by his or her condition that it endangers the child's safety, emergency intervention may be necessary. In all other situations, the individual should be informed that the worker will return in a few hours to resume the interview. If discussion with the intoxicated person can't be postponed, the worker may find that patience is necessary. Keep questions simple and focused on the situation at hand. Consider the need for

leaving a note to remind the individual of an expected return visit. Before leaving, the worker should see the child who is the subject of the report. If a caretaker won't permit access to the child, the worker should return with law enforcement/juvenile court personnel immediately, if necessary. Additionally, the worker should find out what arrangements have been made for the child's care and supervision.

- **Using Interpersonal Communication Techniques:** Effectively using interpersonal communication techniques is critical to successful interviewing. The following techniques will increase the worker's skills and enhance investigatory abilities:
 - Use clear and concise wording and phrasing in all questions and explanations;
 - Appear energetic, alert, and attentive rather than sleepy, lethargic, and disinterested;
 - Establish direct eye contact with interviewees, however, staring or glaring can be as distracting as failing to look directly at the individual;
 - Be aware of the impact of physical proximity on an interview. The greater the physical distance between the worker and the interviewee, the more difficult it may be for the worker to communicate a helping attitude. Conversely, sitting or standing too close to the interviewee may be so distracting and discomforting that it impedes the interview;
 - Consider the effect of body posture on the interview process. The worker should face the interviewee with the worker's body inclined forward; and
 - Be attuned to the effective use of nonverbal gestures. A spontaneous use of nonverbal gestures (i.e., head nods, hand movements) can enhance communication. However, overuse can be distracting.
 - In order to encourage individuals to discuss problems and concerns openly and candidly, the worker may utilize the following techniques:
 - Use unstructured invitation-to-talk statements that enable or encourage the interviewee to begin talking about personal concerns. For example, "Can you tell me how Cindy got hurt?" "Can you tell me what happened to Cindy";
 - Use minimal verbal responses (i.e., yes, no, um-hum, sure) to reinforce the interviewee's effort to talk about issues and concerns, while reflecting the worker's attentiveness and interest;

- Use responses or questions that require more than the minimal yes or no closed-ended responses. Probing questions are generally prefaced by "what," "where," "when," or "how." For example, rather than asking "Did you beat Cindy and make those marks?" The worker would ask "How do you discipline Cindy?"
 - Use restatements to let the interviewee know you are listening attentively and you understand what was said. Restatements may include all or a selected portion of an individual's remarks. In addition, restatements provide the interviewee an opportunity to correct the worker's perception of what was said but misunderstood. The worker may also ask the interviewee to restate all or part of an answer for clarification;
 - Periodically summarize the content and central feelings expressed by the interviewee to demonstrate your attentiveness and interest; and
 - Repeat statements when it is not evident that the interviewee has heard or understood the first time. Repetition should also be used when it is important to emphasize certain points.
- **Observation Techniques:** Worker's observations of a variety of conditions and situations during child protective services investigation will contribute to a reason to suspect, unsubstantiated, or unsubstantiated-preventive services indicated conclusion. In order to be prepared to assess the abuse or neglect or risk of abuse or neglect to the child and the child's need for protective services, workers should make observations about:
 - Indicators of abuse and neglect;
 - Family interactions and functioning;
 - The caretaker's attitude toward the child and the parenting experience;
 - The developmental milestones of the child;
 - The physical condition of the surrounding neighborhood;
 - The physical condition in the home; and
 - The influence of cultural differences.

Because observations may be clouded by subjective interpretations, workers should document their observations with specific data.

Nonverbal communication occurs during regular day to day interactions. While a variety of these communications may be observed, the worker should strive to interpret them accurately. For example, the worker may observe that the child avoids all physical contact with and remains at a noticeable distance from the caretaker at all times. While this behavior may suggest that the child is afraid of the caretaker, other interpretations are plausible. In fact, the family may disapprove of all physical displays of affection in public, prompting the child to behave as described. The variety of individual and cultural differences dictates that interpretations of observed behavior be tested and that supporting evidence be gathered before reaching a conclusion that abuse or neglect has or is occurring or the child needs protective services. Discussing observations with the family may give the best insight.

- **Interviewing The Reporter:** The reporter is one of the most important sources of information about the allegations of abuse and neglect. In fact, the reporter may be the only source, other than the child and caretaker, who provides information about the abuse or neglect of the child. Consequently, gathering complete information from the reporter is a critical part of a comprehensive investigation. Remembering that each piece of information collected during the investigation is key to obtaining additional facts should guide the worker's interviews with all persons, including the reporter.

Upon receipt and review of the report, the worker should determine what additional information and detail should be secured from the reporter. The worker should confirm the information on the report form by contacting the reporter and gathering additional information before contacting the child and caretaker.

The information about what has happened to the child is of particular importance. The worker should encourage the reporter to relate the history of events which preceded the notification of the county agency and to discuss how he or she became aware of the situation and circumstances.

Although the relationship of the reporter to the child and family will often suggest how the information was obtained (i.e., the maternal grandmother who resides with family), the worker should pursue this line of questioning to elicit all relevant facts and details. Reporters are abuse/neglect victims and the worker should express appreciation for their contacting the Division.

Interviewing the school liaison. If the child is enrolled in school, the worker should initiate contact with the school district liaison to gain and share information throughout the investigation/assessment process. The school

Liaison may be considered a member of a multi-disciplinary treatment team, depending on their relationship with the child and/or family. The amount of detail given will reflect the school liaison's prior involvement.

- **Interview Parent/Perpetrator:** Investigative interviews with adults provide workers with opportunities to secure facts relevant to determining whether a child has been abused or neglected or is at risk of future abuse or neglect and to determine if the child is in need of protective services. Techniques utilized by workers as they interview adults will vary with the educational level, maturity, emotional state, relationship of the adult to the child, and condition of the interviewee. The worker should consider a variety of factors and techniques to complete interviews with adults in an effective, comprehensive, and timely manner, including the following:
 - **Language Usage:** The worker should communicate information in a concrete and specific manner, using commonly understood vocabulary. Jargon or abbreviations (i.e., CD) should be avoided. Focusing questions and discussion on the child's health and safety provides structure to the interviews and minimizes the number of distractions which might interfere with the fact-finding process.

Words that imply blame should be avoided in order to defuse the crisis and stress created by the investigation. For example, it is better to say, "The agency is trying to determine whether Cindy has been neglected." The worker should obviously avoid using value-laden language such as, "What a horrible thing to do."

Serial questioning may be used by workers to obtain information about specific factors and issues relevant to the fact-finding process. Serial questioning differs from open-ended questioning in that it is tailored to elicit specific information. Because these questions are less vague and less open to interpretation, answers may be more concrete and behavior-specific. For example, rather than asking a caretaker about the child's discipline which makes the worker vulnerable to questions such as ("What is discipline?"), a series of questions should be asked to elicit information indirectly on the particular topic, for example:

- Does Cindy listen to you when you give her instructions;
- Is Cindy a cooperative child;
- Does Cindy follow instructions;
- How has Cindy been acting lately;

- Is Cindy difficult to manage;
 - How do you control Cindy's behavior when she does not do what you want?
 - In addition to stating questions precisely, the worker should avoid hurrying the tempo of the interview.
-
- **Full Expression Of Ideas And Feelings:** The worker should encourage interviewees to express their side of a situation in an open-ended fashion. Allowing them to convey the facts and their impressions will help to establish the worker's impartiality and will demonstrate respect for the individual's viewpoint. Workers should be careful that the use of "why" and "how" questions are not interpreted as accusations. They should create an environment in which caretakers can feel free to discuss their own concerns about the care they are providing to their children.
 - **Reenactment Of The Incident:** The worker should consider using reenactment of the incident as a technique to gather information about an incident in which the child was physically harmed. Specifically, the caretaker should be asked to demonstrate how the child received a particular injury by showing the worker where and how the accident occurred. The reenactment allows the worker to make specific observations about the scene of injury and simultaneously to discuss the specifics of the caretaker's account of the injury. This technique is particularly helpful when discussing injuries that the caretaker says are accidental. For example, observing the distance between a crib and the floor, the condition of the floor or carpet, and the position and the movement of the child may pinpoint discrepancies which can be explored by additional questioning. When faced with the impracticality or implausibility of the explanation, the individual may be prompted to provide a factual account of the incident.
 - **Discrepancies In Information:** Discrepancies in the information provided during investigations are inevitable. The worker should assume that this will occur and be prepared to acknowledge the inconsistencies. The interviewee should be confronted with discrepancies and given an opportunity to clarify, restate and possibly negate information provided earlier. Confrontation is most effectively handled in a calm, matter-of-fact, non-threatening manner. For example, "I'm slightly confused by the information you have provided me. You first said that Cindy turned on the hot water faucet when you left the room, but later you mentioned that you mistakenly turned on the hot water faucet while she was reaching for soap." A request for clarification phrased in the manner does not imply the individual is lying.

- **Candor:** The worker should avoid the tendency to agree with everything the interviewee says or to offer false reassurance. Statements such as "Everything will be fine," or, "Don't be so upset, there is nothing to worry about," may create a false and often temporary sense of security for the interviewee. The nature of investigations precludes these guarantees. A candid acknowledgement of the situation and the range of possible outcomes is preferred to broken promises which weaken the worker's and agency's credibility.
- **Behavioral Manifestations Of Feelings:** The worker should be aware that a person who is uncomfortable or inexperienced with directly expressing feelings may instead communicate them indirectly through behavior. Feelings of anger, hostility, rejection, or fear may be expressed by refusing to let the worker enter the home, keeping the worker waiting at the door, being preoccupied with a television or radio program, or missing or being late for appointments.
- **Silence:** Silence may be a very effective way to stimulate conversation. Many people are uncomfortable with long pauses and are inclined to begin talking to break the silence. The pause may also provide a break from the intensity of the emotion-laden topics being discussed. The worker should be careful not to break the silence in an effort to reduce discomfort.

Interviewing Children

An interview of the child who is the subject of the report is necessary to make an assessment of the abuse or neglect and the risk of abuse or neglect to the child. In addition, these interviews provide the worker valuable opportunities to gather information, particularly the child's perception and account of the situation and events which precipitated the child's present condition.

Because the child and the perpetrator may be the only witnesses to the abuse or neglect, the child's account is important. However, the worker should not put the child in the position of having to prove the abuse or neglect.

At the time of a Child Abuse/Neglect report, interview the child(ren) using current policy. If a Juvenile Officer or Law Enforcement Official takes temporary custody (using the CS-33) of a child and the child requests a parent, guardian or attorney be present, the interview shall cease until such time a parent, guardian or attorney is available. This only applies when the person asked for by the child is not the alleged perpetrator and that if the interviewer believes that the parent is protecting the alleged perpetrator they can be excluded from the interview. It is important the CD staff document exactly why they believe the parent is trying to protect the alleged perpetrator. Nothing shall prevent the asking of any questions necessary for the care, treatment, or placement of the child. At the time a child is placed into the custody of the Children's Division, interviewing the child(ren) will be allowed using current policy.

When at all possible, children should be interviewed alone and away from parents, or other persons responsible for their care, especially the perpetrator.

Young children may be interviewed with a person whom they trust and who will not obstruct the interview, in order to alleviate their fears or apprehensions.

Taking into account a child's level of maturity or understanding, they should be informed realistically about various actions and outcomes likely to result from the child abuse or neglect.

The worker should also be sensitive to the child's feelings and attempt to avoid frightening the child or contributing to the child's sense of guilt or betrayal.

Children should be interviewed in settings in which they feel comfortable and which offer privacy without interruptions.

Techniques used by workers to interview children should vary based on the worker's professional assessment of the child's age, maturity, mental health, primary language and communication skills.

Interviewing the child may upset the balance of a precarious relationship between the caretaker and the child. The interview may prompt the caretaker to become suspicious, fearful, jealous of, or enraged with the child. In some situations, the interview may prompt retaliatory action by the caretaker which may place the child in increased danger or compound emotional stress. Consequently, the worker should be prepared to assess the impact of the interview and the risk of future abuse or neglect to the child.

The interview may cause the child to experience a wide range of emotions including fear, anxiety, and guilt at being asked to talk about family matters. The worker should be prepared to discuss these feelings with the child in an effort to allay fears and concerns.

- **Individual Interviews:** Interviewing the child and adult caretaker separately is preferred, particularly if the adult caretaker is the perpetrator. In other situations worker should use discretion and judgement.
- If interviews are conducted together, it is unlikely that either the child or caretaker will feel free to speak openly; and
- Individual interviews help prevent situations in which the alleged abusive, neglectful, or passive participants feel challenged by the child's statements and accusations. Such a confrontation not only impedes the fact-finding process, but also may place the child and others involved in danger.

- **Play As An Interview Technique:** One of the early decisions made by workers should be how to interview the child. Play as an interview technique has a number of advantages:
 - It provides workers either an effective method for establishing rapport while obtaining information about the child's experience;
 - It provides a mechanism for the worker to capture the child's interest and to interact on a level that the child understands;
 - It provides an opportunity to describe the situation while decreasing the guilt, fear, or anxiety of the situation for the child who has been coerced or coaxed into silence;
 - It has an added advantage of promoting expressive responses rather than yes or no replies to closed-ended questions; and
 - Its use in interviewing the young child can also be less threatening to the caretaker because it will be seen less frequently as a means of interrogation. As a result, the caretaker may be more willing to allow the child to be interviewed alone.

Workers need to be aware of the child's developmental stage when they are considering the use of play or have an opportunity to choose from a selection of play materials. Generally, the preschool child will readily be occupied with puppets, dolls, and fantasy play as well as drawing pictures and telling stories. The worker may wish to ask the child to draw a picture of the family and tell the worker about each person. The elementary school aged child may play with dolls and puppets but may show more interest in art supplies and action toys. Early adolescents may be more interested in direct interviews and table games.

The unavailability of dolls, puppets, and drawing supplies should not discourage the worker from the use of play interviewing. In addition to using whatever toys or props are available in the child's home, the worker can use pens and paper brought to the interview.

The young child's imagination makes it feasible to use a medium that is less symbolic, such as clothes pins, pencils, sticks and paperclips. Workers who choose this technique should be prepared to observe the child's actions, nonverbal communication, and the products of play (i.e., drawings) are important components of communication.

When interviewing the child about allegations of sexual abuse, worker may use anatomically correct dolls. The anatomical features of these dolls provide the child with a visual representation of the parts of the body which can be used to

demonstrate what took place. The worker should have the child identify body parts on the anatomically correct doll to learn the child's names for various parts, especially the breast, buttock, anus, penis, vagina, and groin. Anatomically correct dolls are a tool, and should not substitute for verbal interviewing or be used in all situations.

- **Physical Environment:** The physical environment may affect how relaxed and comfortable the child is during the interview and should be adjusted to meet the needs of the child. Workers should interview the child in an area that will be free of interruption and provide room for the child to move around and engage in play. Workers should arrange to sit close to and facing the child and make every effort to sit on the child's level (i.e., on the floor or on a low chair). The impersonality of sitting across from the child separated by a desk or table, should be avoided.

The worker should be mindful of the child's maturity and communications throughout the interview.

A five year old should be addressed differently than a more mature fifteen year old. The worker's assessment of the child's communication capabilities should determine which techniques are most appropriate. For example, the worker may ease into the interview by discussing the child's toys or pets when interviewing a five year old and may adopt a similar tactic with the adolescent by focusing on hobbies or school interests.

The content and the language of the conversation should be understood by the child. Jargon should be avoided. If the child appears perplexed, the worker should restate or clarify the content of his/her communication. Similarly, if the worker does not understand a word or expression used by the child, the worker should ask the child to clarify it.

If the child appears embarrassed, the worker may revert to a more general exchange until the child appears relaxed. The child should never be criticized for his/her choice of words, language or difficulty in articulating. The child's feelings about talking with the worker and understanding about the investigation should be discussed.

At an appropriate time, the conversation should move from the general to the specific. At this time the worker should determine what preparation the child has had for the interview and how the child feels about recounting the details of past experiences. The worker should ask if the child understands why the worker came to talk to the child. If the child has not been prepared, the worker should address the issue honestly. The worker should encourage the child to ask questions and be sure to answer him/her.

The worker should ask what the child's fears are, what the child would like to see happen and would like the worker to do. It is important that information provided to the child be accurate. However, over-informing the child about the process and potential outcomes of the investigation may be overwhelming. The worker should use the child's questions as a guide for deciding how much information to share.

Taping or videotaping the interview, or interviewing jointly with police, may minimize the number of times the child has to discuss the abuse or neglect.

Related Subject: Section 2, Chapter 4, Attachment B, Videotaping of CA/N Victims

The effective use of the following communication techniques can enhance the interviewing process with the child:

- The worker should give the child undivided attention;
- The worker should control personal reactions to the child's statements so they will not distract the child from sharing experiences. The worker should not express judgment such as "Your mother is a bad person because she abused you." Such a statement may be very offensive to the child and prompt the child to defend the integrity of the parent;
- The worker should try to fit comments or questions into the context of the topic being discussed by the child in order to be responsive. Switching topics abruptly or interrupting the child's train of thought interferes with the discussion of the child's concerns;
- The worker should avoid leading the conversation by suggesting responses. For example, the worker should ask, "Tell me what happened," or "Tell me how you got the bruises;" and
- The tempo of the interview should be slow.
- **Self Blame:** In all circumstances, the worker should accept and respond to the child's expressions of feelings and provide support. Regardless of the abuse or neglect sustained, the child may still have strong positive feelings about the perpetrator and may in fact feel responsible for the abuse or neglect. In order to counteract this self-blame the worker should not reinforce the label of victim for the child. The child should be told the worker is glad about their discussion, that abuse has happened to others, and that the worker wants to help protect the child from any further abuse. The worker should refrain from speaking unfavorably when discussing the caretaker and other family or household members and should not expect the child to take sides against them.

- **Clarity:** The worker should make every effort to clarify unclear and confusing information without suggesting answers or pressing the child for superfluous details or for information the child is not ready to discuss. However, the need for clarity should be balanced with the need to allow the child to describe experiences in his or her own way and at his or her own pace. At no time should workers try to frighten or intimidate the reluctant child into revealing information. Because intimidation is often used by the perpetrator, it can cause additional harm to the child and still fail to elicit the desired response.
- **Time Considerations:** Workers should be aware of the child's conception of time. Children may not recount events according to the time of day or the day of the month or year. The child may be confused or frightened, and not remember specifics. To clarify dates and details of incidents for legal proceedings, children may be able to relate to the significant times in their lives (i.e., seasons, school time, vacations, holidays, birthdays, meal times, bath time, television program slots).
- **Video/Audio Recording:** Video or audio recording of meetings, interviews, or interrogations conducted by the state of a child in the state's custody are presumed admissible as evidence in proceedings involving the child, regardless of whether the recording was made before or after the child was taken into the state's custody and such recordings were made prior to the adjudication hearing in the case and are inadmissible only upon a showing by clear and convincing evidence that the recording lacks sufficient incicia of reliability.
- **Child's Input Into Decision:** At some point, the worker should consider asking for the child's opinion about how the situation could be solved. To the degree possible, the child should have input into decisions that will affect the child without being misled to believe that he or she will influence the decision when this is not the case. In many instances, it may be beneficial to tell the child how the decision will be made.
- **Techniques For Interviewing Collateral Sources:** To complete a comprehensive investigation it is often necessary for the worker to interview persons outside the home who can provide factual information and additional perspectives about the child, caretaker and family situations. The following persons may be able to provide important statements and supporting documentations regarding the allegations:
 - Police personnel;
 - School officials and personnel;
 - Medical personnel;
 - Child care and preschool personnel;

- Regular babysitters;
- Extended family members;
- The child's friends and acquaintances;
- Neighbors; and
- Other agency personnel.

The worker should consider the following, when selecting a collateral source to interview:

- Which collateral sources are concerned about the child, have information concerning the child and the investigation and will respect confidentiality;
- The worker should make every effort to preserve confidentiality when interviewing collateral sources. The worker should be guided by revealing only that which is absolutely necessary to obtain the desired information; and
- The worker should seek to obtain the direct observations of collateral sources and should determine when and where the observations were made. Impressions may also be gathered if the collateral sources are able to distinguish and label their impressions as different from the reported facts.

Many collateral sources may be reluctant to share information with the agency regarding the child or caretaker. Current statutes give the agency authority to obtain information; however, a written authorization may be helpful. The worker should inform collateral sources that the information they provide will be recorded in the Division's record, and subjects of the report have the right to view the record.

V. Techniques For Closing Interviews

Certain techniques should be used to help draw interviews to a close. The worker should summarize the major issues and feelings and ask the interviewees if there are any other concerns they would like to discuss. Interviewees should have an opportunity to clarify any unclear or confusing information and should be left with an understanding of the purpose of the interview. Asking interviewees to summarize what has gone on in the interview is one way to gauge their understanding. Similarly, the worker should clarify any confusing or ambiguous statements.

The worker can begin to wind down the interview before terminating it by clarifying whether there will be future contact. When appropriate, the worker should state that the investigation may continue and that other sources of information may be contacted. The individual should also be told whether and when he or she will be notified about the

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worker's findings. The worker should leave the office telephone number, but inform the interviewee that the worker is not always available. When a worker has concerns about future abuse or neglect and the child remains in the home, the worker should tell the child how to contact the worker and give the child the office telephone number. The child should understand that the worker is not always available. The worker may inform the caretaker that the child has been given the worker's phone number.

Before closing the interview, the worker should express appreciation for the interviewee's participation and continued cooperation.

Chapter Memoranda History: (prior to 01-31-07)

CD04-79

Memoranda History:

19: Parental Behavior/Ambivalent

Chapter 19 Overview

This chapter will look at some of the behaviors that parent(s) may exhibit during separation from their child and appropriate responses the Children's Service Worker may utilize.

The Center for Development of Human Services, New York State Child Welfare Training Institute, Buffalo State College developed the following list of behaviors that the parent(s) may exhibit during separation from their child and appropriate responses the Children's Service Worker may utilize:

- **Shock/Denial:** The parent(s) may show no emotional reaction to the child's placement; be unable to plan for visitation, since he/she may not be able to understand or accept what is happening; and appear disinterested in the child. The Children's Service Worker may respond by eliciting parents' input in the development of a visitation plan; support and encourage parent-child visitation; promote, when possible, contact of the parent and child independent of visitation, i.e., letter writing, telephone calls, etc.; explain to parents the effects of the placement on the child and how they can be helpful; validate the parents' importance in planning for permanency; encourage parents to provide information about child's connections, thus validating their role as parents and importance in planning for permanency.
- **Anger:** The parent(s) may become furious and express anger by yelling, swearing, threatening, refusing to cooperate, plan, visit, etc. and/or blame the child, foster parent, Children's Service Worker, school, etc., in an attempt to cope with their own feelings of frustration and inadequacy. The worker may respond by validating the parents' feelings and encouraging continued expression, reassure parents that he/she will work with them to facilitate visitation, provide services and whatever else is needed to achieve permanency and encourage parent-child visitation as well as other contacts.
- **Bargaining:** The parent(s) may downplay the seriousness of problems resulting in placement or child's needs in order to get the child back, try to bargain with the Children's Service Worker or foster parents by becoming adaptive or acquiescent, make changes in personal care habits, living arrangements, employment, care of other child, attend counseling, drug rehabilitation programs, and/or return to religious systems. The worker may respond by supporting parental involvement in visitation, provide parent information regarding reasons for placement, needs of child in care, ways to help child while in care, explain how drug or alcohol abuse by a parent can harm the child, validate, encourage expression of feelings and support their attendance in programs that will demonstrate their willingness and ability to provide for the needs of their child.

- **Despair/Depression:** The parent(s) may experience feelings of worthlessness, emptiness, loneliness, and hopelessness, give up visitation, stop attending counseling and/or other self-help programs and withdraw from other established relationships. The Children's Service Worker may help parent(s) identify and express feelings, identify all previous successes and praise parent(s) for those accomplishments, connect them to their responsibilities relative to permanency planning and help them identify things which may be impeding their progress relative to achieving permanency and offer suggestions to help them.
- **Acceptance:** The parent(s) may demonstrate willingness and ability to participate in planning, visitation, accomplishing other goals, appear more optimistic about life and having the child returned. The Children's Service Worker may respond by encouraging and recognizing any participation in programs related to achieving permanency, encourage parent-child visitation and recognize progress made toward goal achievement and permanence.
- **Detachment:** The parent(s) may demonstrate a lack of ability to plan for permanency, be unable to maintain essential connections and believe he/she is helpless to do anything about the situation. The Children's Service Worker should keep in mind that the parent has probably suffered multiple losses, which worsens the impact of subsequent losses and continue to encourage the parent to make an appropriate plan for permanency.

Ambivalent Parents

Workers often have questions about the willingness of parents to assume their role as appropriate caretakers. The following list, adopted from PRAG List, provides some factors to consider and approaches to working with the ambivalent parent. It is important to identify these concerns early in the treatment planning.

The following list includes possible behavioral and verbal indicators that suggest the need to explore whether a parent has strong or serious ambivalence about parenting generally or about parenting a specific child. When present and unresolved, parent places child at risk to meet own needs, these feelings may affect the success of family reunification.

Behavioral Indicators

Before Placement/After Return:

1. Fails to provide basic needs.
2. Non-compliant with medical health, sanitary requirements.
3. Minimally meets requirements while child is in placement; after child returns, parents lack investment in child's care.

4. Creates frequent situations to be separated from children, i.e., respite, hospitalization, drops off children at sitter or child care and does not return as agreed, abandonment.
5. Long, frequent or inappropriate use of respite.
6. Lack of nurturing between parent and child(ren).
7. Voluntarily places child in foster care, once or several times.

During Placement:

1. Inconsistent in visiting, in court appearance, and/or in use of services.
2. Refuses to participate in services.
3. Barely meets requirements or fails to complete that "one last thing" required for reunification.
4. Name calling/verbally abusive to the child.

Verbal Indicators:

1. In some instances parents are more direct regarding their ambivalence.
2. Parents state they don't think they can handle a specific child or that the child might be better off somewhere else, such as in foster care.
3. Parent requests adoptive services, then changes mind.
4. Parent repeatedly calls police, caseworker, or service provider to have child removed, but when help arrives the parent has a change of heart and gives the child "one more chance."

Approaches In Working With Ambivalent Parents:

1. Throughout the case clarify the range of options for permanency, including return home, permanent placement with relatives, voluntary relinquishment for adoption or other options. Explore parent's interest in pursuing return home at each decision point (i.e., placement, move to unsupervised and overnight visits prior to return, etc.)
2. Develop case plan or service contract with parent that is very clear and specific regarding what behavioral changes are expected in relation to risk. **Expect**

- follow through.** When it is clear parents will not follow through, request staffing to consider change in permanency goal.
3. Be careful to interpret correctly the meaning of parent's statements and behaviors. For example, lack of follow through may reflect service obstacles or a realistic reaction to an inappropriate referral instead of ambivalence.
 4. Don't lessen expectations for changes that are necessary to ensure the child's safety.
 5. Verbally recognize parent hesitancy, reflect on parent's feelings, and give permission for conflicting feelings. Explore the history, depth and consistency of the ambivalence and provide counseling regarding ambivalence and the choice of permanency plan. Be specific with others serving the family about indicators of parent's ambivalence and the goal of the services requested.
 6. Increase frequency and length of visits and parental responsibility for the child during visits.
 7. Staff case with parents, child, foster parents, and all other service providers before making major case decisions.
 8. Use supervision to process own reactions to parents' feelings, behaviors and the stress related to case ambiguity.

Chapter Memoranda History: (prior to 01-31-07)

Memoranda History:

20: Working With Resistant Families

Chapter 20 Overview

This chapter will examine those skills needed to effectively work with clients who may be resistance to treatment and to prevent the potential for violence.

Introduction

Children's Service Workers need to know some techniques to effectively work with threatened or hostile clients. It is important to gain some knowledge of the ways to reduce resistance to treatment and to prevent the potential for violence in the casework interview.

It is basic to the humanitarian value of social work practice that services be available to all who are in need. Traditionally, the treatment process is set in motion when someone decides he/she has a social or psychological problem for which he/she desires help and he/she acts on the feeling by contacting a social agency.

Most clients who see Children's Service Workers because of child welfare problems have been referred or in some way are required to obtain services. They are involuntary clients in that someone else has determined that the client is in need of intervention by a social agency.

Client self determination is the practical recognition of the right and need of clients to make their own choices and decisions in the child welfare process. This right is limited by clients' capacity for constructive decision making, by the law and by the agency functions. In actual practice, the Children's Service Worker assesses a family's situation and sets intervention goals based on that assessment. It is urgent that the worker be aware of the problems involved in working with a client who did not consciously choose to be "helped" and in establishing goals that may go beyond the client's wishes. We need to be directive and purposeful. Care must be taken not to threaten, devalue or apologize.

Interviewing Techniques

Prior to the first contact, the Children's Service Worker may need to review his/her repertoire of skills and select the approach to use with a new client with which he/she is most comfortable. More specifically, the worker should review interviewing techniques which are essential in establishing the relationship. Many times the worker is judged by the client on the basis of the initial interview and subsequent contact reflects the positive or negative reaction of the client and the worker. Interviewing techniques can be non-directive or directive.

Non-directive techniques include:

- Head nods, smiles, frowns;

- Eye contact and body posture/gestures indicating that the listener is responsive to what the speaker is saying;
- Minimal verbal exchanges such as "yes," "I understand," "I see," "um hum," etc.;
- "Verbal follows." In using "verbal follows" the listener simply repeats a key word that the speaker has used in a statement to demonstrate attentiveness. Verbal follows may be used to get the speaker back on track. They may steer the speaker in the direction the listener wants him/her to go. (Verbal follows may also be directive if the word is repeated in questioning tone, indicating that the listener wants clarification in that particular area.)
- Non-directive techniques can be powerful means of expressing empathy. They tell the speaker that the listener is tuned into the speaker's feelings and concerns. The skilled use of non-directive techniques, combined with the more directive, assertive interviewing techniques convey positive regard even when facing a client with unpleasant truths.

Directive/Assertive Techniques:

- Clients in the child welfare system often enter the agency on an involuntary basis. Either they come to the agency as a last resort or enter due to legal and/or community requests. Often the client would prefer not to talk about the reasons they have become involved with the agency. This may be specifically true in early contacts. Once a relationship is formed, information may be given more freely and clients will talk about themselves and their problems. In working with involuntary clients, Children's Service Workers must assume the responsibility for the directions of interviewing. This requires the use of directive or assertive interviewing techniques.
- It is important that Children's Service Workers not confuse assertive interviewing with aggressive interviewing. In assertive interviewing the worker acts with authority. In aggressive interviewing the worker acts with authoritarianism. The first is from a non-defensive stance. Assertive interviewing implies an understanding of one's right to intervene in family dynamics in order to protect a child. It also assumes a respect for the parent of the child as a worthwhile individual whose concerns will be listened to but whose actions, in regard to treatment of the child, must change. Assertive techniques include:
 - Active Listening - It is important that the Children's Service Worker focus on what the client is saying. The worker listens to the client rather than focusing on concerns about how the worker will respond.

To let the client know the Children's Service Worker is listening, from time to time, the worker states in his/her own words what he/she thinks he/she has heard. This technique is called **reflection of content**. For example:

Mother: Mary is my problem. She isn't as grown up as she wants you to think. She's got a mind of her own and does she know it! She thinks she has the answer to everything. If I make a suggestion she always finds some reason it won't work.

Worker: Mary won't follow your suggestions.

OR

Mary: Everything I do around her is wrong. My mother nags, nags, nags. Nothing ever works. It's all my fault.

Worker: Your mother constantly finds fault with what you do.

Another technique is the **reflection of feeling** in what is stated. By using this technique, the Children's Service Worker's response to the mother might have been:

Worker: You are frustrated because Mary won't follow your suggestions.

OR to Mary

Worker: You are angry because your mother constantly finds fault with what you do.

Reflection is especially helpful in trust building. If the Children's Service Worker accurately reflects what the client has said, the message is conveyed that what was said was important. If the reflection is not what the client really meant, he/she had been given the opportunity to clarify for the worker. The worker has trusted the client enough to risk being wrong in stating his/her perceptions.

Reflection skills are especially valuable at the beginning of an interaction because they are trust building. They are also helpful when the speaker is angry or defensive. Reflection tells the client that the Children's Service Worker is trying to understand his/her point of view, but only the client knows what the point is and must clarify what it is.

- Confrontation - In child welfare services, the Children's Service Worker must be a skilled confronter. Confrontation is, basically, facing the client

with the facts in the situation and with the probable consequences of behaviors:

Client: The doctor is telling lies about me. I didn't hurt Angie, she fell downstairs. She is always having accidents.

Worker: I understand that children have accidents. Angie's injuries could not have been the result of a fall down stairs. There are two partially healed fractures in addition to the new head injury. Angie's buttocks and back are marked with bruises in the shape of a hand.

Client: I know we haven't been to counseling in three weeks. Get off my back! My husband and I have other things to do.

Worker: Going to counseling regularly is a part of your agreement with us to regain custody of your children. If the agreement is not followed, we can't recommend that the children come home.

Or confrontation may be tempered with reflection which puts the client less on the defensive.

Worker: I know it is difficult to get into counseling. However, getting there is necessary if we are to recommend return of the children in our agreed time limit.

Questioning Techniques

Asking questions effectively is an essential skill in child protective services interviewing. There are two general types of questions:

- **Closed-ended questions**

These can be answered with "yes," or "no," or a brief word or phrase. They are used to structure conversation and to get to the point quickly.

Worker: Who was there when Angie fell?

Client: No one.

Worker: Where were you at the time?

Client: In the kitchen.

Worker: Did you hear her fall?

Client: Yes.

- **Opened-ended questions**

These encourage discussion and give the client a more free range to come up with information than in a closed-ended question.

Worker: What did you do when you heard Angie fall?
Client: (generally feels obligated to describe a series of behaviors)
Worker: How do you see the situation now?
OR
What would you like to do at this point?

- **Probing questions**

These may be either open or closed-ended. They are questions designed to clarify the facts. They ask the questions: Who, When, What, Where, and How.

Client: She had those bruises on her when she came home from school.
Worker: When was that?
Client: Tuesday evening.
Worker: What did you say when you saw the bruises?
Client: I didn't say anything.
Worker: Who else saw her come home in that condition?

Questions are often used in non-productive ways in interviews. Children's Service Workers need to be aware of some habitual ways of using questions that can be threatening, devaluing, or apologetic. For example:

Don't you think you'd better stick to the agreement? (or else!)

Why don't you follow through as you agreed? (You're inadequate.)

Let's review the agreement. How about it? (I'll back down, if you insist.)

Avoid: Is that O.K.? Why don't we _____? Do you agree? Do you mind telling me _____? Would you like to know why _____? Why did you _____?

"Why" questions are among the most provoking of defensive responses. They imply an attack by insisting on a defense of some action.

Self Awareness In Communications And Interviewing

The following questions should provide the Children's Service Worker with a quick overview of issues that relate to his/her ability to function effectively as a child welfare worker. The list of questions can help the worker check his/her self-awareness in communicating and interviewing others. Read the question and review to see what themes emerge:

- 1. What emotions or attitudes do you seem to have difficulty expressing?** Emotions or attitudes which cause the Children's Service Worker distress or to experience difficulty in expressing will interfere with effective communication and the ability to form a relationship.
- 2. What have you tried to overcome these difficulties?** Once an individual recognizes that he/she feels that "all poor people are lazy" or "I have difficulty in letting people know I am angry" work should be focused on changing these attitudes or managing to communicate feelings where appropriate.
- 3. What emotions or attitudes are easy for you to express?** Expressing emotions can be healthy and personally rewarding but may also create conflict and direct hostility towards the Children's Service Worker if the worker's expressions threaten the client.
- 4. Which emotions or attitudes do you have difficulty identifying when expressed by someone else? Which are easy for you to identify?** Do you avoid or deny anger when expressed by others? Have difficulty acknowledging compliments, etc.? Then you have normal reactions which are often socialized into everyone at an early age. Getting in touch with these attitudes and emotions aids the Children's Service Worker in the development of skills and recognition of areas in which he/she may feel vulnerable.
- 5. Can you communicate your interest in another person? Do you come across as a person who can be helpful?** These skills are essential in the development of good working relationships. The Children's Service Worker who holds him/herself in reserve and avoids involvement may be interpreted by the client as lacking interest, hostile, or fearful.
- 6. Can you correctly mirror the content of the other's statement?** Can you "hear" the feelings expressed along with the content or context of what has been said? This is a good listening and communication skill which can be very useful in helping the Children's Service Worker who feels particularly threatened by the client or the situation. Many people "hear" the words but avoid or ignore the feelings expressed. The tone and pitch of voice and the compatibility of verbal and non-verbal content are important to listen for, along with the words expressed.
- 7. Are you able to time your leading responses (influencing, advice giving, questioning) from your perception. What aspects of your verbal response behavior are of poor quality?** It is important to accurately communicate

- feelings and attitudes. For example, the Children's Service Worker should avoid the use of "I understand" as a show of empathy when he/she may not have a firm grasp of the problem as it not only cuts off information but may unintentionally alienate the client. If the worker feels strongly about a situation but communicates an easy-going attitude, expectations may be misunderstood.
8. **Are you free to respond with your personal reaction (feelings rather than beliefs or thoughts) to client systems expression, behavior or attitude? Are you free to express the reasons behind your personal reactions? Are you able to judge when these are appropriate?** The Children's Service Worker should be able to appropriately share personal feelings that contribute to relationship formation or working to change client problems. Do you avoid any personal contact or expression with the clients? If so, it is important that the worker examine this and consider what effect this may have on practice.
 9. **Do you tend to categorize people? Do you tend to have similar reactions or feelings toward most people?** If the answer is yes, this may interfere with accurate understanding of the client and his/her life situations which bring him to the agency. While particular characteristics or diagnostic symptoms may hold generally true of a client group, the risk of over-generalization should be avoided.
 10. **Do you criticize quickly - or feel critical?** Individuals who criticize quickly may cause the client to withdraw or react with anger or hostility. The Children's Service Worker should give praise when appropriate and not only point out negative or destructive behaviors by the client. Some clients resort to withdrawal when criticism is constant in the worker's involvement on his/her case.
 11. **Do you minimize or universalize problems of others in an attempt to make them feel better? Do you feel a need to offer immediate solutions?** In an attempt to make the client feel better, the Children's Service Worker might try to state the "problem isn't as bad as you think" etc. This may result in the client feeling put down, or otherwise misunderstood. This may also indicate that the worker feels the need to resolve problems quickly either to help the client or to gain success for themselves. It may also indicate that the worker has some problems in dealing with conflict.
 12. **Do you tend to shy away from distressing problems? Do you feel a need to shy away from expressed feelings which are troublesome to you?** Essential to the role of the Children's Service Worker is the ability to deal with distress both in others and in themselves. Avoidance usually results in delaying appropriate intervention and may at times have life and death results in abuse cases. The ability to express troublesome feelings serves to enhance communication and to set examples for the client.

Below are some simple and effective responses to commonly made remarks and questions that can help you to be more comfortable in dealing with threats to your authority. Face-to-face encounters can be threatening enough that you may lose track of what you know about yourself and how you want to act with the client. It helps to

have some stock answers you can give no matter how you feel. The following is an introductory sample of suggested responses to some usual remarks and questions.

Client:	You:
You have no right to be here.	Mr. (or Mrs.) Jones, I am required by law to be here.
Who told you we abuse our kids?	I'm not at liberty to share that information.
Are you gonna take my kids away?	My job is to protect your kids and try to keep your family together.
We used to hit Johnny, but we don't anymore (or we won't anymore).	I'm glad to hear that. I am required by law to visit the home and get an updated report. This shouldn't take much time.
All you want to do is take my child.	My job is to help you, and your family, not split it up.
I never touched the kid.	Perhaps not, but we are required to visit the home and get a report.
It's my husband, and I don't dare say anything or he'll beat ME up!	I appreciate your position. Can we discuss this more inside?
He only does it when he's drunk.	That's often the case. Perhaps we can work together to find some way to deal with the drinking problem, too.
The kid taunted me into it.	Kids can be overwhelming sometimes, can't they? Maybe we can discuss it more inside and see what we might be able to do to prevent it from happening again.
I bet it was that nosy neighbor	I'm not at liberty to say, but that really doesn't matter. The issue is what we do to help you, not who reported it.

Understanding Crisis Situations and Reactions

It is also important that Children's Service Workers are able to know and be able to recognize that there are many reactions to crisis situations. The following is a good

reference to point out some causes for disorganized thinking and behavior as well as poor and ineffective methods of coping.

It is important that each Children's Service Worker review and understand the variety of reactions a crisis situation creates. Individuals vary in personality, specific situational circumstances, and timing of events. However, there are some common reactions to stress and crisis which should be considered when a worker responds to a family plagued with chronic problems or reported for abuse or neglect. Generally, crisis events tend to produce difficulties in terms of intellectual, emotional, and social functioning. The client system in crisis may display disorganized behavior and thinking, poor functioning, hostility, impulsive behavior, dependence or psychiatric problems. The troublesome behavior may be intensified by the client's chronic anger and a continuously frustrating environment.

Disorganized Thinking And Behavior

People in crisis may have a difficult time giving information or relating ideas and events in a logical fashion. They may overlook or ignore important details, confuse sequences of events or fail to see environmental factors which may contribute to the problems. The individual may jump from one idea to another in a manner that interrupts communication or repeat the same statement and phrase regardless of the question or comment made by the interviewer. Under severe stress, fears and wishes may be confused with reality. Difficulty with memory may be apparent when significant or stressful questions are asked; or the individual may give various responses to the same questions at different points during the interview. The client's activity may be disorganized and at times aimless. Solutions attempted in resolving problems may seem illogical or poorly thought out. The client may pace constantly, check the door or otherwise act suspiciously. In summary, when a client is in crisis he/she may not know what to think about the problem or how to realistically evaluate what course of action to take. It is important to note that upon initial intervention the client's disorganization of behavior and thought may be compounded in response to having to deal with an external agent.

Poor Or Ineffective Functioning

When confronted with a crisis, people tend to become involved in activities that relieve tensions arising from their fears and inability to cope. When too much emphasis is placed on insignificant activities, the individual's ability to deal with the crisis is decreased. For example, the mother who focuses on her favorite soap opera or talks about her activities as a child when questioned about an injury or problem with one of her own children. It is the Children's Service Worker's responsibility to redirect thinking toward more important activities and assist the client in the development of appropriate behavior. Disorganized thinking and/or behavior are normal in stressful situations. However, there may be indications for psychiatric or other psychological assessments. These indications include:

- Severe depression, withdrawn or suicidal behavior.
- Religious or culturally-biased fanaticism that interferes with daily functioning.

- Drug/alcohol addiction.
- Bizarre ideas that make little or no sense.

Dealing With Your Own Omissions

It is very important that the Children's Service Worker deal with his/her own omissions in working with the client. The worker's behavior can increase the client's feelings of anger and hostility. Every worker has experienced times when his/her caseload became unmanageable, either because of the number of cases requiring some action or the number of families who were all in crisis at the same time. During these times it is quite easy to work on those cases requiring immediate action such as a court hearing or locating a run-away, and "forget" promises the worker has made to a client especially if the client is a child. Failing to keep promises may include:

- Failing to inform the client that you would be several hours late for an appointment, or even worse forget to cancel an appointment;
- Failing to make an appointment and "just dropping in" for an important visit;
- Not including your clients, especially children, in the decision-making process; and/or
- Failing to treat your clients as professionally as you do other team members who are involved in the treatment process.

As a Children's Service Worker, you become an important person to your client, and, therefore, how you treat the client can affect how he/she feels toward you. As a child welfare worker you may have to help the family members confront things about their behavior which they must change. How you conduct your professional responsibilities may justify the client's being very angry or "mad" at you. In a situation where you have failed to follow through on your part of the contract or promise that you have made, it is important that you acknowledge that you did "goof up" or that you failed to keep a promise. Explain the reasons honestly why you didn't follow through as planned. It is also helpful to acknowledge that your client has every right to be upset, angry, mad, or whatever feelings he seems to be having. Say that you plan to try and avoid something like this happening again in the future. It is important to remember that not all anger or hostile behavior of clients is unwarranted.

Interviewing And Practice Techniques In Working With Hostile Clients

There are a variety of interviewing techniques the Children's Service Worker may use in the development of a working relationship with the client. These can help the worker and client move from helplessness to competence, from anger to acceptance and finally to a willingness to change. These techniques include:

- **Focusing**

The Children's Service Worker should maintain the focus of the interview at all times with a clear understanding of the purpose and ultimate goal. For example, a client who has come in contact with the agency for abuse or neglect of a child may have great difficulty in maintaining focus due to high levels of anxiety and fear. It is the worker's responsibility to redirect the subject when necessary, acknowledge the client's anxiety, and finally refocus the interview by a repeat of the purpose of the interview. When clients feel anxiety, fear, or hostility they often wander from point to point, give extraneous information or avoid questions. The worker can empathize with the client while moving the interview forward. Statements such as:

"I know this is difficult for you, but we must get back to how your child was injured."

"Let's get back to the problems you say you are having since your husband lost his job."

"It is not clear to me how your oldest daughter left home."

"You stated on the phone that everything was going wrong. Can you tell me the two things that are causing you the most problems?"

These statements show concern for the client while moving the interview on to what may be painful issues.

- **Partialization**

Clients who enter the child welfare system often present multiple problems. They may be confused and/or overwhelmed by their environment, and/or their feelings. They may also feel urgent need to solve or avoid the presenting problems. The Children's Service Worker should assist the client in partializing by:

1. Setting priorities based on the most urgent needs of the client and agency;
2. Determining what can be realistically handled within the context of the agency; and
3. Separating out and dealing with one problem at a time.

- **Universalization**

The Children's Service Worker uses this technique to point out that most individuals in the client's situation would have similar reactions. Clients often believe that they are different from most other people. A word of caution: this

technique may be misunderstood by the client resulting in his/her feeling that the worker is minimizing his/her concerns.

- **Recognition of Difference**

The Children's Service Worker and the client may be from different socio-economic, cultural, or ethnic backgrounds. It is important to establish that the worker recognizes these differences and will make every attempt to understand the client. This technique may also be used as a method of engaging the client around issues of special concern.

- **Acceptance**

It is important to all people that they feel accepted. Acceptance of the client demonstrates an attitude of receptivity by the Children's Service Worker. It is important that the client feels comfortable enough with the worker to begin to face himself, the problem and the situation that brought the client and the agency together.

- **Education**

The sharing of information and the provision of new knowledge become important aspects of work with clients especially when external agencies such as court systems and juvenile authorities or collaborating agencies are involved. In order to make informed decisions and contract for goal attainment, the client needs to be given information and facts. Education involves repetition and elaboration on the information in relation to new situations.

- **Logical Discussion**

Organization of interview material to be covered in a given session is the responsibility of the Children's Service Worker. The maintenance of flow in conversation and the integration of the client's needs and the agency's purpose are achieved by the use of logical discussion.

- **Relating to Affect**

Relating to affect is a method of engaging the client in the casework relationship and becomes important in specific treatment techniques and processes. The Children's Service Worker may want to explore the affect, i.e., "You seem depressed today." or acknowledge and accept the affect, i.e., "Your housing problem puts you in a depressing situation." It is appropriate to name specific feelings or accept feelings only if the worker understands the feeling and there is a therapeutic reason for the client becoming aware of and working through feelings.

- **Demonstrating Behavior**

The Children's Service Worker should set the tone and expectations of counseling sessions by demonstrating expected behaviors such as openness, listening, and giving direct feedback. The worker may serve as a role model to the parent having difficulties in parenting. How to handle discipline, sharing and play activity with the child can all be readily demonstrated by the worker. A second method of demonstration may be role-playing with the client. If employment is a goal for the client, role playing what the client should expect may be useful for developing a client's skills.

- **Setting Realistic Limits**

It is the Children's Service Worker's role to set the limits on the nature and type of contact that will take place in the interview situation. Contracting is one method that clearly states what is expected of each party in the casework relationship. If unrealistic goals or limits are set in the working relationship, the worker runs the risk of building-in failure.

- **Ventilation**

The client may come to the relationship with many pent up emotions or reactions to current or previous life situations. The Children's Service Worker should encourage and/or allow the clients verbal and non-verbal expressions of anger, frustration, depression or simply a sharing of information and feelings.

- **Direct Intervention in the Environment**

Modification of the environment may be accomplished by providing concrete services (housing, financial assistance, homemaker, parent aides, medical assistance, job placement, etc.) or assisting in the client's use of available community resources. When the client is overwhelmed by environmental problems, offering concrete services provides a beginning point for change both in physical surroundings and personal feelings of worth.

- **Summarization**

The process of summarization involves the Children's Service Worker adding up for the client all feelings and facts shared in a given situation. This should be done in a concise, organized and purposeful manner. Summarization should enable the client to see the inter-relatedness of fact and feelings, analyze the positive and negative of a situation, develop clarity on the scope and nature of the problems, and finally to share in the selection of alternative courses of action. The worker summarizes after sufficient exploration of information and sharing has taken place in the interview situation.

- **Confrontation**

The goal of confrontation is to point out inconsistencies and/or contradictions in the client's affect, attitudes, behavior or information given during the interview

and casework process. The goal is **not** for the Children's Service Worker to interpret or otherwise explain what the client means, but to point out the problems with the client's functioning or ability to handle a problem.

When The Children's Service Worker Feels Threatened

Several specific interviewing techniques should prove particularly useful when the Children's Service Worker deals with a difficult or uncooperative client:

- **Negotiating**

The client who does not cooperate often reacts to a fear of authority or sense of loss of power. It is important that the Children's Service Worker aid the client by allowing any degree of autonomy possible. Use comments such as:

"I know this is difficult for you but it is a requirement that we get this information. Would you like to rest a minute before we go on?"

"If you are able to keep the agreements we made two months ago, your children will be able to come home."

Ultimately, negotiating with a client should result in a verbal or written contract. Contracts are useful in the development of a working relationship and in the completion of a case plan.

- **Identification of Danger**

While this is not a specific verbal technique, it is important that the Children's Service Worker develop strategies for insuring personal safety in potentially problem situations. Identify:

- Is the client usually loud or aggressive in manner?
- Is there evidence of drug use such as alcohol, pills, or cocaine?
- Does the client move to cover the door as soon as the Children's Service Worker enters?
- Does the client use direct verbal threats that seem likely to be carried out?
- Is there evidence of a weapon or potential weapon?

The Children's Service Worker should develop a "sense of judgment" with time and experience. If a new worker feels unusually uncomfortable, request a more experienced worker accompany him/her. If in a situation where fear of safety arises, leave as soon as it is reasonable or possible.

Defusion Of Potentially Violent Situations

The following information was obtained from the [Homebuilder Resource Guide](#) provided by the Behavioral Sciences Institute, Homebuilder's Division, and used with their permission:

- **If you have reason to believe the situation might be violent:**
 1. Call first and consider spending a lot of time calming people over the phone before you go out. Consider asking them to wait for you in separate rooms so you can meet with them one at a time without their having a chance to re-escalate before you get there.
 2. Ask if they mind if you bring a co-worker.
 3. Consider asking clients to come to your office.
 4. Ask them if they're worried about losing control. Do they have any ideas of what might help them to avoid doing something they'll regret?

- **When you get there:**
 1. Separate people if they are all yelling at each other. Structure the situation with "I messages" of concern - where they go and what they do.
 2. Be sure to ask clients' permission - check out everything you do - don't steal territory and make clients feel even less in control than they already do.
 3. **Listen** until what to happen next appears obvious. Keep thinking about trying to understand instead of trying to fix things.
 4. People are usually really hurting or really scared when they are angry. Be very gentle with them now. They are very vulnerable.
 5. Some people respond very well to touch when they're upset. Be sensitive. **Do not invade territory unless it looks like they will respond positively.**
 6. Your compassion is more important than your "handling" the situation at this point. Keep this in mind.
 7. Liking the people is probably the best thing you can do for them. They have good, sensible reasons for doing what they're doing. It will help you to be aware of those reasons. Work on your own feelings of acceptance.

8. Believe everything and at the same time withhold judgment. People are telling you how they see things; but how they see them will change as they calm down.
9. Try to model relaxation and calmness. Take a deep breath when you feel yourself tighten up.
10. Leave the door open; both of you may feel less trapped. Consider staying between them and the door.
11. Don't back the client in a corner; give them plenty of room.
12. Keep your voice low.
13. Don't be afraid to have silence.
14. Remember that you can't deal with anger perfectly. Let up on your self demands to do everything exactly right. You **will**.
15. Look concerned.
16. Ask "Do you like what is going on?" If they say no, you can get them on to "What can we do about it?"
17. Use the person's name; make the contact personal.
18. Self disclosure - "I feel attacked now and I wish we could find a better way of dealing with this."
19. Just keep on being calm.
20. Nod and feedback instead of asking questions.
21. If they're too furious, no feedback - **just sit there**.
22. Let them cry.
23. Agree they're right - "You have a right to be angry."
24. Once things are calmer, focus on one thing: help prioritize and minimize being overwhelmed.
25. Remember that this anger won't go on forever.
26. Set anger limits - "I have 15 minutes to listen now."
27. Call your supervisor or co-worker from the home to get ideas.

28. Take a half hour break to go to a nearby restaurant and sort out your own feelings.

29. Call the police if it looks like things are really getting out of hand.

- **When you're out of time and want to give them some quick techniques to hold them over until you can return or, if you're talking on the phone until you can get there, the following techniques are good.** It is also sometimes helpful to put them on 3 x 5 crisis cards so the clients can keep reminders handy and begin using themselves more, and you less, right away.

Ideas for clients to try when they feel they might be losing control of their anger:

1. Take three deep breaths.
2. Send an "I message" that you really need a few minutes to be alone and to calm down. Consider a code system with self and others - "I'm at 'stage 1' so please don't say any more."
3. Focus not on your feelings of **anger**, but feelings which are more basic and true, **hurt, lonely, embarrassed, afraid**.
4. Lock yourself in the bathroom for five minutes or until you're calmed down.
5. Run around the block.
6. Call someone who has helped to calm you down in the past.
7. Call the therapist (or Children's Service Worker).
8. One or more family members stay in their own rooms until the next appointment.
9. One or more family members stay with friends or relatives until next appointment.
10. Schedule many outside activities until the next appointment.
11. Tell it all to a tape recorder.
12. Write down all the things that are going through your mind; bring to next appointment.
13. Call crisis clinic (write down the number).
14. Practice identifying irritation feelings and take time out before they reach such a high intensity. Keep a log. Therapist reinforce.

15. Do push-ups.
16. Do relaxation exercises.
17. Go for a walk.
18. Do some housekeeping task.

- **When you've gotten to the point of trying to help them deal with their anger:**

1. **Active listen.** Find out what the person wants to change and what ideas he has about doing this. Find out what he has tried before, what worked and what didn't.
2. Reflect back the feelings of hurt and/or fear or helplessness that frequently underlie the feelings of anger. See if the client wants to work on these.
3. Disclose your own feelings about their anger. Scared? Confused? Give an "I message" about your experience.
4. See if they're interested in a crisis card - options for the clients when they feel like they're starting to blow up. Put these on a 3 x 5 card:
 - a. Locking self in the bathroom five minutes.
 - b. Doing push-ups.
 - c. Going for a walk.
 - d. Brushing the dog.
 - e. Calling the therapist (or Children's Service Worker).
 - f. Telling himself "stop" over and over loudly in his head.
 - g. Other ideas that they may have.

They carry this in their wallet and contract with you to at least pull it out and look at it the next time they feel like they're blowing up.

5. See if they're interested in learning to identify and respond to anger at a lower level of intensity. Have them log their feelings of annoyance and irritation on a 1 to 10 scale where 1 is very mild and 10 is exploding. Many people feel that angry feelings are "bad" and then try to block them out and ignore them until they just explode.

Ask the clients if they are interested in trying it out (writing things down). If they are, ask them how long a period they'd like to start with. Encourage them to keep it short (one day or three hours) so they'll have a successful experience. Be interested in the log. Reward them for noticing anger before it gets overwhelming.

One message to get across is that we all get annoyed, but it is important to respond to these feelings in a way that doesn't get us into trouble. It's possible to learn ways to do this, although sometimes tedious to do so and it often requires a fair amount of practice. Don't promise them results. Stress how hard it is to really change.

6. See if they're interested in learning to be assertive instead of aggressive or hostile. The main point is learning to give gentle "I messages" at low levels of irritation.
7. See if they're interested in role playing new ways of handling anger with you. Be sure and reinforce attempts even if they're not perfect.
8. See if they're interested in fair fighting where you and a co-worker play their roles and exchange information using good communication skills. Gradually phase them into their own roles.

Sources:

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2. Working With Threatened/Hostile Clients, from Region VI Child Welfare Training Center; Tulane; New Orleans, Louisiana; Publication No. 11, 1982.
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5. Defusion of Potentially Violent Situations was obtained from Anger and Defusion chapter of the Homebuilder Resource Guide, Copyright 1978, Jill Kinney and David Haapala; Behavioral Sciences Institute, Homebuilders Division, Federal Way, Washington. It is used with their permission.

Other material in this chapter was adapted from Basic Job Skills Training in Child Welfare Services Trainees Coursebook, developed by the Texas Department of Human

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21: The Teaching And Training Role

Chapter 21 Overview

This chapter is meant to provide the Children's Service Worker with information on the learning and teaching process.

"It is impossible to teach anyone anything; rather, what the teacher can do is set up the conditions in which a person can learn." Carl Rogers

Introduction

According to the classic definition of "learning," learning has taken place if a measurable change in behavior occurs. Learning - reflected in altered behavior - is a major goal of Family-Centered Services. In-home and community interventions are designed to produce changes in behavior which will achieve the goals of the family and of the community representatives who may be participating in defining the problem. Many of the activities of Children's Service Workers aim to facilitate learning-induced behavior change.

The Learning Process

By considering the process of learning more carefully, we can find many answers to the question, "How do I help people change?" Perhaps Mary Ann Fahl best describes its importance in teaching coping skills to parents and children: "the more we ... can know about the nature of the learning process and about how each person or client learns, the more refined will be the treatment process for a family."

The implications of this statement extend to many aspects of Family-Centered Service. Listed here are the primary areas in which Children's Service Workers teach:

- Home management and life skills;
- Communication and relationships skills;
- Parenting and child management;
- Assertiveness and self-advocacy;
- Problem solving;
- Using community resources; and
- Constructive, productive coping.

Learning is naturally one of the most pleasant and rewarding human activities, provided that it occurs in an atmosphere of trust and freedom. However, many client family members (adults and children alike) are the victims of years of punishing experiences in formal school settings, of negative social and familial circumstances, or of others trying to force them to change. It is the practitioner's responsibility to establish relationships and circumstances in which learning and change can become pleasant and reinforcing.

Adult Learning Styles

We next need to be aware of our own learning styles so that we can best first understand how we learn and then predict how our clients learn and see how we will relate to our development of a relationship. Adults tend to favor one of four main learning styles:

- **Concrete Experience** - Use specific experience examples, involvement, discussion. Many clients learn best in this style. Their own current experiences serve as the learning examples. Often the particular abusing incident may be too emotionally charged, so some other incident they bring up in discussion can serve as the situation from which to learn.
- **Reflective Observation** - Try to get client to impartially observe specific situation of others, then generalize self to the situation.
- **Abstract Conceptualization** - Have client fantasize how they would use authority and direction in an impersonal situation, then theorize how this could be applied. This done, move to active experimentation or concrete experience.
- **Active Experimentation** - Use projects, homework, discussion.

Determine which style suits your client best by experimenting with each style early in the treatment, or by talking with persons who know the client well.

Applying Sound Teaching Principles in the Home

A number of basic teaching principles are valid for work with clients of all ages:

- Begin by determining what the individual already knows, as well as what he or she wishes to learn. Devise methods that discover, recognize, reinforce and build on what the person already has learned. It is demeaning to the learner and potentially damaging to the Children's Service Worker/learner relationship to presume to teach someone what they already know;
- Recognize the capacities of family members, as well as the things which may hinder their learning. Become aware of the tremendous variations in the ways people learn. Try to identify each client's learning style (see "Learning Styles,"

above). When interventions are chosen, attempt to adapt techniques to each client's learning style;

- Plan and structure teaching to ensure early experiences of success. Structure teaching in small, sequential steps to avoid frustration and discouragement;
- Plan for strong reinforcement as both short-term and long-term goals are achieved. Find out what reinforces the learner; remember that reinforcement can be just as important to adults as to children;
- Relationship is a powerful catalyst to learning, and the desire to please is an excellent motivator. Believe in the family's capacity to cope, and they may be able to begin believing in themselves;
- Show that learning is pleasant. The chance to teach you something that they do well can build clients' self-esteem. Perhaps the client could teach the worker to play pool or a card game, how to fix a favorite food, or a craft or skill.

As Children's Service Workers and families assess goals and priorities, recognizing the hierarchy of needs will help workers to understand their clients' natural agenda. The following guidelines are presented to assist in teaching information related to specific problems that are often encountered by families.

Housing

Finding adequate housing for client families can be a virtually impossible task. The Children's Service Worker may want to first determine if the family knows how to use the classified section of the newspaper and how to make the necessary contacts to locate housing. Arranging telephone and transportation services may assist in these efforts.

Children's Service Workers should become familiar with both official and unofficial channels for information about available housing in their communities. Workers and families need to be familiar with public housing programs and special programs for limited-income families.

Regulations issued by the U.S. Department of Housing and Urban Development (HUD) establish federal preferences for families most in need of housing assistance through Public Housing and Section 8 Housing programs. Applicants who qualify for any of these preferences will receive housing assistance before other applicants, regardless of local preferences and priorities or their position on waiting lists which often accompany these programs. The HUD regulations establish federal preferences for three groups:

- Families who have been involuntarily displaced from their homes;

- Families living in substandard housing; and
- Families paying more than 50% of family income for rent.

The regulations also allow some local discretion in setting up tenant selection systems to administer the federal preferences. Public housing authorities may allocate up to 10% of their annual housing assistance awards to families who do not qualify for the three categories of federal preference. This provision permits public housing authorities to implement their own local preferences and priorities, such as a special priority being established for families who have children at risk of being placed in foster care, or whose children remain in foster care, because of the lack of adequate housing.

It may be helpful if Children's Service Workers have the knowledge and skills to help the family make household repairs and improvements. This can help the worker and family join together in the relationship building process.

Moving to new housing or completing a home improvement or decorating project may be important therapeutic activities, giving hope and a sense of accomplishment, developing the Children's Service Worker's relationship with the family, raising their self-esteem and serving as a "proving ground" for skills learned in family counseling, such as problem solving and communication.

Budgeting And Debt Management

Families who are referred for services may be seriously in debt or behind in meeting their financial obligations. It is crucial to address financial problems early in the treatment process. Pressure from creditors can be a serious source of stress, and the family may be unable to focus on other problems until this is resolved. Getting this area under control can facilitate hope and promote a good worker/client relationship. Some causes of financial problems will be obvious or readily shared. The Children's Service Worker should also be alert to hidden causes, but should avoid threatening questions during the early stages of building a relationship with the family. Some common causes for financial problems are:

- Difficulty with basic math (perhaps an inexpensive calculator is needed);
- Problems with alcohol, drugs, or gambling;
- Lack of experience in managing money;
- Difficulty in talking about money with a spouse or lack of family cooperation on money matters. Perhaps finances have become the battleground for family members;
- An inability to say "no" to salespeople, children or friends;

- An inability to face up to the reality of changes in income or expenses.

Once a family has indicated that they want help with financial matters, the Children's Service Worker should organize help in the following manner:

- Ask the client to collect all outstanding bills, including all money owed and all monthly bills.
- Provide forms for listing income and bills and determine the family's total monthly income and the total amount of money they owe. If possible, ask the client to do the writing and figuring from the beginning, with the Children's Service Worker available only as a consultant. Avoid embarrassing the client. It is better to offer assistance if the tasks of writing or figuring seem threatening to the client;
- Jointly determine the family's minimum monthly expenses;
- Work with the family to plan a proposed payment schedule;
- Visit creditors, if appropriate, with the client to negotiate payment schedules. It may be helpful for the Children's Service Worker to phone the credit manager in advance to lay the groundwork for a successful interview;
- Help the family arrange a monthly plan for paying bills and recording expenses and payments. Families may devise a variety of budgeting systems, which may include using money orders, joint checking accounts, envelopes for each category of expenses and a system for organizing and filing bills and receipts;
- Arrange for participation and monitoring appropriate to the causes of the client's financial difficulties;
- Gradually withdraw worker participation as new habits are learned;

For long-range resolution of financial problems, Children's Service Workers will need to determine if the problems are the result of a simple lack of skills or symptoms of problems in the family system or the family's interaction with other systems. Often financial problems result from a combination of such factors.

Home Management

Raising the level of home management and child care skills is often a key component of service programs designed to prevent out-of-home placement of children at risk. Determining whether a given family's home and habits are "adequate" is always a tenuous task for the child's Children's Service Worker. A family-centered approach is ideal both for assessment and for providing services to improve the home environment. Working within the home and family system, the worker is able to distinguish conditions that merely reflect variations in personal values and life-styles from those that are detrimental to the children's well-being.

Help parents meet their own basic needs first. Many parents need both permission to and instruction in how to nurture and care for themselves. Getting a parent to feel better, emotionally and physically, may be the single most important step toward improving his or her functioning:

1. Include all family members in planning and programming for home management goals. It is frequently a mistake to work only with mothers. A key advantage to family-centered programs is that they provide an opportunity to involve the entire family in the program:

- Include men as part of the in-home service team as role models and to emphasize the importance of the men in the family system, if applicable.
- Be sensitive to the family's values. For instance, housework may be out of the question for some men, but they might be comfortable learning to enjoy activities with their children in order to give the mothers a break, or teaching or supervising children in putting away toys or picking up trash in the yard.
- Remember that working on life skills is an excellent way for the entire family to practice interpersonal skills learned in the counseling relationship, such as conflict resolution, new communication patterns, use of praise and positive reinforcement.
- Teach normal child development and reasonable expectations of children at all ages.
- Teach parents how to teach their children how to perform multi-step tasks, such as doing the dishes or cleaning their room.
- Organize and initiate an appropriate division of labor by using chore charts.

- Negotiate in what ways other adult members of the household are willing and able to assist. Consider gaining consistency by using contracts. Establish what each person can be counted on to do.
- 2. Decide on home management standards which are essential to the well-being of children and parents. Distinguish those from standards which merely reflect the helpers' own values. Insight into culturally determined values and activities is essential.
- 3. Be sure that parents understand the social and health implications of household neglect. Families may have become accustomed to home management situations without realizing the medical and social ramifications. For instance, a parent who rarely leaves their apartment may become accustomed to the odor of dogs which pervades the household and her children's clothing. Because of this they may not realize that the odor is causing the children to be treated cruelly at school.

Effectively addressing these situations will require the Children's Service Worker to develop a good relationship with the parent and gently, but accurately, describe his/her own responses to the dogs' odors. By being helped to a real understanding of the problem, the parent may then follow through by sanitizing the apartment and eliminating the odor.

- 4. Teach the basic skills of how to establish priorities among tasks and how to schedule realistically in relation to available time. These skills are usually developed in childhood through close contact with an adult model. They can be dramatically affected by individual differences in the perception of time. These are relatively complex skills, but they can be taught by carefully applying the teaching principles introduced in this chapter.
- 5. Develop realistic expectations. Expect only limited progress if a family has been severely damaged by years of deprivation and isolation. The family may feel hopeless about the possibility of change. If depression or anxiety prevents a parent from beginning home management tasks, the Children's Service Worker may work with her or him simply as a catalyst to get an activity started. Constructive activity may in turn alleviate depression and anxiety.
- 6. Recognize and build on strengths. Do this in an organized, purposeful manner. Let the family know you are aware of their strengths. Often the strengths of a family unit will be obvious to anyone who spends time with them in their home. In other instances, skill, patience and time will be needed to draw them out.
- 7. Time the interventions at an appropriate pace. Timing is always a critical factor in motivating and involving family members. Strive for balance between

stagnation and pushing the family too fast. For many families there seems to be a limit to the degree of growth and change that can occur in a given time.

8. Provide concrete resources when necessary. If discretionary funds are available, they can be used for such items as basic cleaning supplies, reinforcers for behavior modification programs, school supplies or materials for special school projects, occasional recreation opportunities, and birthday or other remembrances or celebrations. Some agencies maintain a storehouse of furniture, appliances, clothing and toys. By soliciting contributions from both organizations and individuals, a steady supply of usable items may be obtained. Some items may be obtainable through crisis intervention funds.

Related Subject: Section 3, Chapter 4, Attachment C: Crisis Intervention Funds
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9. Carry out life skills assistance within the context of the comprehensive family service plan. Life skills problems, such as how a family maintains its living space, often involve much more than issues of orderliness or sanitation. For example, accumulated debris is often a part of the family's history and identity, and should be disposed of only with their permission. Children's Service Workers may help sort and point out choices/alternatives, and facilitate decisions, but the ultimate choices should be the family's. This process may take days or even weeks, but the time is well spent if the family is gaining maturity and self-respect and their relationship with the worker is preserved.

Employment And Training

Because Children's Service Workers serve entire families, locating and maintaining satisfactory employment is frequently a service goal for at least one member of the family. For individuals who have never worked outside the home or who have had negative work experiences, this may require a great deal of the worker's effort.

Children's Service Workers should be familiar with all the career counseling, education, training and employment resources available to their families. Explore special programs for women, for those seeking a high school diploma, for veterans and for mothers on AFDC. Be sure you are aware of the broadest definitions of those entitled to vocational rehabilitation or other training programs.

Testing, training and job hunting all involve evaluation and can be threatening to clients. Be creative in helping them overcome their fears. Arrange for them to take a lot of tests, get copies to practice at home, or take tests with clients. Consider taking them to meet counselors or evaluators ahead of time to establish relationship and gain familiarity with the testing setting and procedures.

When you have a realistic idea of a client's employment potential, help the client meet people who are doing that kind of work. Visit job sites and training programs. Both

employers and instructors are often willing to describe their programs enthusiastically and to answer questions.

Once clients are in career programs, Children's Service Workers should maintain contact with program personnel and with the client. Many potentially successful programs are derailed merely because no one was available at a crucial time to help with transportation, to trouble-shoot, to negotiate misunderstandings, or to provide support and reassurance during a difficult moment.

When a client wishes to look for a job, it may be necessary to teach the skills involved in job hunting, completing job applications, and interviewing successfully. The principles and techniques discussed in this chapter again are applicable. When appropriate, Children's Service Workers may accompany clients to job interviews and make themselves known to employers. Prospective employers are often willing to hire young, inexperienced people when they know a worker is available to provide support.

Health And Nutrition

Basic health care and proper diets are essential to healthy families. These basic needs will require the involvement of the Children's Service Workers before other needs are addressed.

Nutrition - Children's Service Workers will need skills and techniques to help families adapt their meals to meet basic daily nutritional requirements on limited budgets. Families will be more motivated to work for a balanced diet if they realize that their physical appearance and physical and emotional energy depend upon what they eat. Family, cultural and religious dietary customs and personal preferences should be taken into account in planning menus. Providing the family with lists based on the four basic food groups will help them plan nutritionally balanced meals. Everyone needs the same basic nutrients, but these can be supplied in many ways. Attempts to help families balance their dietary intake will be more successful if workers respect and use the variety of cultural and ethnic customs.

Health and Dental Care - Children's Service Workers should be familiar with all the medical and dental services available to families in their community. Many families need help in learning to negotiate the health care system. Clinics are sometimes difficult to find, and facilities are often large and impersonal. Treatment instructions may be confusing or misunderstood, and patients often lack the assertiveness to get their questions answered or their concerns heard.

Rest, Relaxation, and Exercise - The importance of physical well-being to emotional health and energy cannot be overemphasized. Children's Service Workers often establish exercise or jogging regimens with depressed or anxious parents as key elements in their overall treatment plan. The ability to structure simple relaxation sessions is also a valuable skill.

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Suggestions on Health and Nutrition are adapted from Faye Strayer, Homemaker-Home Health Aid Manual (Iowa City: The University of Iowa, 1976). It was also included in Section 7, Chapter 6 of this handbook.

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22: Preventing Worker Burnout

Chapter 22 Overview

It is important for Children's Service Workers to make sure that they are functioning at their most efficient level. Staff who are panicked, overwhelmed, or self-righteously angry are working with a severe handicap in their efforts to help a family become calm and learn problem-solving skills. This chapter will discuss those things a worker can do to prevent worker burnout.

Self Awareness And Positive Self Talk

Albert Ellis' Rational Emotive Therapy (RET) is a valuable framework to use in trying to become as clear and calm as possible before going out to work with a family in crisis. The basic idea of RET is that our feelings are not a product of the particular situation we face, but rather of what we tell ourselves about the situation. For example, if the Children's Service Worker says to him/herself, "I'm so scared, I will probably faint when these people answer the door," he/she will make a less calm and organized entrance. More positive self-talk is "This looks like a difficult situation. I will just do the best I can. I know many approaches to try, and even if I cannot do the most perfect job, I may still be able to help this family."

One of the most helpful concepts is what Ellis calls "rational beliefs" about one's job, oneself, and one's clients. Rational beliefs are logical and based on facts. They help us feel the way we want and get the outcome we desire. Rational beliefs involve a good deal of consideration for others.

Irrational beliefs distort the facts, often emphasizing only the negatives. Some of the more common irrational beliefs are:

- People must love and approve of me and what I do;
- Making mistakes is terrible;
- People should be condemned for their errors;
- It's terrible when things go wrong;
- Threatening situations must keep me terribly worried;
- I should be thoroughly competent, intelligent and effective in all areas; and/or
- Things have to be fair.

Usually irrational beliefs are just good ideas that are so distorted that we function less effectively due to the additional pressure we place on ourselves. For example, the rational belief "I'd like to do a good job" can be distorted in the high pressure idea "I've got to do everything exactly right." "I'd like to be able to work with most clients,"

becomes "I must be successful with all clients." "I'd like things to be clear," becomes "They have to let me know exactly what I should do," and "I don't like some things that are happening," is transformed into "They shouldn't do that to me."

It is important to be aware of our potential for such irrational beliefs so that we can challenge them, reduce our negative emotions, and free our energy for work with families. Identify the unpleasant emotions you are feeling. Specify some emotional beliefs which may be involved. Find other, more comfortable ways of conceptualizing the situation. The list below presents some common irrational ideas associated with feelings of anxiety, depression, or anger. These are followed by alternative beliefs which can alleviate them:

Irrational

**If I can't do it perfectly
I shouldn't do it at all.**

**I must succeed in all cases.
If I don't, I'm a lousy
Children's Service
Worker and a worthless person**

I should have done better.

Rational

**I will never do it perfectly.
My work can still be worthwhile,
even if it's not perfect.**

Who made up these rules?

a. If I don't have a perfect track record, that means I didn't perform as well as I had hoped. That's unfortunate, but not catastrophic. Not succeeding can even give me information, if I'm open to it.

b. My job performance is independent, or at least only a small part of what makes up my worth as a person."

I wish I had handled situations differently. But maybe I couldn't have done things differently in that context. It's not the end of the world if things proceed more slowly than I wish.

I should be a good therapist and if I'm not I'm less of a person.

Skills as a counselor do not directly transfer all the time, to value as a human being. I'm too much of a perfectionist when I say "all the time." Like everyone else, I am fallible.

I will never be able to do as well as others.

I may not ever be as good as the others, but that doesn't mean my work is no good or that I'm a worthless person. There are ways that I can try to improve my performance.

I am not good enough for this job.

I have this job now. Someone thought I was qualified. Where is my evidence that I'm not good enough. I might be able to improve my skills by asking my supervisor for help.

This family should be more motivated.

Others are fallible too. Demanding that they be motivated won't help them change. The family has a right to be wrong.

It's not fair.

The world isn't fair and that's okay. There is no reason things should be easy for me.

One of the recurring problems involved in human services is that helping persons often have developed strong beliefs that they should be able to do everything perfectly. They believe that they should not need help. Supervisors and fellow Children's Service Workers should challenge these notions. Offer support from the day a new worker begins. Support and questioning of unreasonable self-demands should continue for everyone involved in working with troubled families.

Providing Family-Centered Service is a difficult job. We will never know everything we would like to know. We will never be able to implement everything we do know. Although it does get better, there is always the element of surprise and the risk of the unexpected. The same factors which make Family-Centered Service exciting and meaningful also make it demanding.

Children's Service Worker Needs

The demanding, unpredictable and stressful nature of work with families in their homes has long-term effects on staff. Several factors help sustain Family-Centered Children's

Service Workers. They are urged to plan for adequate nurture for themselves and to seek supervisory consultation when feeling powerless, isolated, or frustrated.

It is a rewarding experience to see even limited progress by families who have been discarded as hopeless. Children's Service Workers experience real gratification from their frequent presence with the family, from their continuity of relationship with family members, and from being able to help with the problems which are most important to the families they serve.

Ultimately, the most important factor in preventing Children's Service Worker burnout is unquestionably the increased likelihood of success which Family-Centered Services achieve. Seeing families learn to change and cope gives workers feelings of satisfaction and empowerment that go a long way to support their continued commitment to Family-Centered Services.

Stress Management Strategies

Stress is the discrepancy between what is and what is wanted. Develop an action plan and integrate this plan into daily activities. Some messages and activities that should be listed include:

1. Deep Breathing;
2. Take Control;
3. You Create Your Own Life;
4. **I Count Too!**;
5. Take Care of Your Body - You Only Have One;
6. Know What Results You Want;
7. Turn Stressors into Stimulators; and
8. Leave No Unfinished Business.

There are many hidden stressors in our work. They often lead to achievement anxiety. Do not create unreasonable discrepancies. You do not have to be perfect. You do not need to always please others. Know your own realistic expectations.

Taking Control

When you are in control stress levels are significantly reduced. Learn to take control over events and interpret them with control. Manage your life and your thoughts. Do not be afraid of asking for help. Recognize choices and alternatives.

What we focus on creates discrepancies. Examine things and decide if the issue is really important. If something jeopardizes your physical or emotional welfare, or if it threatens your safety, take a stand. If it does not, assess the issue to see if it really matters.

Making Choices

Examine the issues and events in your life that have become aggravating. If they are insignificant, let them go. If they are important, actively seek a resolution to the problems. Never take a stand on an issue if you are not willing to follow through later.

Remember, you cannot fix everything. You are learning and teaching coping skills.

Ten Major Stressors for Professionals:

1. Balancing personal and professional life;
2. Concern with advancement - getting ahead;
3. Financial concerns;
4. Intimate relationships;
5. Generalized job-induced stress;
6. Residence move - living conditions;
7. Super "person" syndrome;
8. Looking for a new job;
9. Not enough recognition on the job; and
10. Time pressures at work.

(Taken from 1987 National Survey, Bee Epstein, Ph.D.)

How And When To Dig An Emotional "Foxhole"

Sometimes we are hit from so many pressures and negativity that we need the adult equivalent of Linus' blanket. Here are some suggestions for what to do when the world is coming down on you:

- Imagine yourself in a calm and peaceful place, a mental "Shangri-La". Stay in that place for a while. Imagining a quiet natural scene will reduce your stress significantly.

- When it is time to face the real world, do so with affirmations. Say positive things to yourself and about yourself, such as "I can stay calm during stressful situations."

Positive Addictions - How To Get Hooked

What are positive addictions? They are things that are good for you. Laughter is a perfect example of a positive addiction. Laughter turns off the emergency stress system, promotes healing, lights up our faces, relaxes muscles, restores objectivity, and enhances hope. Dr. Ashton Trice of the Mary Baldwin College has found that humor has mood-altering effects. Subjects were given a frustrating task. Then, one-half were shown cartoons. Those who had the cartoons overcame their frustration and approached a new test with fresh enthusiasm and confidence. Those subjects who had not had the humorous interlude continued to exhibit symptoms of stress and frustration.

Prevent Energy Drains

Some people are able to perform at their peak consistently. Their secret may lie in their attitude. Negative attitudes are a terrible drain on energy. Ask yourself if you are prone to the following energy drains:

- Denial syndrome: You bemoan the fact that things are not as you feel they should be.
- Procrastination syndrome: Even though you may think you are "putting something off" your subconscious does not let you off the hook. This creates anxiety. Procrastination takes energy. You have to figure out how long you can wait and still make a deadline.
- "What will the boss think?" syndrome. Trying to second-guess all the time can be debilitating, not to mention futile. Clarify what the boss expects and then do it without undue speculation.

Coping With Deadlines, Priorities, And Hassles

The major causes of going crazy over deadlines are procrastination and perfectionism. A deadline is simply a time frame allotted to a task. The first step when you receive a project with a deadline is to establish what you want to achieve. Be specific. List the action steps you will need to take in order of their importance. Do the most important steps first. Assign a time frame to each step. Move steadily from step to step. Avoid perfectionism. Trying to be perfect takes an incredible amount of energy. You do not need to be perfect in order to be effective. Twenty percent of your efforts achieve eighty percent of your results. Finally, do not forget to enlist the help of others if you need it:

- How you can cope when several people come to you with "top priorities:"

Be clear on your own goals and priorities. Then, choose to do first the tasks that are most in line with those priorities. How about when you report to more than one supervisor? Ask them to clarify priorities between them.

- Ever find yourself with an "Anger Hangover"?

This is when you keep replaying stressful moments over and over again in your mind. If you catch yourself doing this, STOP. Your body reacts to what your mind perceives. Even though your mind is merely thinking about a stressful event, your body will respond with the same stress reaction as if it actually were happening. Do not replay those stressful moments and compound your stress.

- A simple way for keeping daily hassles to a minimum - and feeling less frustrated by them:

When running errands - do them at off-peak hours so that you do not have to wait in lines. Bring along something else to do in case you are delayed. That way, you will not think of it as wasted time. You will focus on something else, not your anger. Deep breathing always helps relieve your rising stress level. Do not forget positive self-talk.

Handling Conflicts

Conflict is inevitable. It is simply not possible for everyone to always agree on everything and problems never to occur. Here are some of the reasons why conflicts occur:

- People do not have the same information;
- People have different perceptions of the problem; or
- People have divergent goals or values.

There are various styles for handling conflicts; each appropriate in certain situations. Sometimes a conflict is not worth the fight. In this case it will be easier for you to withdraw or give in. If the conflict is very important to you, confront the person or situation assertively. Arriving at a consensus is important. Using compromise as a solution is often the method to choose. The most advanced style of handling conflict is collaboration. This style is appropriate when both the issue and the relationship are important. It is a win/win style in which you each reveal openly relevant needs, separate people from the problem. Use "I" messages, and truly listen.

The Supervisor's Role n Minimizing Stress

The following list contains hints that may be useful to the supervisor in minimizing stress within the workplace:

1. Be aware of your staff's work load.

2. Give staff plenty of advance notice of deadlines.
3. Do not impose last-minute requests unless it is an emergency and you:
 - a. Acknowledge the inconvenience and pressure; and
 - b. Express appreciation for taking on the request.
4. Keep staff informed of what is going on in the agency, particularly at times of change or uncertainty.
5. Let staff know where they stand in terms of the quality of their work, in the organization and with you.
6. See to it that staff are adequately trained for their jobs.
7. Meet with your staff to define expectations and goals, areas of responsibility, and limits of authority.
8. Reinforce people for doing jobs well.
9. Encourage staff to take adequate breaks, maintain healthy habits, and take care of themselves physically.
10. Be aware of the signs of excess stress and watch for them in your staff.
11. Be aware of your own level of stress and practice stress reduction techniques yourself.

Sources:

Segments of this chapter were obtained from Placement Prevention and Family Reunification: A Handbook for the Family-Centered Service Practitioner, authored by June C. Lloyd and Marvin E. Bryce with assistance from LaVonne Schulze, published by The National Resource Center on Family Based Services, Revised 1984, Chapter 14.

Other sources are cited in the text.

Chapter Memoranda History: (prior to 01-31-07)

Memoranda History:

23: Working With Culturally Diverse Families

Chapter 23 Overview

This chapter will explore the ethnic and cultural differences that affect family systems.

Culture refers to a learned pattern of thought and behavior that is passed from one generation to the next. These patterns are methods for meeting human needs and solving problems of living. Even though these methods may vary greatly from the chosen methods of others, they have value and are important to the culture.

Related to culture is ethnicity. An ethnic group consists of a group of people who identify with others in a group through common culture, language, religion, ancestry, physical appearance, or some combination of such characteristics. People outside the group also recognize this commonality. Members of an ethnic group see themselves as sharing the same or very similar past and present and also perceive sharing the same future.

It is helpful to understand the difference between prejudice and discrimination. Prejudice refers to a person's unfavorable beliefs and attitudes toward a particular group. Discrimination refers to behavior and actions that are unfavorable toward a group that deprives them of certain rights and opportunities. Being prejudiced does not always lead to discrimination. Also, it is possible to discriminate without being prejudiced. This may occur when a person acts out of ignorance, or when an insensitive policy or procedure directs them.

It is difficult to completely rid ourselves of prejudice. We all acquire some prejudgments during our upbringing. It is possible, and necessary, for Children's Service Workers to be aware of their prejudices and refrain from acts of discrimination. The following behaviors are characteristic of professionals who are prejudiced in their thinking:

- Stereotyped explanations are given for the behavior of persons of a specific ethnic or minority group:
- The same helping strategies are used for all clients in that group;
- The importance of cultural and ethnicity are easily dismissed, or are used to explain all behavior; and/or
- Discussions of culture are avoided or are talked about constantly.

Some of the common techniques used to help people may not be effective cross-culturally. Different groups may have different expectations as to what constitutes "help". This may make it even more difficult to select appropriate intervention tools. For example:

- Self-disclosure may be difficult between dominant culture workers and discriminated minority groups, since it presumes a degree of trust which may not be there;
- Reflection, reaching for feelings, or asking for insights may appear intrusive;
- Some groups may view help seeking as shameful and may not disclose personal problems; and
- Many groups may expect a more active helping relationship with the worker offering advice and tangible assistance.

Techniques such as self-talk, imagery, and challenging irrational beliefs may run counter to important cultural values and beliefs.

Grief and loss may be experienced differently across cultural groups. Awareness and sensitivity to these differences is important to the helping relationship shared with families and youth. A tip guide for helping professionals, [*Cultural Guidelines for Working with Families Who Have Experienced Sudden and Unexpected Death*](#), was developed by the Missouri Department of Mental Health and the University of Missouri Terrorism and Disaster Center. The guide illustrates how cultural and religious beliefs and customs may differ with respect to loss and death. Practical cultural guidelines for working with families experiencing sudden and unexpected death are provided throughout the guide. The tip guide is posted on the following websites:

Terrorism and Disaster Center, University of Missouri:
http://tdc.missouri.edu/doc/culture_guide_unexpected_death.pdf

Missouri Department of Mental Health:
<http://dmh.mo.gov/docs/diroffice/disaster/culturalguidelines.pdf>

The Children's Service Worker should be aware that minority children and teenagers make up a disproportionate amount of the out-of-home care population.

In making decisions on appropriate treatment and possible out-of-home placement, the Children's Service Worker must be aware of the following important points:

- A child's culture plays an important role in his/her development;
- Ignorance or lack of understanding of a particular culture can influence a decision in favor of a child's out-of-home placement. The Children's Service worker's knowledge of customs, religious beliefs and practices, educational practices, housekeeping standards and eating patterns are essential before the best decision can be made;
- Parents in minority groups may feel more threatened with the possibility that a child may be removed and need reassurance and clarification about what problems are seen as minor and what problems could result in the removal of the child; and

- A child's culture plays an important role in his/her development;
- Ignorance or lack of understanding of a particular culture can influence a decision in favor of a child's out-of-home placement. The Children's Service worker's knowledge of customs, religious beliefs and practices, educational practices, housekeeping standards and eating patterns are essential before the best decision can be made;
- Parents in minority groups may feel more threatened with the possibility that a child may be removed and need reassurance and clarification about what problems are seen as minor and what problems could result in the removal of the child; and
- A Children's Service Worker may need to become an advocate for the minority family and may need to educate public officials in the community who have misconceptions about a certain group.

Chapter Memoranda History: (prior to 01-31-07)

Memoranda History:

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24: Domestic Violence

Chapter 24 Overview

The purpose of this reference chapter is to assist staff in identifying, assessing, and intervening with families who confront issues relating to child abuse and domestic violence. Current research indicates that domestic violence and child abuse/neglect frequently exist together within a family. In a review of 200 substantiated child abuse reports, the Massachusetts Department of Social Services found that 30% of the case records documented adult domestic violence. This was prior to the Department requiring specific documentation of domestic violence. Domestic violence may also present a barrier to effective interventions with the family if the issue is not identified or addressed. A better understanding of the relationship between domestic violence and child abuse is necessary.

Operating Definition

A pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as stalking and economic coercion, that any person uses against a family or household member including, spouses, former spouses, any person related by blood or marriage, persons who are presently residing together or have resided together in the past, any person who is or has been in a continuing social relationship of a romantic or intimate nature with the victim, and anyone who has a child in common regardless of whether they have been married or have resided together at any time. (Section [455.010 RSMo.](#))

Guiding Principles

To give balance to the various conflicting values between child welfare and domestic violence advocates, as well as to recognize not only the Division's ongoing priority of child protection but also the state of the law, practice and policy must focus on the **best interest of the child**. The Division recognizes that it is in a child's best interest to live in a safe family and therefore it is the goal of the Division to preserve the child's family if at all possible while recognizing that the safety of the child is of primary concern. The Division's mandate by law remains the investigation and treatment of child abuse and neglect. Services should be tailored to the specific needs of the individual family with the best interest of the child. This position is the current state of the law and supported by agency history.

The preferred manner in which to protect children in most instances of domestic violence is to join with the abused adult or family if intact, in safety planning for each family member. This will facilitate in holding the perpetrator accountable for his/her violent behaviors.

Collaboration with domestic violence providers on the community level is imperative in providing the best and most comprehensive services to families.

Domestic Violence and Children

Children are often the unintended victims of domestic violence. They are faced with the threat of physical violence and/or the threat of witnessing violent events in their homes.

Children may:

- Be injured during an incident of parental violence;
- Be traumatized by fear for their abused parent and their own helplessness in protecting them;
- Blame themselves for not preventing the violence or for causing it; and/or
- Be abused or neglected themselves.

Current Research:

- Children are at greater risk of physical harm in families with domestic violence. In a national survey of over 6,000 families, researchers found that 50% of the men who frequently assaulted their wives also frequently abused their children. Researchers also found that “the rate of child abuse by those (mothers) who have been beaten is at least double that of mothers whose husbands did not assault them.”
- A large number of the severe and fatal injuries to children occur in families when men batter women. In a 1993 study, the Oregon Department of Human Resources found domestic violence in 41% of the families experiencing critical injuries or deaths due to child abuse and neglect (Oregon Department of Human Resources, 1993). Of the 67 child fatalities analyzed in Massachusetts in 1992 by the Department of Social Services, 29 (43%) occurred in families where the mother identified herself as a victim of domestic violence (Massachusetts Department of Social Services, 1993).
- Children are harmed emotionally as well as physically and sexually by domestic violence perpetrators. Between 3.3 million (Carlson, 1984) and 10 million (Straus, 1991) children in the United States are at risk of witnessing woman abuse annually. Studies find that children who witness domestic violence exhibit more aggressive and antisocial, as well as, fearful and inhibited behaviors. These children also demonstrate lower social competence (Wolfe et al., 1986). Furthermore, child witnesses exhibit more anxiety, aggression, depression, and temperament problems (Christopherpulos et al., 1987; Forsstrom-Cohn &

Rosenbaum, 1985; Holden & Ritchie, 1991; Hughes, 1988; Westra & Martin, 1981).

Adult Indicators of Domestic Violence:

- Evidence of physical injuries;
- Feelings of depression, anger, and emotional distress;
- Low self esteem and suicidal thoughts;
- Frequent medical problems;
- Violence in family of origin;
- Requests for financial assistance;
- Isolation from friends and family;
- Damaged property (holes in the wall, etc.);
- Victim minimizing abuse;
- Offenders accusations of infidelity;
- Abuse of family pets;
- Limitation of access to financial resources;
- Children overly protective of one parent;
- Reluctance of adults to be interviewed separately; and/or
- One adult answers all of the questions.

Child Indicators of Domestic Violence

The impact of domestic violence on children may be demonstrated by behaviors similar to those exhibited by children who are physically abused:

- Child may blame self for the abuse;
- Child may identify with the offender by “acting out” aggressively toward the adult victim;

- Child may be depressed, confused, or exhibit animosity, anger, or sadness;
- Infants may be moody, restless, sleepless, or lack responsiveness;
- Regression, such as bed wetting or thumb sucking;
- School phobia - a manifestation of leaving the adult victim alone in the home;
- Guilt or the inability to establish trusting relationships;
- Child tries to hide the fact domestic violence is present in the home;
- Child may take on the “mothering” role;
- Child may demonstrate fear when the offender is around; and/or
- Child may be withdrawn, apathetic, or feel insecure and powerless.

Understanding Barriers to Leaving

The dynamics in a battering relationship, along with the lack of support to the adult victims, make it very difficult for them to leave the relationship. Following are some of the barriers preventing victims from leaving their abusers. The barriers must be taken into consideration when developing case plans and/or safety plans with the family:

- Economic dependence;
- Desire to keep family intact;
- Fear of future abuse;
- Lack of perceived alternatives;
- Lack of knowledge and access to services;
- Social expectations;
- Religious beliefs;
- Parenting responsibilities;
- Denial of abuse;
- Perceived responsibility or guilt for abuse;

- Shame or humiliation;
- Disability;
- Elderly;
- Language (primary mode of communication is a foreign language);
- Isolation from family and friends; and/or
- Hopefulness/Optimism about the relationship getting better.

Identification and Assessment of Domestic Violence

Identification and assessment are both essential ingredients of an effective response to domestic violence. Identification procedures should include routine, direct inquiry with families regarding whether they have been hurt by their partner, along with continual observation for possible indicators of domestic violence. The identification and assessment process should be ongoing during all phases of working with the family as violence can begin at any point. When domestic violence is identified, staff should offer referrals for shelter services, legal services, counseling, etc.

Additional Considerations in Conducting Assessments

It is important to identify the influence of a family's culture as it pertains to domestic violence. If you are unaware of the values of a certain culture, consult your supervisor or local community provider for assistance. Issues regarding family roles, male dominance, and other beliefs must be understood in order to do an accurate assessment and provide effective intervention.

Related Subject: Section 7 Chapter 23 Working With Culturally Diverse Families
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Depression is symptomatic of trauma and may not subside until safety is achieved. In order to promote a sense of empowerment and competence for the adult victim of domestic violence, his/her input is important in safety and service planning.

Persons who have experienced chronic abuse may need greater assistance in accessing resources and strong reinforcement for positive service outcomes. Examine closely the history of abuse the victim may have experienced and patterns of relationships that the person has had. The presence of natural support systems is also vital for successful outcomes.

Often it is difficult to decipher who is the primary initiator of the violence within the adult relationship. To assess self-defense and other responses to violence accurately, examine who holds the control in the relationship, who has been injured, who is afraid,

and who has access to resources. Court records, police reports, and other documentation may assist in providing critical information.

Substance abuse should also be taken into consideration while conducting assessments. Substance abuse may increase the problem, but does not cause domestic violence. It is important to examine what role substance abuse plays with each family member. Does the perpetrator become more violent when under the influence? Does the adult victim's use of substances impede his/her ability to provide safety? Confronting the offender or adult victim while they are under the influence of substances may increase risk of harm to the worker or other family members and is discouraged.

Interventions

The worker's interactions and interventions with the family should attempt to meet three goals of successful intervention in domestic violence cases. These goals are:

1. To protect the child;
2. To assist abused parents referred to the agency for child abuse and neglect in protecting themselves and their child by providing services that are non-coercive and supportive; and
3. To document in the case record the violent behaviors of the domestic violence offender that places the child and adult victim at continued risk of harm.

The optimal intervention would meet all three goals. However, when no intervention exists that will meet all three goals simultaneously, the child's safety is of most importance. The other goals may be revisited once the safety of the child is assured.

When the results of an investigation or assessment indicate that child abuse and/or neglect is not present, involvement with the family is often terminated. However, in instances where domestic violence has been identified, information regarding community resources can be shared with the family if they are interested. This may be an important step in order to reduce the risk of the escalation of violence, which will reduce future risk to the child and the adult victim. Examples of services that play a crucial role include:

- Emergency shelter and longer-term transitional housing programs for victims and their children;
- Legal assistance and advocacy for victims of domestic violence;
- Law enforcement or prosecution based domestic violence programs;
- Programs that will teach perpetrators how to have non-violent relationships and how violence impacts their children;

- Programs that help victims and their children recover from violent relationships; and
- Programs that work with children who have witnessed domestic violence in their homes.

Interventions with families can be strengthened through collaboration with other service providers in the community. Collaborative relationships with service providers could include working out referral procedures that allow for adequate follow-up by Children's Division staff. Sharing of information with service providers will better enable them to help meet the needs of the adult victim and their children.

Service Planning

Service plans are important tools that staff use in providing structure for the process of working with families. Domestic violence is one more issue of importance to address when developing these plans with families. Service plans can incorporate measures that will provide for the safety of the adult victim and child and place responsibility upon the domestic violence offender for stopping the violent behaviors that jeopardize the safety of the family. Following are some suggested strategies to use in developing service plans:

- Documentation in the case record of each violent episode and the effect it has had on each family member;
- Work with the courts to increase safety by removing the domestic violence offender from the home when necessary, rather than the child, if the child and adult victim can be reasonably assured of safety in the home;
- Refer allegations of domestic violence to the prosecutor's office, if adult victim is agreeable;
- Encourage the domestic violence perpetrator to attend a treatment program for abusers and monitor any progress that has been made in becoming nonviolent; and
- Refer adult victim and child to domestic violence service providers in the community.

It is important to note that programs offered by domestic violence service providers are voluntary. Domestic violence service providers do not force or require victims to attend any of their programs. If the adult victim does not want to pursue any of the above options, it is counter-productive to attempt to force cooperation. Most often the adult victim and children are in the greatest danger and he/she is trying to protect the family by remaining silent. Outside intervention may increase the risk.

Safety Planning

Safety planning is an important step in assuring the safety of the child and adult victim. Safety plans can include all of the family members. These plans can be used to indicate what each family member including the perpetrator must do to make the entire family safe from future harm. Following are questions that can guide the safety plans that are developed with the family:

- In what ways can others and I help you?
- What do you feel you need to be safe?
- What particular concerns do you have about your children's safety?
- What have you tried in the past to protect yourself and your children (i.e., left for a few days, sought help from family or friends, fought back, got an order of protection)? Did any of these strategies help? Will any of them help you now?

If the adult victim has had the perpetrator evicted or is now living alone, evaluate the following options:

- Changing locks on doors and windows;
- Installing a better security system - window bars, locks, better lighting, and smoke detectors;
- Teaching the children to call the police or family and friends if they are snatched;
- Talking to schools and child-care providers about who has permission to pick up the children and developing other special provisions to protect the children;
- Finding an attorney knowledgeable about family violence to explore custody, visitation, and divorce provisions that protect the children and victim. Attain attorney referrals from local shelter and/or domestic violence coalition;
- In rural areas where only the mailbox may be visible from the street, covering the box with bright colored paper so the police can more easily locate the home; and
- Obtaining an order of protection.

If the adult victim is leaving the perpetrator, review the following:

- When is the safest time to leave? Is transportation and money available? Do you have a safe place to go?
- Do you feel comfortable calling the police?

- Who will you tell and not tell about leaving?
- What can you and others do to prevent the abuser from finding you?
- Who in your support network do you trust to protect you?
- How will you travel safely to and from work or school to pick up the children?
- What community/legal resources will help you feel safer? Write down these addresses and phone numbers.
- Do you know the number of the local shelter?
- What custody provisions would keep you and the children safe?
- Would an order of protection be a viable option? Provide him/her with the information regarding how to obtain one.

If the adult victim is staying with the perpetrator review the following:

- In an emergency, what will work best to keep you and the children safe?
- Who can you call in a crisis situation?
- Would you call the police if the violence begins again? Is there a phone in the house or is there a signal that can be worked out with the children or the neighbors to call the police or get other help?
- If you need to flee temporarily, where can you go? Write down the addresses and phone numbers of these places.
- Identify dangerous locations in the house, such as basement or room without windows, and advise him/her not to get trapped in them.
- Are there any weapons in the house? Explore ways to make them the least dangerous (i.e., make sure not loaded, hidden away).
- Advise him/her to make an extra set of car keys and to keep some money stored away in case of an emergency.

Advise the adult victim to have the following available in case an emergency exists:

- Birth certificates;

- Social Security cards;
- Marriage certificates, driver's license, and car title;
- Bank account numbers, credit and ATM cards, savings books;
- Lease/rental agreements, house deed, mortgage papers;
- Insurance information;
- School and health records;
- Welfare and Immigration documents;
- Medications and prescriptions;
- Divorce papers and other court documents;
- Phone numbers and addresses for family, friends, and community agencies;
- Clothing and comfort items for self and children;
- Family photos or other significant mementos;
- Children's favorite books, toys, etc.; and
- Keys.

Suggestions for Interview Questions

Child Interviews

These questions should be used only if staff have determined through the assessment process that the child is aware of the domestic violence. Interviews with the child should focus on their account of what they have witnessed, the impact of witnessing the violence, and their perception or worries about safety:

- What kinds of things do Mom and Dad (boyfriend, etc.) fight about?
- What happens when they fight?
- Do they yell at or hit one another?
- What do you do when this is going on?

- What do you think about when this is happening?
 - Do you ever get hurt when Mom and Dad are fighting?
 - Do you think about your parents fighting a lot?
 - Do these thoughts ever come to you at school or while playing?
 - Do you have trouble sleeping at night? Do you have nightmares?
 - Why do you think Mom and Dad fight?
 - What would you like them to do to make it better?
-

- What do you do when Mom and Dad are fighting?

<input type="checkbox"/> Stay in the Room	<input type="checkbox"/> Go to a Sibling
<input type="checkbox"/> Leave or Hide	<input type="checkbox"/> Ask Parents to Stop
<input type="checkbox"/> Phone Someone	<input type="checkbox"/> Other
<input type="checkbox"/> Go for Help	

- When Mom and Dad are fighting, what do you worry about the most?
- Have you talked to any grown-ups about this problem?
- In an emergency, whom would you call?

Adult Interviews

When staff have assessed the situation and concluded that domestic violence is present, it is recommended interviews with the adults are done separately. Interviewing the abused adult alone may be difficult, if not impossible. Creativity is often necessary in arranging these interviews. However, being unable to talk to the adult victim alone may be a signal of danger and related to the level of control the perpetrator has over the family. Following are some suggested questions to use in the interview to further assess danger to the adult victim and the children:

- Tell me about your relationship?
- How do decisions get made in your family?
- Do you feel free to do and believe what you want?

- Does your partner ever feel/act jealous?
- Have you ever felt afraid of your partner; if so, why?
- Has your partner ever used physical force on you?
- Have you ever been afraid for the safety of your children?
- How are you able to keep your children safe?

Has your partner:

- Prevented you from going to work, school, or church?
- Prevented you from seeing friends or family?
- Listened in on your phone calls or violated your privacy?
- Followed you?
- Accused you of being unfaithful?
- Controlled your money?
- Called you degrading names?
- Humiliated you in public or at home?
- Destroyed your possessions?
- Threatened to hurt you, the children, or other family members?
- Threatened to kill you?
- Forced you to perform sexual acts against your will?

These questions will help you to further assess the level of risk to the children:

Has your partner:

- Called your child degrading names?
- Threatened to take the children from your care?

- Accused you of being an unfit parent?
- Threatened to hurt or kill you in front of the children?
- Hurt you in front of the children?
- Hit your children?
- Touched your children in a way that made you or them feel uncomfortable?
- Asked your children to report on what you do during the day?

Has your child:

- Overheard the yelling and/or violence?
- Behaved in ways that remind you of your partner?
- Physically hurt you or other family members?
- Tried to protect you?
- Tried to stop the violence?
- Hurt him/herself?
- Hurt family pets?
- Been fearful of leaving you?
- Exhibited emotional/behavioral problems at home or school?

Offender Interviews

Assessing the dangerousness of the offender is important in order to protect yourself and to lessen the risk for children and the adult victim. If you feel that the offender is too dangerous, close the interview and consult with a supervisor regarding what steps to take next. Following are some questions that may be used in the assessment of the offender:

- Tell me about your relationship.
- What things do you like about your partner and family?
- How does your family handle conflict?

- What kinds of things do you expect from your partner/family?
- What do you do when you do not get your own way?
- Have you ever been so angry that you physically hurt someone?
- Have you ever been told that violence is a problem for you? By whom?

The questions provided are a guide for staff to use in assessing the danger posed to children and adult victims in households where domestic violence is present.

Chapter Memoranda History: (prior to 01-31-07)

Memoranda History:

CD11-75

25: Diagramming Families for Assessment

Chapter 25 Overview

Out of family systems theory has come a useful way of assessing families in which the families themselves can participate. The purpose of this chapter is to examine the implications of the family systems approach and to introduce some assessment tools that have been developed. The assessment process and procedures described here depend upon the mutual engagement and participation of both the Children's Service Worker and family.

The use of diagrams to describe complex family relationships can reduce or replace the use of lengthy written narrative. The four methods of diagramming discussed in this chapter are:

- Genograms, used to describe and gain insight into relationships and roles within the family unit
- Culturagram, used to help staff recognize the cultural differences between families. By completing the Culturagram, staff develop a better understanding of the family's needs and can begin to plan for appropriate interventions on an individual, family, and community basis
- Ecomaps, used to document the family unit's relationship to outside systems;
- Time Lines, used to observe the relevant events experienced by the family, and
- Sequences of Behavior, used to observe the behavior patterns that surround the presenting problem.

By using the various methods of diagramming, the Children's Service Worker and family may learn something about the relationships within the family, the location of the family's boundaries, and the variety and quality of the family's connections to outside systems. In addition to assessment, the use of these diagramming methods may be useful as:

- Interviewing tools that can be used with individuals, couples, or the entire family
- A way to facilitate participation by providing a clear structure and can assist people who might have difficulty entering into discussion
- Helpful additions to the case recording, since they give a clear quick view of the family, and
- Tools for organizing information to assist in the case planning and preparation for services.

Family Participation is Crucial

The use of these assessment methods recognizes the family as the most knowledgeable source of information about itself. As the kind of data requested is concrete and not extremely personal, their use encourages an interviewing style that tends to be non-threatening. Most people will more readily discuss themselves and their backgrounds under these circumstances and share more personal information as rapport is established.

The use of these methods offers the Children's Service Worker an opportunity to observe and engage the family in their environment. Having the family members sit **beside** the worker and assist in a diagram's completion (rather than across the table in an adversarial position) is a good example of how this method fits in with family-centered approach to providing social services. It leads the family to open communication and insight into their past and present. Through these methods, the worker and family can learn about:

- Who the family is - their names, ages, relationships, occupations, and religion
- Roles in the family and who performs them - Are grandparents, older children or others involved in the parenting? Do members identify any unfulfilled tasks? Who is perceived as having the most power in this family?
- Family rules - What are the family rules regarding decision making; child care; discipline; intimacy/distance; expressions of love and anger? What are the rules with respect to relationships between generations?
- The family communication - Are there identifiable channels of communication? Who communicates to whom and how?
- The relationship system(s) - How do members of this family feel about the other members? Who is close to whom in this family? Are there identifiable alliances? What are the major conflicts within the family from the point of view of each member?
- The family through time - What is the significant history about the development of the family (marriage, children, etc.)? What are the significant themes, patterns, events in the family history, major losses, changes, and how has the family handled them?
- The family network - What persons or systems are important to the family? Outside the immediate family, where does the family turn for support?

household. Symbols describe the sex of the individual. A male is indicated by a square; a female is indicated by a circle.

A triangle is used to indicate if the sex of the person is unknown (i.e. the sibling of a great-grandparent or a still-born child whose sex is unknown).

An "X" through a figure indicated the person is no longer living.

2. Draw connecting lines between these symbols to describe the composition of the family system. (See Figure 2 on the next pages).

Marital separation is indicated by a single slash along the connecting line; a divorce is indicated by two slashes.

Location of the slashes on the connecting line denotes which parent has custody of the children. See the genogram in Figure 1. The slashes on the marital line indicate the couple is divorced. The location of the slashes set the father off from the children and indicates the mother has custody of the children.

Additional lines are drawn between the symbols to describe the emotional quality of the relationships. (See Figure 3).

3. Children born to the couple are drawn below the parents and the child's symbol is connected to the line between the parents, starting with the oldest to the left.

Twins are connected to one another and a single line connects their line to their parent's line.

Again, additional lines are drawn to describe the type of relationship that exists between the children and the parents or between the siblings.

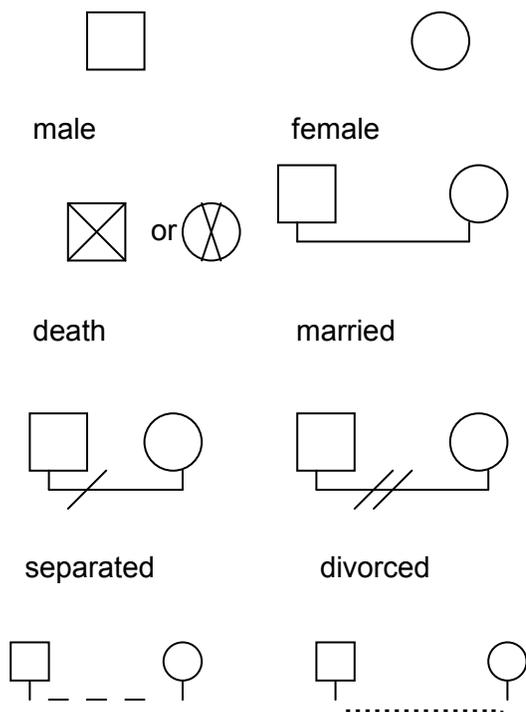
4. A dotted line drawn around the group of individuals denotes the household composition.
5. Repeat the process vertically and horizontally to include persons in the extended family.

Grandparents are connected and diagrammed above the parents (vertically). Connecting lines extend from the grandparent's line to the parent.

Repeat the process horizontally, as needed, to include the aunts, uncles, and cousins of the children.

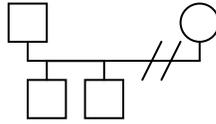
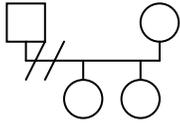
6. Upon obtaining the skeletal structure of the family, it is important to fill in the diagram with identifying and historical information, such as:
 - a. Names, birthdates, and death dates that are written next to the person figures;
 - b. The age of the individual can be written inside the person figure for quick reference;
 - c. Marriage dates and dates of separation and divorce are written next to the connecting lines between the individuals.
 - d. Occupations, interests, and descriptive characterizations, health condition, etc., can be written next to the individual.
 - e. Information that further describes the family unit, such as race, income, religion, ethnic or cultural influences family can be written in the border.

Figure 2. Conventions Of Diagramming Family Structure



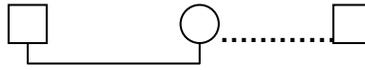
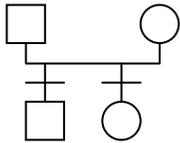
living together significant non-cohabiting
 continuing relationship

Figure 2. (Continued)



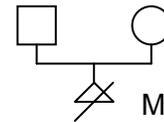
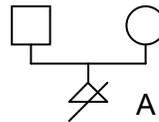
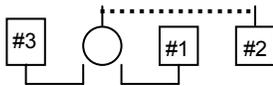
divorced mother with
 custody of two female
 children

divorced father with
 custody of two male
 children



children out of
 the home

wife with extramarital
 affair (current)



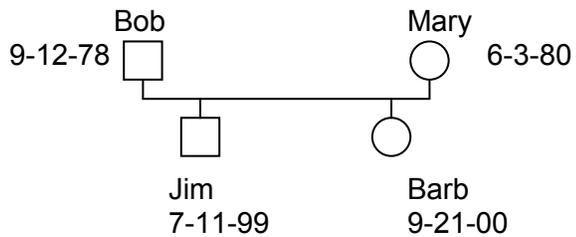
woman having significant
 non-cohabiting relation-
 ship between two marriages

abortion(A) and miscarriage(M)

General Rules:

- Put age inside and
 date of birth outside

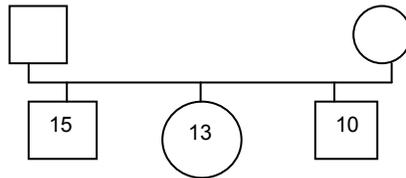
- Put first name of
 each person



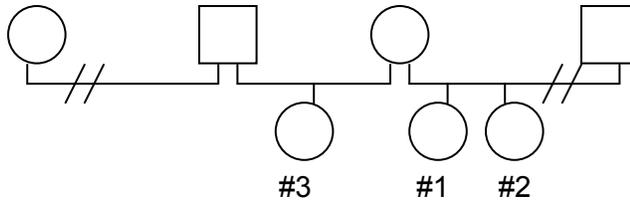
┌────────── 5-10-76 / 3-14-77 ─────────┐
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- Put exact dates of marriage, divorce and separation if different

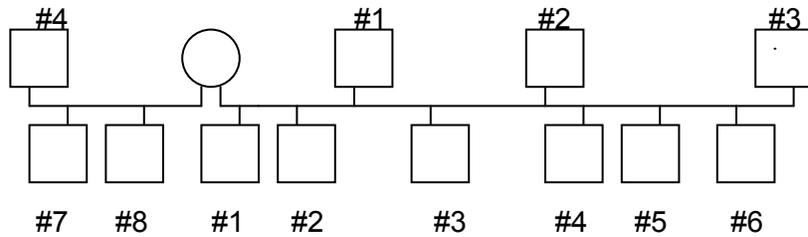
- Put children in birth order, oldest at left, except in case of multiple marriages (see examples, next page)



Examples:



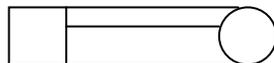
Two spouses each previously married; wife had two children, husband had none; current couple has one in-common child.



Wife's four marriages: 2 children in first; 1 child in second; 3 children in third; 2 children in fourth.

Figure 3. Diagramming Emotional Relationships

intense relationship



intense relationship cut-off

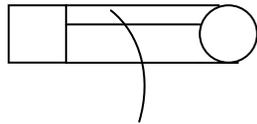
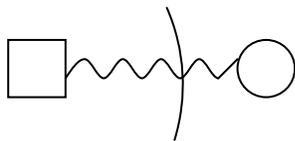


Figure 3. - Continued Diagramming Emotional Relationships

conflictual relationship



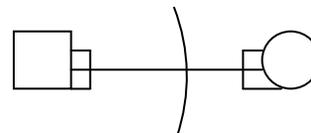
conflictual relationship cut-off



distanced relationship



distanced relationship cut-off



intense conflictual relationship

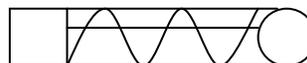
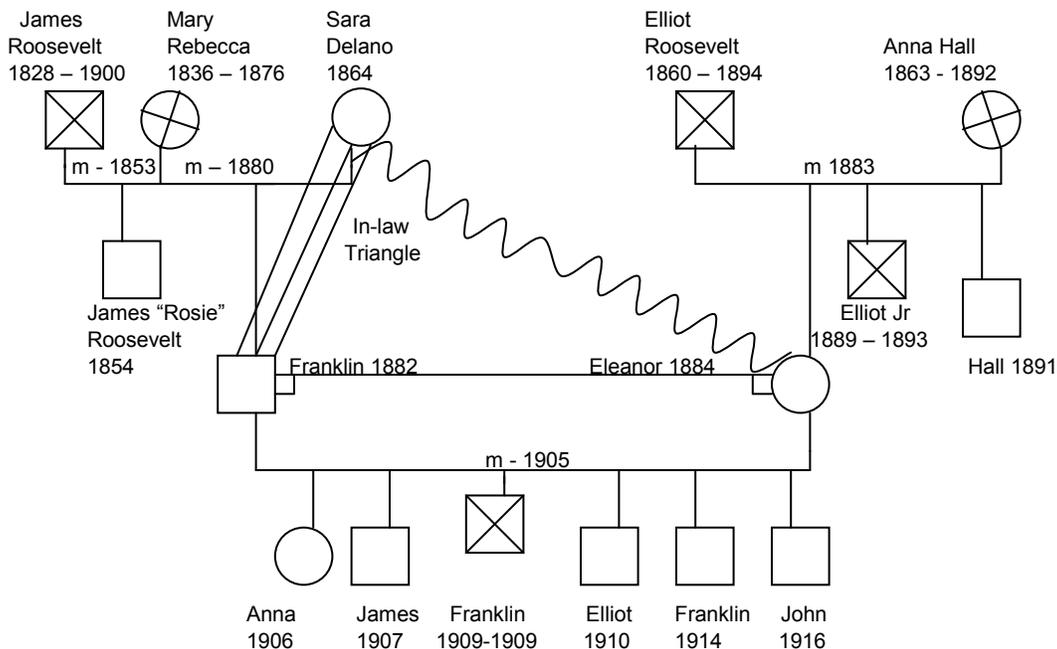


Figure 4. Example Of Completed Genogram



Written Narrative on Roosevelt Family Genogram:

Household family consists of seven members: Father is Franklin, born in 1882. Mother is Eleanor, born in 1884. They were married in 1905. Their relationship is a distant one.

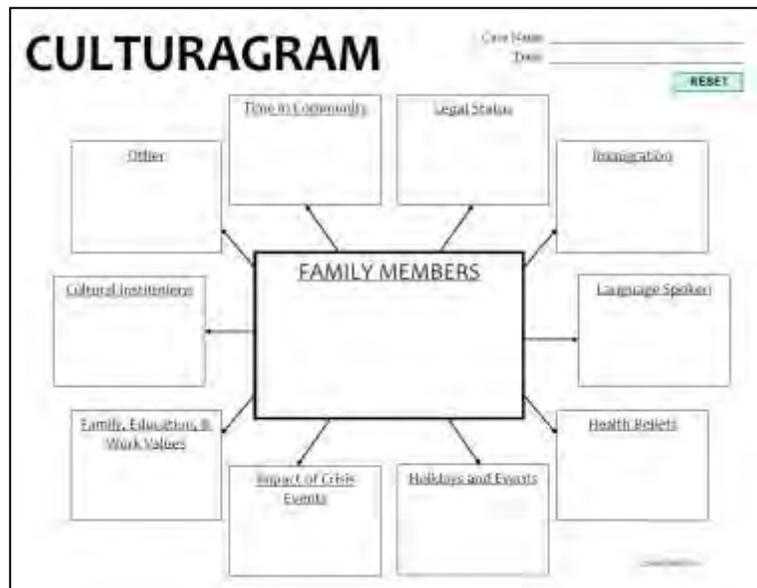
Their marriage has produced six children; five male and one female: Anna, born in 1906; James, born in 1907; Franklin, born in 1909, and died in 1909; Elliot, born in 1910; Another child named Franklin, born in 1914; John, born in 1916.

Franklin (father) has a half brother, "Rosie," 28 years his senior. His father, James Roosevelt, was born in 1828 and married his first wife, Mary Rebecca, in 1853 when she was age 22. Rosie was their only child. Mary Rebecca died in 1876. James remarried to Sara Delano, Franklin's mother, in 1880. At age 52, he was twice Sara's age. Franklin, born two years later was their only child. James died in 1900, age 72. Franklin has an intense relationship with his mother. Sara's relationship with Eleanor is conflictual, resulting in an in-law triangle.

Eleanor Roosevelt is the oldest of three children born to Elliot Roosevelt and Anna Hall. Elliot, born in 1860 married Anna in 1883. Anna was born in 1863. Elliot was related (relationship unknown) to Franklin's father. Eleanor had a brother, Elliot Jr., who was born in 1889; he died of scarlet fever in 1893. Another brother, Hall, was born in 1891.

- **Culturagram**

The culturagram focuses on ten aspects of culture, including time in the community, legal status, reasons for relocating, languages spoken at home and in the community, health benefits, holidays and special events, impact of crisis events, values about education, work and family, and cultural and religious institutions.



The culturagram should be completed with the family within the first 30 days of the case opening. The culturagram should be updated when there is a change in family dynamics. Areas to cover include:

Time in the Community: How long have you been in the community? Each family member's time in the community may be different, especially in families that immigrate.

Legal Status: Different people inside the same family can have different legal statuses. There are illegal immigrants, people who have Green cards, there may be refugees, or people who have been given special status based on a fear of persecution based on religions/political opinions, race, nationality, or membership to certain groups. Legal status can contribute to people avoiding

needed medical or social services because there is a lot of fear of having their immigration status known.

Immigration: Why did you choose to live here? You could be working with newly immigrated families, or families that have been your area for years or even decades. It is important to ask why they selected here. You may find that people came to be close to other family members, or for economic reasons, or for political/religious persecution.

Language Spoken: Does the family speak more than one language? What language(s) are they stronger in? Often families speak one language at home and another in the community.

Health Benefits: What do families seek treatment for? When do they go to the doctor? Many people have very different beliefs about diagnosis and treatment. In the United States, well-child clinics are available from the time children are born. But many other countries you only go to the doctor if you or your children are very sick. The same may be true for rural families or families struggling economically.

Holidays and Events: There may be holidays that the larger society celebrates but also holidays that are important to the family unit.

Impact of Crisis Events: What crises have the family experienced? Crisis families tend to go through two types of crises. First is the developmental crisis, where you can see every kind of new stage of life can lead to a developmental crisis. The other type of crisis a family experiences is the “Out of the Blue” crisis. These are usually unexpected events such as: accidents, sudden illness, violence, unemployment, and death. It is important to look at all of these traumatic and crisis events because they really affect a family.

Family, Education, & Work Values: What are the families thoughts on education and work? Is the family hierarchical or egalitarian? Each family is set up and organized differently and it is important to look at what are the family myths, rules, and what is unique for the family.

Cultural Institutions: Is the family involved with ethnic social clubs? Next, consider religion because many families are involved with church, temples, or mosques. Religion and spirituality is very important to understanding the culture of the family.

Other: Additional values that the family feels are important to their culture.

- **Ecomap**

Briefly, the ecomap is a way of mapping the family system in its world. It provides the family and Children's Service Worker with a way of actively gathering data about itself and drawing conclusions about that data. This method of diagramming depicts the family in their dynamic ecological system. Other important systems that influence the family are included in the ecomap. Ann Hartman describes the following functions of the ecomap. The mapping procedure:

- Portrays an overview of the family in their ecological situation
- Pictures the important nurturant or conflict-laden connections between the family and the world
- Demonstrates the flow of resources, or lacks and deprivations, and
- Highlights the nature of the interfaces and points of conflicts to be mediated, bridges to be built, and resources to be sought and mobilized.

Instructions for Ecomapping:

1. Draw a large circle in the middle of the map. This represents the members of household.
2. Inside the large circle, draw a genogram that describes the makeup of the household. It is often useful to add names and ages. Limited space may prevent adding additional descriptive information.

Use the symbols that are normally used in genograms (see figure #1).

3. Inquire into what outside systems influence the family unit and its members. Examples of these outside systems may include work, extended family, church, school, health care, social welfare, recreation, and friends.

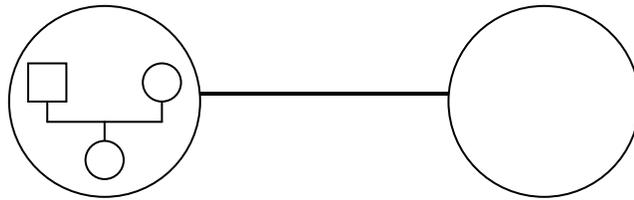
Draw smaller circles around the large household circle and label them to represent the outside systems.

4. The next step is to begin to draw the connections of the family unit and its individuals to the various systems in their environment. These connections are indicated by drawing lines between the family and the circles representing the outside systems.

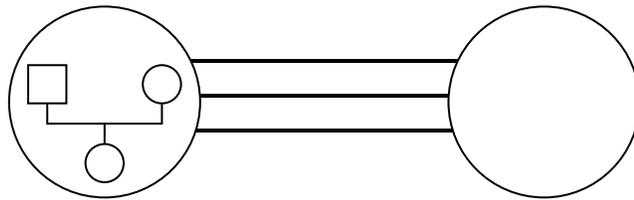
Some of the connections may be drawn to the family unit as a whole or to the individual members. This differentiation demonstrates the way the various family members are connected to the environment.

The nature of the connection is described by the type of line that is drawn:

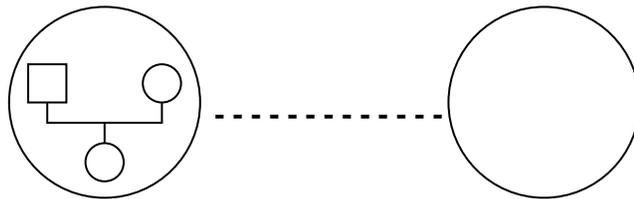
- a. A solid or thick line represents a strong connection



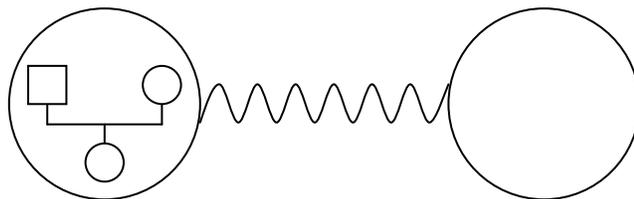
- b. Three solid lines indicates the strong connection is an intense relationship



- c. A broken line indicates a tenuous relationship

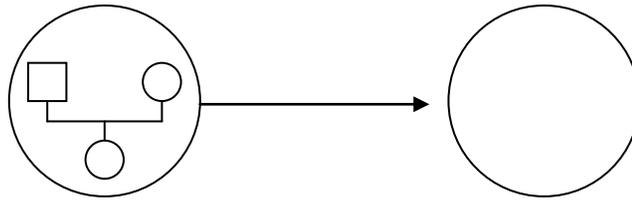


- d. A zig-zagged line shows a stressful or conflictual relationship



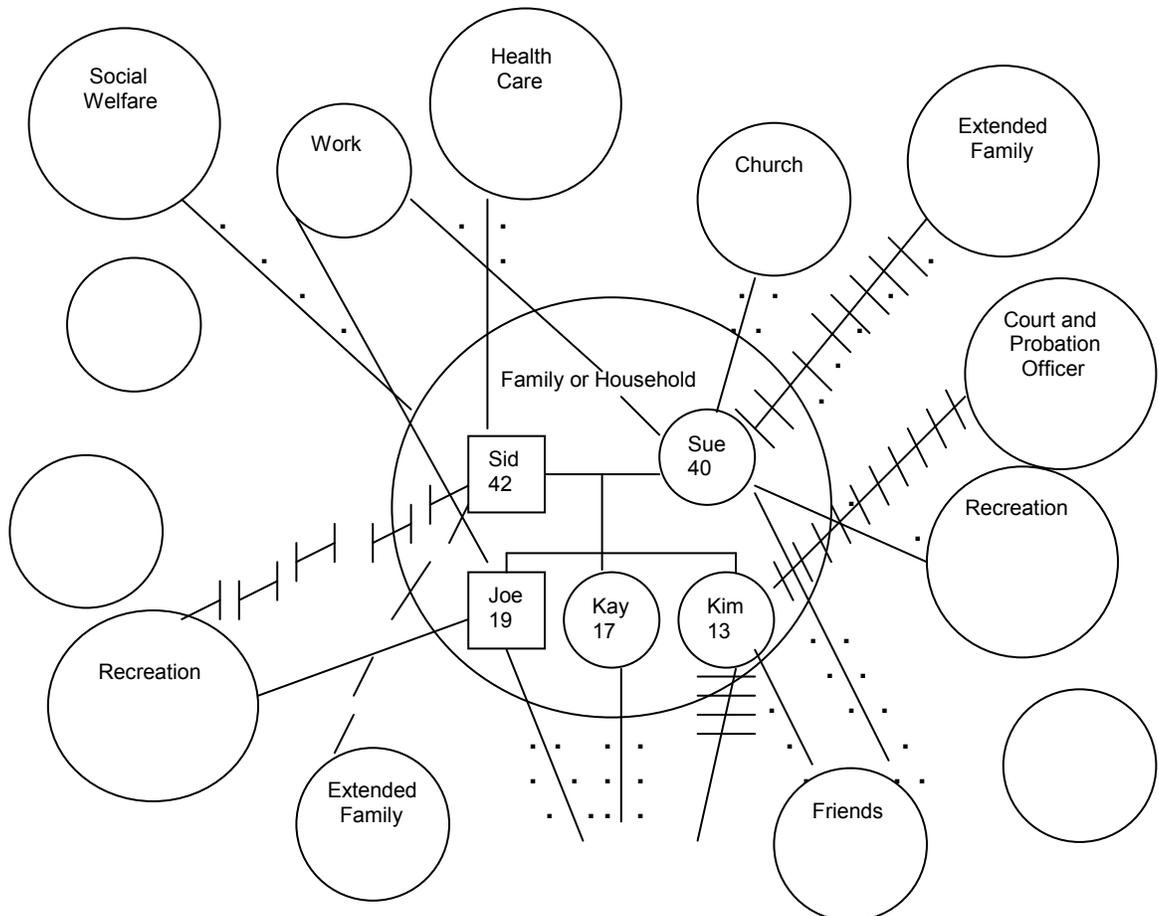
Refer to Figure #2 for other variations and examples for diagramming emotional relationships.

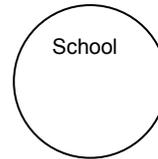
- Next, indicate the direction of the flow of resources, energy, or interest by drawing arrows along the connecting lines.



- Finally, write a word or two beside the connecting lines or smaller circles to further describe, clarify or highlight information drawn on the ecomap.

Figure 5. Example Of Ecomap





It is important for the Children's Service Worker to study the family's presenting problem and its function within the family system. The presenting problem is usually the behavior which brought the family to the attention of the Division. The techniques presented here to assist in this study are:

1. Time lines, and
2. Diagramming the sequence of behaviors.

The same type of non-confrontive interviewing techniques that are used when completing genograms and ecomaps should also be applied when completing time lines and behavior sequences. Use of these methods should come after the completion of the genogram and ecomap. This should allow the Children's Service Worker an opportunity to develop rapport with the family. The family may be more willing to share information about the presenting problem when rapport is established.

- **Time Lines**

Time lines are used to identify the significant events experienced by the family. By plotting these events on a linear line, this method can help determine the onset of the presenting problem and what was generally going on before and after the onset. (See Figures 6 and 6a.)

Instructions for Completing a Time Line:

The Children's Service Worker may start anywhere in time, but it may be more useful to focus on significant events (such as the birth of a child, loss of a job, death of a family member) that surround the presenting problem. This will usually be the incident that brought the family to the attention of the Division, such as an incident of abuse.

1. Mark the particular date(s) that identifies the onset of the presenting problem on the line(s).
2. Next, mark the significant events as reported by the family that led up to the presenting problem behavior.

These can immediately precede the presenting problem but may also have been in the more distant past.

3. Next, mark any significant events that followed the presenting problem. This can demonstrate the event(s) experienced by the family after the problem's onset and its consequences.
4. Inquire into whether the presenting problem had occurred before. Mark the significant events that surround any previous incidents. This should help determine if this is an acute or chronic problem.

The Children's Service Worker may also use a line for each household member if it is more helpful to track the events surrounding an individual. (See Figure 6a.)

Figures 6 And 6a. Examples Of Time Lines

Dad loses Job	12-20-98	Dad leaves home	3-1-99
12-4-98	Mom tells dad she is pregnant	1-4-99	Dad returns to work
Dad returns Home	6-20-99	Dad loses job	8-15-99
4-15-99	mom gives birth	7-5-99	CA/N Report
			Dad moves out
			9-15-99

6a.

Mom	3-10-99	her mom dies	5-1-99
	Mom loses Job	4-1-99	CA/N Report
Dad	3-13-99	Dad: DWI	5-5-99
	Dad assaults	4-15-99	Dad in detox

• **Sequences of Behavior**

Sequences of behavior that surround the presenting problem can be diagrammed in a circular manner. This allows the Children's Service Worker and family to see how the presenting problem is embedded within precise sequences of observable family behaviors. It can help gain insight into:

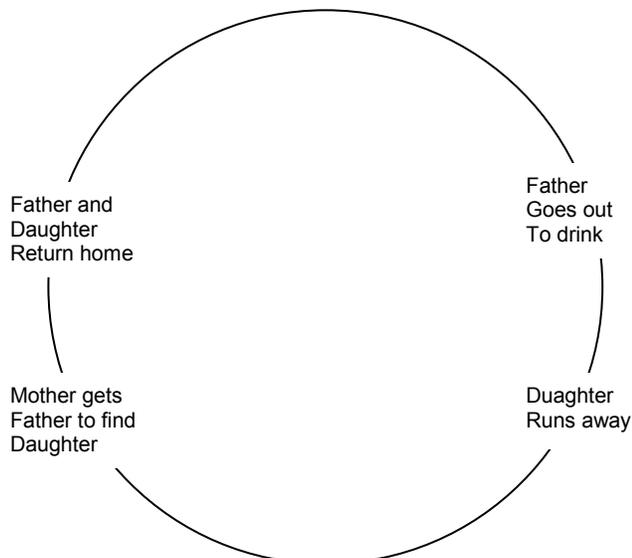
- What behaviors act as antecedents to the presenting problem so that the antecedents can be avoided or altered
- How the family members react to the presenting problem behaviors and how the family system is influenced by the problem behaviors

- What functional aspects the presenting problem serves within the family system and why it has become ingrained within the family, and
- How these repetitious sequences may create counter-productive patterns that the family might have become accustomed to.

Instructions for Diagramming Behavior Sequences:

1. Mark the presenting problem behavior on a point on a circle (Daughter runs away).
2. Inquire into what observable behavior **immediately preceded** the problem behavior (Dad left home).
3. Inquire into what observable behavior preceded this behavior (Dad and Mom were fighting). Follow this process backwards to document the series of behaviors (Dad was drinking) that eventually led up to the presenting problem.
4. Next, inquire into what observable behavior **immediately followed** the presenting problem behavior (Mom seeks Dad for help).
5. Inquire into what observable behavior immediately followed this behavior (Dad finds Daughter). Follow this process forward to diagram the series of behaviors that followed the presenting problem. (Dad and Daughter return home together; Mom and Dad reconcile; Dad starts drinking again; Mom and Dad fight again, etc.)

Figure 7.



Title: Child Welfare Manual
Section 7: Glossary/Reference
Chapter 25: Diagramming Families For Assessment
Effective Date:
Page: 18

Sources: This chapter was adapted from Understanding Families, written by Jo Ann Allen, with contributions by Eloise Cornelius and Consuelo Lopez, and edited by Kittsu Swanson. It was developed under Contract #105-79-1107 for the Children's Bureau, Administration for Children, Youth and Families, Office of Human Development Services, United States Department of Health and Human Services.

The instructions for completing genograms and ecomaps were adapted from "Diagrammatic Assessment of Family Relationships," *Social Casework* (October 1978), and "An Ecological Framework for Assessment," from the book Finding Families, 1979, both authored by Ann Hartman.

Figures No. 2 through 5, and 7 are used with the permission of the National Resource Center on Family Based Services, The University of Iowa School of Social Work, Oakdale, Iowa.

Technical assistance was provided by the National Resource Center on Family Based Services for information on diagramming time lines and sequences of behavior.

Chapter Memoranda History: (prior to 01-31-07)

Memoranda History:

CD13-90

26: Supervisory Considerations

Chapter 26 Overview

Good supervisors are able to think and act responsibly, work cooperatively with others, and provide their staff with opportunities through which they can work together effectively and derive satisfaction within the group. These supervisors have the basic knowledge of social work theory, values, methods, and techniques. They also have the capacity to facilitate the professional and personal growth of their staff.

Effective methods of supervision are adapted to the individuality of each Children's Service Worker and to the group as a whole. Thus, good supervisors are able to identify an individual's learning needs in relation to the job requirements and professional experience. They use this information to develop training materials and appropriate teaching methods relative to the specific needs of the workers.

There are a number of specific skills and techniques that are of special importance to a supervisor. This chapter identifies some of them and describes how they can be used to increase supervisory effectiveness.

Enhancing the Supervisor/Children's Service Worker Relationship

Supervisors are the most visible and accessible role models for Children's Service Workers. By actions and words, supervisors can implicitly and explicitly establish the limits of permissible behavior. Further, modeling provides workers with non-threatening opportunities to introduce new behaviors.

The basic question which the supervisor must ask is: "How do I want Children's Service Workers to relate to families?" Despite the need to temper one's response according to different circumstances, there are some guidelines that can be established. These guidelines indicate that a good supervisor/worker relationship has the following characteristics, that will hopefully be carried over into the worker/client relationship:

- **Cooperation and Mutuality**

Ideally, ideas, opinions, and solutions to problems should be contributed by both the supervisor and the Children's Service Worker. Supervisors who permit and encourage cooperation and mutuality with workers provide an effective model for these behavioral characteristics between the worker and client.

This concept is particularly important since most Children's Service Worker/client relationships are involuntary. Parents may often feel that the worker is disrupting their privacy. Cooperation and mutuality may help break down the threatened, defensive behaviors of the family, and help initiate a more positive relationship.

- **Explicitness and Honesty**

To the maximum extent possible, communication between supervisors and Children's Service Workers should be clear, unambiguous, and concrete. Above all, communications must be honest and frank. On occasion, workers and supervisors will withhold information or opinions from each other. For example, workers may withhold information regarding the nature of a specific report, believing that they are doing the supervisor a favor by not burdening him/her all at once. In the same way, supervisors may decline to discuss certain questionable aspects of the worker's performance in the belief that such a discussion might undermine his/her confidence.

While there may be times when discussion of certain issues would be inappropriate (i.e., it is bad timing to provide a Children's Service Worker with a great deal of negative information just before a scheduled court appearance), supervisors should avoid withholding information or opinions indefinitely. Instead, supervisors must find the best way and the best time to address sensitive areas or concerns. The following are "standards" to work toward:

- Nothing is bad enough to hide; the question is not whether to bring up a topic, but when and how it is best to approach it.
- The supervisor is an honest person; the worker can trust the supervisor's response.
- The supervisor has confidence in the worker's ability to handle sensitive situations.

- **Firmness and Consistency**

Related to the ability to make decisions is the ability to see decisions through. This is not intended to imply rigidity, but rather to indicate the need for carrying out plans with some sense of continuity and stability. Families need this from Children's Service Workers and workers need it from supervisors. If workers cannot have confidence in the supervisor's decision-making ability, they may be unable to extend a sense of commitment to their clients.

- **Empathy**

The ability to feel what another is feeling - to walk in another's shoes - is a key concept in child protective work. In Supervision, it may mean being able to feel a Children's Service Worker's sense of failure or sense of confidence at succeeding. Child protective work, after all, is people working together, and people experience a broad range of emotional responses. If workers perceive their supervisors' empathy and know how good it makes them feel, they can more readily extend it to clients who may never have had someone else demonstrate this kind of understanding.

- **Flexibility**

Plans or decisions which do not prove to be effective or appropriate ought to be changed. It is important for supervisors to demonstrate in interactions with Children's Service Workers that plans can and should be changed, provided it is clear that the change is reasonable. This technique, in turn, should apply to the worker's dealings with clients. Flexibility on the supervisor's part permits the worker to learn two key lessons:

- It is permissible, even desirable, to admit making a mistake.
- It is permissible to change plans or approaches.

- **Participatory Leadership**

The primary concern in this area relates to the need for Children's Service Workers to feel some sense of control over their own lives, although they are aware of the supervisor's ultimate authority. Staff should be involved to whatever extent possible in case decisions and policy making, not just in trivial matters. The staff's advice should be solicited on matters concerning them and their work environment. Of primary importance, workers should be given latitude to disagree with their supervisor and to formulate their own positions on policy and procedures based on the information available to them. The supervisor who interacts with workers in this way will model this behavior for workers, who in turn will be able to increase the capacities of clients to determine their own lives while protecting the rights of others.

Working With Stages Of Children's Service Worker Development

In most instances, Children's Service Workers require at least a full year of work before being able to function on an independent level. For this reason, supervisors should anticipate devoting more time to workers during their first year of employment. At this early stage, it is essential to train workers in basic procedures, such as dictating case records immediately after the events occur. As workers develop, less constant and intensive supervision will be required. It is important to remember that workers who have previous social work experience and/or an MSW are likely to become acclimated to the social work process more quickly than untrained workers. One way of looking at the development process is to identify various stages of worker development:

- First stage - a period of high anxiety.
- Second stage - make it or break it.
- Third stage - good assessment skills, rudimentary intervention skills.

- Fourth stage - relative independence.

In general, the amount of supervisory intervention will diminish as the Children's Service Worker passes through these various stages of development.

- **Stage One: The High Anxiety Stage**

During the first three to six months on the job, exposure to abusive and neglectful families may result in a great deal of confusion. The Children's Service Worker will be searching for information on how to respond and examining personal feelings toward clients. If the supervisor has not effectively set standards and provided guidance, the worker may have a particularly difficult period initially and may feel inadequate to the tasks at hand. While this period is the most difficult for the worker, it is also the time in which the greatest amount of learning can take place. There are several types of interventions which the supervisor can employ to aid in this process.

Accept and meet Children's Service Worker dependency needs: During phase one, it is appropriate for the worker to seek security and stability from the supervisor. The supervisor can be somewhat more directive than might be appropriate with more experienced workers. Expectations regarding independence at this point are likely to be premature. Frequent reinforcement for positive behaviors, as well as the idea of unconditional caring, are key supervisory guidelines. Just as the supervisor accepts the dependency needs of the worker, the supervisor should encourage them to accept dependency needs of their clients. This is a necessary and positive stage in the clients' treatment.

Provide factual tools: The supervisor should provide new Children's Service Workers with whatever standards, priorities, and information are required to perform their work function. The supervisor should be assist in recognizing how these standards and priorities relate to specific cases and to intervention. Inexperienced workers need as much structure and specific instruction as they can be given at this stage.

Accept the confused feelings: The confusion and sense of inadequacy felt by new staff should be viewed as a normal part of their development. If they can see that these feelings are acceptable to the supervisor, they will come to accept them and view them as a natural part of personal and professional development.

Allow Children's Service Workers to express anxiety: Undoubtedly the worker will be experiencing anxiety over performance and client interactions. These feelings must be elicited. The supervisor must help and encourage expression of this anxiety and provide the necessary acceptance and support to enable professional development. The supervisor also needs to help the worker sort out realistic anxiety feelings from unrealistic ones.

Constructively assist in identifying mistakes: New staff do not always know when they make mistakes. They have not developed sufficient knowledge and skill to be able to identify gaps in their work performance, and the supervisor will need to assist them in doing so. This should always be done, however, by building on strengths and by discovering ways in which positive qualities can be applied to counteract shortcomings.

Pair new Children's Service Workers with experienced staff: A team system works well in a Treatment Unit. Pairing new staff with experienced ones provides a safety net and, in addition, shows new staff what they can aspire.

Be regularly available for conferences: Beginning with this initial stage, and continuing through the next two stages of development, the supervisor should expect to spend approximately two hours per week with each new Children's Service Worker in individual conferences. In addition, crises and emergencies will arise which will also require time and effort on the part of the supervisor.

Substitute for new Children's Service Workers only in cases of extreme emergency: Workers develop a sense of confidence in themselves and in their own skills by successfully handling emergencies. They need to know that the supervisor will support them and is available if really needed. The supervisor demonstrates confidence in the ability of the worker to handle emergencies by remaining in the background except for those times when intervention is absolutely necessary.

Build caseloads slowly: If possible, for the first month or two limit the number of cases. This allows time for confidence building and reduces pressure.

Clarify client and Children's Service Worker behaviors: Questions asked during supervisory conferences should be directed toward ways in which clients have responded to the worker's behavior. Conferences may also include clarification regarding the reasons clients have responded in this way. Focusing on both client and the worker's behaviors enables staff to be aware of which of their interventions are successful and which need to be changed.

- **Stage Two: The "Make It or Break It" Stage**

At this level, Children's Service Workers have developed enough knowledge and skill to have some degree of confidence in making plans and decisions. However, they may still experience some anxiety and still have a limited ability to identify mistakes.

The supervisor needs to continue to encourage independence while remaining available to provide a considerable amount of support. Interactions at this stage should be characterized as follows:

Expect and allow some mistakes: Children's Service Workers at this level will begin experimenting with new behaviors in working with clients, and will experience a crisis of confidence if these attempts fail to meet their personal standards. A worker who is beginning to take some risks and who is pressing to learn new things will inevitably make mistakes. The supervisor will need to expect this and to help in accepting these mistakes. If supervisors demonstrate a willingness to accept their own mistakes, they will, at the same time, show that making some mistakes is acceptable and should not be viewed as failure.

Introduce a greater degree of participatory leadership: During the first stage, the supervisor may have needed to be more direct in providing information to the Children's Service Worker. In this second stage, the supervisor should assume that workers have most of the necessary basic knowledge to perform their functions. The supervisor generally needs to help draw this knowledge out. This can be done by presenting alternatives that may not be evident.

Help the Children's Service Worker organize observations and ideas: Workers will now begin to spontaneously identify patterns occurring in families and across caseloads. Similarities will be seen from one case to another. The supervisor should begin to underscore these similarities and permit the worker to synthesize them into some principles of practice.

Analyze intuitions without stifling creativity or spontaneity: As Children's Service Workers in this stage gain confidence, they will begin to operate on hunches, guesses, common sense, and intuition. While these may be more effective than the supervisor might initially suspect, supervisors should assist in validating the intuitions.

- **Stage Three: Mastery of Assessment Skills With Rudimentary Intervention Skills**

At this stage, Children's Service Workers are generally able to identify and analyze errors; basic knowledge has been incorporated and gaps in casework are more apparent to them. In the third phase personal and professional goals are set and the identification of times when their behavior is incompatible with these goals. This is the beginning of independent practice. During this stage, the supervisor can begin to allow the worker to take the initiative in the supervisory process.

Listen carefully: Careful listening is the primary task of the supervisor in relating at this level. Basic listening skills and the ability to identify not only what is said, but what is not said are important. The supervisor may ask clarifying or informational questions, but the function of the supervisor at this point is to listen first, then to talk.

Identify resistance and discuss it in relation to clients: While resistance may require some attention in earlier stages, it is at this third stage where the supervisor must be certain that any resistance is specifically addressed in supervisory conferences. When the Children's Service Worker is reluctant to deal with certain clients or client behaviors, these behaviors should be discussed specifically in terms of how they affect the relationship with the client. Focusing on the worker's personality or specific characteristics out of the context of client relationships can be detrimental to both the development of the worker and of the worker/supervisor relationship. Attention should be directed to the way in which clients react to intervention, and the worker should be assisted in using personal and professional strengths in overcoming barriers and resistance in the worker/client relationship.

Help identify and examine options: The first plans, intuitions, and perceptions of a Children's Service Worker on a case may or may not be the best way to proceed. While the supervisor may tend to agree with the options or ideas presented, it is essential to open up as many options as possible. This should be done in such a way that the worker may still come back to the first option if it is the best one. The very nature of the process of option exploration in and of itself will assist in identifying options for other clients and in expanding the ability to work effectively with a variety of clients and cases.

- **Stage Four: Relative Independence**

At this stage, Children's Service Workers can identify problems and options and generally can determine most of the agenda for supervisory conferences. They should have a good idea of their own supervisory needs and should have a sense of what is needed to promote further professional development. Supervisory conferences can be scheduled less frequently. The supervisory role at this point is more that of a consultant and colleague than that of an authority figure, although the worker will always be subject to supervisory direction. The most critical supervisory function at this stage is to assist in clarifying professional development and in identifying learning needs. A serious mistake is made when the supervisor or the worker begins to assume that the ability to function independently and autonomously somehow marks the end of the need for learning and growing. Failure of the worker to continue to learn and grow may well result in "burnout." The supervisor can assist in identifying resources and opportunities for continuing education and development.

Enhancement Of Children's Service Worker Skills

Beyond the formal means of developing the professional capacities of staff, such as continuing education and establishing and encouraging the use of a unit or agency library, there are some general supervisory skills that, if used on a day-to-day basis, will lead to professional growth. The following material presents some guiding principles for this type of supervisory behavior. This material also identifies several stages of normal

development that the supervisor can use as a measure of the staff's current level of development. This scheme can serve as a needs assessment tool for future developmental activities.

The wisdom of building case plans on the basis of family strengths is a widely accepted dictum of social work practice. As a corollary, it is true that effective supervision builds on staff strengths. While each supervisor will develop special techniques for assisting the Children's Service Worker in taking advantage of the individual strengths which he/she bring to the job, there are a number of suggestions which may be useful to any supervisor:

- **Give suggestions, not prescriptions.** Children's Service Workers should be assisted in identifying as many options as possible for dealing with a specific case problem, in analyzing these options in terms of the potential risks and benefits, and in selecting the "best" option based on the strengths of both the worker and the family.
- **Note and acknowledge accomplishments.** Supervisory conferences should always include recognition from the supervisor for something which the Children's Service Worker has done well. The accomplishments should be pointed out, and the supervisor can then assist in identifying ways in which the strengths evidenced by these accomplishments can be translated into problem-solving strategies in more difficult areas.
- **Enable Children's Service Workers to assess and be responsible for personal learning needs.** The supervisor should ask the worker to assess his/her own learning needs and to assume responsibility for fulfilling them. Workers generally acknowledge that clients probably will not change until they see a real need to do so. The same is true for workers. By encouraging identification of specific areas where improvement is needed, the supervisor can then be in a position to assist in developing learning strategies for overcoming weaknesses. This is much more successful than if the supervisor sets a goal for the worker's development which the worker may not accept.
- **Avoid the role of being a "therapist."** The task of the supervisor is not to serve as therapist to staff with personal problems, but rather to focus on the professional development. However, in situations where personal problems affect work performance, the supervisor needs to discuss them with the Children's Service Worker in a caring way.
- **Don't carry cases by "remote control."** Once in the field, the Children's Service Worker is responsible for the case although the supervisor should provide some basic guidelines. Trying to provide the worker with a set of detailed instructions on specific cases undermines self-confidence and conveys a general feeling of mistrust in his/her ability to effectively handle the case.

- **Supervise on the basis of Children’s Service Worker skills as well as case needs.** Staff have a variety of strengths and weaknesses and each person functions at different levels of professional development. Supervisors should encourage workers to draw their own conclusions about cases. Suggestions for case plans should be offered only when needed. Workers should be encouraged to capitalize on their strengths and skills in making case decisions and implementing plans. Since workers function at different levels of competency, supervision should be geared to the workers' level of functioning.
- **Enable workers to identify various stages of intervention.** Child abuse and neglect cases sometimes become so complex that they often seem overwhelming. In order to overcome this sense of futility, Children’s Service Workers must be assisted in reducing cases to their component parts and viewing the intervention process as essentially a step-by-step procedure. Change should be viewed as occurring in increments, rather than all at once. When workers view a case in this way, they can help clients to assess their own progress on a step-by-step basis, thus making the entire process more amendable to success.
- **Teach the worker individual case management techniques.** Staff should be taught to focus on individual cases. It is necessary for Children’s Service Workers to learn: how to formulate realistic goals and tasks, how to communicate them clearly and concisely in writing, and to the family, how to implement the treatment plan effectively, and how to assess whether the goals are being achieved.
- **Prepare Children’s Service Workers for supervision.** A very important function for the supervisor is to prepare staff to be promoted to supervisory positions within the agency. Supervisors can do this by avoiding complete supervisory autonomy and by allowing workers to make their own decisions based on all relevant information available. The supervisor should also designate a senior worker who is responsible for supervision when the supervisor is absent from the unit.

Supervisory Conferences

Schedule weekly conferences as well as conferences on demand. With highly experienced staff, the supervisor should be providing consultation on demand and emotional support. To do more is to perpetuate unnecessary dependency which may be transferred to clients. Don't provide "coffee shop" supervision which is idle chit-chat about cases and feelings.

The supervisor should learn to relax and not be a slave to drop-in or quickie supervision. Clients' values should not be lost by allowing discussion of cases anywhere in the office. If the discussion involves too many cases discussed quickly, the supervisor may relate the wrong case to the wrong situation and give the wrong advise.

The supervisor should protect him/herself by providing staff a schedule of times for supervisory conferences. Except in "life and death situations," staff should stick to these conference times. If the Children's Service Worker does not stick to the time and it's the first occurrence (and it's not a life and death situation), he/she should be allowed to discuss the case. The worker should be reminded at the end of the conference that he/she missed the scheduled conference time. The supervisor should point out that it is his/her job to help staff learn to manage their time and that the worker is expected to come to the conference at the regular time in the future. The supervisor should resist the worker's pattern to disrupt other conferences.

Selection Of New Workers

The following guidelines are presented for supervisors to use during the selection of new staff.

- **Behavioral Interviewing**

This type of interviewing is based on the idea that job related situations from the past predict future behavior. Don't ask about hypothetical experiences in the future. Think of the most difficult situation of its kind and describe it. Ask an applicant if they have had to respond to similar past situations.

Study the job description and list both the technical and performance skills. Develop job related situations around these skills and ask questions in the form of open-ended questions.

Consider asking questions along the following lines:

1. What is your willingness and ability to follow agency procedures? Can you give an example of where you found it necessary to ignore agency procedures and why?
2. Can you give an example of when communicating with a client was difficult?
3. Can you describe a quick decision that you have made that you are proud of?

Ask about the following issues:

Have you achieved an important goal in the past? How do you access your ability to roll with the punches? Describe a difficult job that you have had and an uninteresting job. Have you had to structure your own work schedule and how have you handled it? What do you do in a situation where upper level decision holds up your progress?

- **Tips for the Supervisor**

In interviews, be comfortable allowing time even when there are pauses. Be patient and don't be afraid of silence. Even people with no prior job skills have life experiences which can indicate how they have handled situations. This is especially true of organizational abilities and managing finances. It is important to establish rapport and to put the applicant at ease. Take notes and explain why. Ask for specific examples of past behavior and use your system and ask for specifics until you get the kind of details that you want. Ask them to tell you exactly how they have handled this situation rather than generalizing about an event. If an applicant is rambling and drifting from topic to topic and doesn't give you a chance to ask a question, begin talking along with them and eventually they will stop to listen to you and you can direct the conversation back to the topic you want.

If you appear to be getting a one-sided picture either good or bad, ask questions which would give you contrary evidence about the applicant. For example, ask for an example of when an applicant followed expected procedure when it would have been easier to alter their policy or ask the applicant to tell you when they have had a problem with decisiveness.

No interview should be complete without asking the applicant to discuss what they consider their areas of strengths and the areas they need to improve.

- **Interpersonal Indicators of Good Children's Service Workers:**

1. How do they feel about authority? It's important to ask directly and find out what experiences people have had with using authority. Can they accept authority? How would they implement the agency authority to intervene with a family?
2. What is the person's ability to be direct and honest in discussing problems?
3. How consistent is the person?
4. Stability and emotional maturity. (Dress may be a good indicator)
5. Degree of firmness and persistence.
6. Ability to accept the client as an individual rather than acting only to the client's behavior.
7. Motivation to learn about the community and resources.

8. Ability to work with suspicious, distrustful clients - ask how he/she has dealt with a person who lies.

Workers Experiencing Difficulties

Supervisors must have enough concern for clients' well-being that they are willing to work with Children's Service Workers who are having difficulty. All of these areas require time and training by the supervisor to help the worker learn how to address these problems.

- **Problems Which Occur Due To A Supervisor's Lack of Training:**
 1. The Children's Service Worker may try to overdirect clients by talking too much. If the worker does this in supervisory conferences, he/she will do so in client contacts. Workers do this because they are anxious and had no interviewing skills.
 2. A lack of focus in interviews with clients and in supervisory conferences is indicated by the worker talking about too many different areas randomly. He/she does this because no one has taught him/her how to focus on a few areas and how to decide what areas are important.
 3. A lack of clarity in thinking about cases and answering questions is exhibited.
 4. A worker projects a hasty, haphazard, or unfocused approach to casework. He/she closes cases quickly because doesn't know what to do in a case or on the opposite extreme, focuses on a limited area for an extended period of time because he/she doesn't know what other areas to concentrate on.
- **Indicators That A Children's Service Worker May Be Having Difficulties**
 1. The inability to discriminate and generalize even though the supervisor has spent time teaching this.
 2. Inter-personal difficulty. The Children's Service Worker holds grudges, stays upset with other staff within and outside the agency.
 3. Intra-personal difficulty. The worker intellectualizes his/her inappropriate handling of cases. For example, he/she claims the client is resisting but he/she has had only one client contact in four weeks or complains that the supervisor won't tell him/her what to do. The worker always blames others and is self-righteous in his/her comments.

4. It is important to make the worker do some level of self-evaluation when discussing his/her strengths and weaknesses. If he/she resists this, then he/she is likely to have an inability or unwillingness to help clients develop the skill to evaluate their strengths and weaknesses.
5. The worker hasn't seen his/her clients or avoids certain clients, due to sex, race, type of problem, etc. He/she avoids organizational jobs such as recording monthly statistics, meetings with the supervisor and unit.

The Principles Of Providing Feedback

"Feedback" is a way of helping another person to **consider** changing his/her behavior. It is communication to an individual (or group) which gives information about how he/she affects others. Feedback helps an individual keep his/her behavior "on target" and thus better achieve goals. Criteria for useful feedback:

- **It should be descriptive rather than evaluative.** By describing one's own reaction, it leaves the individual free to use it or not to use it as he/she sees fit. Avoiding evaluative language reduces the need for the individual to react defensively.
- **It should be specific rather than general.** To be told that one is "dominating" will probably not be as useful as to be told that, "Just now when we were deciding the issue, you did not listen to what others said, and I felt forced to accept your arguments or face attack from you."
- **It should take into account the needs of both the receiver and giver of feedback.** Feedback can be destructive when it serves only the sender's needs and fails to consider the needs of the person on the receiving end.
- **It should be directed toward behavior which the receiver can do something about.** Frustration is only increased when a person is reminded of some shortcoming over which he/she has no control.
- **It should be solicited, rather than imposed.** Feedback is most useful when the receiver has formulated the kind of question which those observing him/her can answer.
- **It should be well-timed.** In general, feedback is most useful at the earliest opportunity after the given behavior (depending, of course, on the person's readiness to hear it, support available from others, etc.).
- **It should be checked to ensure clear communication.** One way of doing this is to have the receiver try to rephrase the feedback he/she has received to see if it corresponds to what the sender had in mind.

The Principles Of Positive Criticism:

- **It is desirable to approve, affirm and give staff as much recognition as possible.** Although everyone needs positive criticism, it is important to note that some Children's Service Workers cannot function without constant support and approval from the supervisor. In such cases, approval and recognition are required to sustain motivation. It becomes highly questionable that such a person could ever achieve independence from an ever increasing dependency on the supervisor.
- **As a general rule, positive criticism is usually given more freely than negative criticism.** It must be valid not artificial. If positive criticism is used invalidly, it can have a negative effect.
- **Convey the positives in the Children's Service Worker's performance and show enthusiasm over improvement.** Always recognize when the basic needs of the clients are being met rather than personalizing comments to the staff person. Do not hesitate to compare recent work with previous activity because this tends to stimulate self-criticism.
- **Some Children's Service Workers seem to need the supervisor's permission to praise themselves.** They will focus on their social orientation rather than on their service orientation to clients. For example, "I don't know why I have trouble relating to Mr. X. I always get along well with everybody." The two are not comparable and the supervisor must take it out of the social arena and keep it focused on the professional aspects of the job.
- **Workers must know where they stand and how they are doing as they progress on the job.** No single factor contributes more to job dissatisfaction than not knowing how we're doing until evaluation time. Then, negatives in the performance can be overwhelming. Workers must have a general understanding and objectivity about what went wrong in their cases at the time it happened.
- **Supervisors must resist striving for personal success in their staff's cases.** The supervisor should not be threatened professionally by lack of improvement in staff performance once he/she has done all he/she can to help.

The Principles Of Negative Criticism Given In A Positive Way

Negative criticism is received with less hostility, and in fact can provide developing staff security on the job if the supervisor:

- **Has an attitude as one of giving help** by defining the problem, the problem-solving situations, and concentrating on giving help.

- **Has professional values that are oriented to the norm and not to individuals.** Never use another Children’s Service Worker as an example of professional competence. Never compare one worker's capability to another.
- **Has realistic expectations of competence** and quality of performance which is related to an agency-wide standard.
- **Elicits self-criticism** and provides affirmation and supplementation of the supervisee's self-criticism.
- **Identifies the components of the negatives** and deals with them one at a time to provide a basis for change. Never generalize negatives.
- **Deals with negatives in the allotted supervisory period.** They should not be given in an emotionally charged situation, a crisis, or when staff is under particular stress. Wait for a more suitable time.

Self Assessment Of Supervisory Skills

Rate yourself on a scale of 1 to 10 (10 being the highest score and 1 the lowest) for each of the following statements:

1. I share responsibility in and provide support to my workers for difficult case decisions. _____
2. I help my workers deal with problems they face in their work with clients. _____
3. I help my workers deal with their professional development. _____
4. I provide my workers with stimulation in thinking about social work practice and theory. _____
5. I provide my workers with critical feed back to enable them to understand what they are doing wrong and make appropriate changes. _____
6. I provide my workers with the emotional support they need to do their job more effectively. _____
7. I provide my workers with some sense of agency appreciation of their work. _____
8. I help my workers feel a sense of belonging to the agency. _____
9. I help my workers grow toward greater maturity as persons. _____
10. I encourage my workers to take their own initiative and to become more

autonomous in their practice. _____

11. I am able to set priorities among my many tasks. _____

12. I provide my workers with sufficient regularly scheduled, uninterrupted conference time. _____

13. I make myself available to workers. _____

14. I encourage the use of peer review and support. _____

Sources:

This chapter was adapted from Supervising Child Protective Workers, authored by Julius R. Ballew, Marsha K. Salus, and Sheila Winett, and developed under U.S. Department of Health, Education and Welfare contract No. HEW-105-77-1050; published by the U.S. Department of Health, Education and Welfare, August 1979.

"The Principles of Positive Criticism" and "The Principles of Negative Criticism Given in a Positive Way" were adapted from Supervision in Child Welfare Services: A Training Program for Children's Aid Societies in the Province of Ontario. John R. MacDonald, Social Services Consultation Limited, October 1979.

"The Self Assessment of Supervisory Skills" was adapted from Supervision in Social Work. Alfred Kadushin, Columbia University Press, New York 1976, pages 212 and 214.

Chapter Memoranda History: (prior to 01-31-07)

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Chapter 27 Overview

Methamphetamine (“METH”) Use; Clandestine Methamphetamine Laboratories; and Guidelines

The purpose of this chapter is to make information available to staff, regarding the dangers of methamphetamine use and production, as well as to provide guidelines for Children’s Division staff that come into contact with or receive information regarding this subject. The following information was gathered from the Missouri State Highway Patrol, the Missouri Department of Public Safety, the Drug Enforcement Administration (DEA), and the National Institute on Drug Abuse (NIDA). Methamphetamine addiction can be treated successfully using currently available behavioral treatments.

Related Subject: Section 2, Chapter 4, Attachment J: Meth Lab Emergency Response Protocol

Description

Methamphetamine is a synthetic stimulant that is produced and sold illegally in the form of pills, capsules, powder, and chunks. It works by artificially stimulating the reward or pleasure area of the user’s brain without causing anything beneficial to happen to the body. Methamphetamine has a high potential for abuse and dependence (addiction). The drug has an addiction rate of 80%, comparable with that of crack cocaine.

Health Effects

Methamphetamine is a drug that strongly activates certain systems in the brain. Methamphetamine is closely related chemically to amphetamine, but the central nervous system effects of methamphetamine are greater. Both drugs have some medical uses, primarily in the treatment of obesity, but their therapeutic use is limited. Pregnant women using methamphetamine may severely damage the fetus. Underdevelopment of the brain stem of the child is the most common resulting impairment. Infants with prolonged exposure to the drug are smaller, show overall slow development, and are prone to illness.

Central nervous system actions that result from taking even small amounts of methamphetamine include increased wakefulness and physical activity, decreased appetite at times leading to extreme anorexia, increased respiration, hypothermia, and euphoria. Further effects include irritability, insomnia, confusion, tremors, convulsions, anxiety, paranoia and aggressiveness. Hypothermia and convulsions may result in death.

Possible visible physical health effects of using methamphetamine that staff should be aware of include uncontrollable movements (twitching, jerking, etc.), impaired speech, dry-itchy skin, acne, sores and numbness. Methamphetamine addicts and users have been known to experience a phenomenon known as “crank bugs,” that are chronic hallucinations in which they perceive insects are crawling on or beneath the skin.

Individuals experiencing “crank bugs” will often scratch and gouge at their skin until it breaks open, subjecting the body to severe infection.

Cardiovascular side effects, which include chest pain and hypertension, may also result in cardiovascular collapse and death. In addition, methamphetamine causes increased heart rate and blood pressure and can cause irreversible damage to blood vessels in the brain, producing cerebral vascular accidents (strokes).

In Missouri’s Comparison of Methamphetamine Users to Others study, the results show that in Missouri’s publicly funded system of care there are no outcome differences between methamphetamine users and other alcohol and drug users.

Supply And Use

Methamphetamine is a Schedule II drug under Federal regulations, meaning it has a high potential for abuse with severe liability to cause dependence. According to the Drug Enforcement Administration (DEA), methamphetamine has been the most prevalent, clandestinely produced controlled substance in the United States since 1979. Recent statistics indicate that Missouri and California rank the highest in methamphetamine laboratory seizures.

Pure methamphetamine is white, odorless and bitter tasting. It is sometimes packaged in tablets or capsules to resemble legal, commercial products. Users commonly swallow methamphetamine powder, sniff it through the nose or dissolve it in water and inject it intravenously. Users also smoke chunks of a very pure form of crystalline methamphetamine called “ice.” While ice and “crystal meth” are chemically the same, they are structurally different. Ice is a crystalline form of methamphetamine that is higher in purity (around 97 percent pure). Crystal meth, while it is called “crystal,” is usually obtained in a powder form and in varying levels of purity. Ice looks like chipped ice, rock salt or chipped glass. The crystal is usually clear but may also be milky white or yellowish brown. While the effects of crystal meth last two to four hours, the duration of an ice-high is said to last anywhere from 7 to 24 hours.

Special problems related to the surveillance of methamphetamine involve the many different street names by which the drug is known. Users rarely refer to the drug by its five-syllable chemical name. Street names for methamphetamine include crank, crystal, speed, crystal meth, glass, peanut butter speed, ice, go-fast, zip, chris, cristy, go or meth. Because of the variety of terms used, it is likely that data collection and reporting of methamphetamine abuse may not always properly classify the substance described. Consequently, it is important that child protective services staff, treatment counselors, emergency room staff, educators and law enforcement personnel be familiar with the various street names. The localized nature of methamphetamine epidemics emphasizes the need for creative prevention strategies created by community-based networks. It is important that local networking occur and for communication and cooperation to be encouraged among key professionals from various disciplines to develop comprehensive strategies.

Title: Child Welfare Manual
Section 7: Glossary/Reference
Chapter 27: Methamphetamine (“METH”) Use; Clandestine Methamphetamine Laboratories; And Guidelines
Effective Date: December 9, 2014
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Manufacturing Methamphetamine (Clandestine Labs)

There is always potential for a fire or explosion with a clandestine laboratory. The chemicals are flammable, combustible and explosive. The lack of proper ventilation and temperature controls at these laboratories further compound this problem of fire, explosion and human exposure. The most likely individuals to be exposed include the drug manufacturers themselves as well as anyone entering or living in the home. Children living in the environment, neighbors, Children’s Division staff, juvenile office staff, law enforcement officers, and home-based professionals such as visiting nurses, Parents as First Teachers staff, therapists, and others who enter the property are at risk of being exposed to dangerous chemicals.

Most productive clandestine methamphetamine laboratories have been reported in secluded, rural areas away from the metropolitan distribution areas that they may service, however they have been found in almost all areas of the state. Meth labs are usually small and portable enough that it is not unusual for them to be set up in houses, garages, apartments, motel rooms, and trailers.

A deserted methamphetamine laboratory poses significant risks to the health of the public in nearby vicinities. Trained professionals must only carry out proper decontamination of such sites. Clandestine laboratory seizure requires specialized training, detection and safety precautions. The hazardous waste cleanup and disposal can range from \$5,000 to \$10,000. In some instances, proper decontamination for reuse of the property may not be feasible, and the property may have to be totally destroyed.

Today, almost anyone with the desire can produce methamphetamine. The various “recipes” are routinely passed around prisons and can also be found on the Internet. Narcotics officers often find the recipes scrawled on scraps of paper on people they arrest. Chemicals for the recipes can be purchased legally and are often very easy to buy. The problem of clandestine methamphetamine production is rapidly increasing. In 1993 there were 6 methamphetamine laboratories seized by law enforcement in the Midwest; in 1996 there were 365 seizures in Missouri, and 750 seized in 1997. Preliminary data for 1998 indicates that there were 839 clandestine methamphetamine laboratory seizures. 481 meth labs were seized by the Missouri Highway Patrol and 358 were seized by the Drug Enforcement Agency (DEA). In 2004, there were 2,788 meth lab seizures statewide.

While over the counter medications containing ephedrine or pseudo ephedrine may not be harmful, many of the chemicals used to process them into illegal meth are dangerous. An underlying, but very important problem with the illicit production of methamphetamine is that the producers possess neither the knowledge nor the skill to carry out the synthesis appropriately. They often do not use the correct proportion of precursors, reagents, solvents or catalysts, and they may not follow the instructions for the synthetic process exactly as stated. The chemicals combined with the limited knowledge and unsafe practices of the laboratory “cooks” contribute to the likelihood of an explosion. The Department of Public Safety reports that explosions of these clandestine methamphetamine laboratories accounted for one out of five labs discovered in 1996. Typical chemicals in a meth lab, such as methylamine, ethyl ether, benzene,

methanol, and lithium aluminum hydride are extremely flammable. Other chemicals such as sodium, magnesium and potassium metals are extremely reactive with air and water and can ignite or explode.

The list of chemicals used in the manufacture of methamphetamine is long and still evolving with new “cooking” methods. The exact chemicals used to produce it may vary from lab to lab, as recipes circulate. Each lab usually has its own variation. It cannot be said with certainty what combination of chemicals will be found.

The following chemicals are associated with illicit methamphetamine manufacturing:

metal/salt reagents	solvents	precursors	acid-base reagents
aluminum foil	acetone	acetaldehyde	acetic acid
iodine	benzene	benzyl chloride	acetic anhydride
lead acetate	chloroform	ephedrine	ammonia
lithium aluminum hydride	ethyl ether	methylamine	hydrochloric acid
magnesium	freon	phenylacetic acid	hydrogen peroxide
mercuric chloride	hexane	P2P	hydriodic acid
palladium	isopropanol		sodium hydroxide
red phosphorus	methanol		sulfuric acid
sodium	pyridine		
sodium cyanide			
thionyl chloride			

According to the DEA, the following chemicals are the most commonly used in clandestine production of methamphetamine:

Ephedrine: a solid made up of crystals and granules; harmful if swallowed in large quantities; do not breathe dust; avoid contact with skin and eyes.

Hydriodic acid: a corrosive acid that is colorless when freshly prepared. Upon exposure to light and air, however, it turns yellowish and brown. It is a solution of hydrogen iodide gas in water. Vapor is irritating to respiratory system, skin, and eyes; liquid causes severe burns to eyes and skin; if ingested, may cause severe internal irritation and damage.

Hydrochloric acid: a solution of hydrogen chloride gas in water. Corrosive, colored to light yellow liquid from traces of iron, chlorine and organic matter. Inhaling may cause coughing or choking, inflammation and ulceration of the respiratory tract; concentrated solutions cause severe burns; irritant to the mucous membranes, eyes and respiratory tract; exposure to vapors may result in pulmonary edema and possibly death.

Iodine: bluish-black scales or plates. It has a characteristic odor, a sharp acrid taste and produces a violet corrosive vapor. Vapor is irritating to the respiratory system and eyes; the solid irritates the eyes and may burn the skin; may cause severe internal irritation and damage if ingested.

Pseudo ephedrine: both the base and salts are crystalline materials. Harmful if swallowed in large quantities; do not breathe dust; avoid contact with skin and eyes.

Red Phosphorus: red to violet powder. Insoluble in organic solvents. Vapor from ignited phosphorous irritates the nose, throat, lungs, and eyes.

Sodium Dichromate: reddish to bright orange, somewhat deliquescent crystals; becomes anhydrous with prolonged exposure to heat. Irritating to the eyes, respiratory system and skin.

Each of the products and equipment listed below have legitimate uses and separately, would not be cause for concern. When found in combination and close proximity, notice and extra precaution should be practiced. If staff develop reasonable suspicion of a methamphetamine operation while in the course a home visit, steps should be taken to conclude the visit quickly without causing concern of the those individuals present, that suspicion has developed. This is especially important in light of the previously discussed effects of methamphetamine use including extreme aggressiveness, rapid mood swings and paranoia.

According to the DEA, many methamphetamine laboratories that have been seized in Missouri since 1993 have used the Sodium-Ammonia method or “recipe” rather than the traditional, more complicated method. This recipe or method is a simple and clean (essentially one-step) method for producing methamphetamine. The yield of methamphetamine is 90-95 percent, with a reaction time of 10 minutes. Counting extraction of tablets and cleanup of materials and containers, the maximum time needed would be about two hours.

The recipe essentially consists of converting pseudo ephedrine to methamphetamine using anhydrous ammonia and sodium metal. The “typical” laboratory uses ordinary beverage containers (Mr. Coffee, Thermos jug, soda containers, and large plastic cups); kitchen utensils (spatulas, stirrers, plastic bowls, etc.) and other items used in the home. Some of the chemicals used may come from local hardware stores (starting fluid, denatured alcohol, and drain opener) and small amounts would not generate suspicion. Law enforcement is working with local merchants, requesting that they notify the police when large quantities of these chemicals are being purchased. The extremely strong odor of ammonia emanating from white powder is also a telltale sign for which professionals should be aware.

Ingredients and products used in methamphetamine production include:

Ingredient	Product or Source
Ephedrine or Pseudo ephedrine	over-the-counter cough & cold medication
Lantern fuel or white gas Acetone or paint thinner	fingernail polish remover
Lye	Red Devil Lye Drano
Lithium	camera batteries
Sulfuric acid	Liquid Fire or drain cleaner
Sodium chloride	table salt, rock salt
Ethyl ether	vehicle starter fluid or spray
Anhydrous ammonia	may be stolen from a farm and is often transported in a propane gas cylinder or a beer cooler
Red phosphorus	road flares or match heads
Iodine crystals	obtained from farm supply store
Water binder	Liquid Heet – from an auto supply store
Muratic acid	
Hydrochloric acid	

Equipment That May Be Used In Methamphetamine Production Include:

- Glass jars or mixing bowls
- Propane tanks (as used for barbecue grills) to carry anhydrous ammonia
- Plastic beer coolers to carry anhydrous ammonia
- Large amount of coffer filters to strain liquids
- Plastic tubing or hoses
- A hot plate, camp stove or electric skillet for a heat source
- A turkey baster to remove liquid from the top of a jar

Indicators Include:

- A trash pile with a large amount of empty packaging of above items
- Chemical odor of ether or ammonia
- Peeled casings from lithium batteries
- Aerosol cans of starter fluid with “church key” puncture holes in the bottom
- White powder residues

- Syringes or needles

Additional Warning Signs Indicating A Methamphetamine Laboratory May Be Present

While most “cooks” prefer secluded areas, clandestine methamphetamine laboratories have been found in almost all areas of the state. Some of the signs that may indicate the presence of a meth lab are:

Smoking breaks: While going outside to smoke is in itself not an indicator, when taken with other suspicious signs it may be. Since ether is highly explosive, “cooks” will often go outside to get away from the lab before lighting and smoking a cigarette.

Chemistry equipment: Flasks, rubber tubing, and beakers similar to those used in chemistry classes may be sign that a lab is operating in the vicinity.

Strong chemical odors: Strong odors of ether and chloroform are common at meth sites. Some people have described the odor as an ammonia smell, similar to the odor of a strong cat litter box.

Containers: Chemical containers or drums with their labels removed or painted over.

Maroon residue on aluminum materials near the lab: Some processes for making methamphetamine do not give off the telltale ammonia odor, but the acids tend to react with aluminum in such a way that a maroon residue is left on the surface.

Containers used for purposes not originally intended: Glass milk containers or re-sealable glass beer containers containing unfamiliar liquids.

Unusual traffic levels: Unusual levels of foot or vehicle traffic. Individuals involved in illicit drug transaction will usually be at the purchase site for only a brief time, sometimes only a few minutes.

No visible means of support: Large amounts of cash with no visible means of support and the presence of other signs can be an indicator of illegal activity.

Unusual security precautions: Extra locks, barred windows, blacked out windows, and expensive alarm systems may be a sign of a clandestine methamphetamine laboratory.

Potential Dangers

For society, one of the most damaging consequences of methamphetamine is the degree of violence that the drug inspires. According to the San Diego Association of Governments, 24 percent of all people arrested in San Diego County in 1992 for violent crime were found to have amphetamines in their systems, primarily methamphetamine. Chronic, moderate-to-high-dose methamphetamine abuse often results in very aggressive behavior and other forms of violent action. The behavioral and psychological

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effects associated with methamphetamine use include hyperactivity, agitation, liability of emotion, and paranoid delusional thinking. These combined with personality factors and the social context, contribute to the occurrence of violence.

Violent and aggressive actions are characteristic of individuals using methamphetamine. The DEA has identified four phases of behaviors associated with methamphetamine use:

Phase One: Early in methamphetamine use, people report mood elevation (euphoria, alertness and excitation). Routine tasks no longer seem monotonous; appetite is suppressed, conversation comes easily, and users feel energized, faster, and stronger.

Phase Two: As months pass, users begin to lose weight. As tolerance increases the user must dramatically increase his/her intake to recapture the initial experience and avoid depression.

Phase Three: This phase is characterized by paranoid thoughts, mistrust of people and heightened sensitivity to sound. A car door slamming across the street may lead the user to think someone is breaking into his or her home. The person is very short-tempered and agitated. An infant crying can provoke rage.

Phase Four: In the final stage of methamphetamine abuse, the user experiences a break with reality. Delusions and paranoia dominate his/her thoughts; voices and hallucinations rule his/her life

Clandestine laboratories producing illicit drugs are operated with little or no safety precautions. Immediate dangers include fire, explosion, inhalation of harmful fumes, and skin contact with dangerous chemicals. Exposure to chemicals found in such laboratories without proper training and protection can cause cumulative, damaging effects to the body. Children’s Services Workers should leave the area immediately, or as soon as possible, if they suspect that a methamphetamine laboratory is in operation. Trained law enforcement officials, DEA agents, or specified drug task force members are responsible for entering the premises, determining if a methamphetamine laboratory is present, and removing any child(ren) if necessary.

PowerPoints:

[Methamphetamine Progression to Addiction](#)

[Drugs of Abuse Detection: Parents, Children, and Home](#)

[Initial Actions for Handling Contaminated Properties](#)

[Drug Endangered Children: Medical Effects](#)

[Drug Endangered Children’s \(DEC\) Coordinator](#)

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[Toxicity Levels in a Manufacturing Environment](#)

[Washington State Dep’t. of Health Clandestine Drug Lab Program](#)

[National Working Group on Remediation of Methamphetamine Laboratories](#)

[The Neurobiology of Addiction](#)

[Clandestine Drug Issues Related to Decontamination of Properties](#)

[Illegal Drug Operations Site Reporting and Decontamination Act](#)

RELATED LINKS:

[Missouri Drug Endangered Children \(MODEC\)](#)

[Missouri Division of Alcohol and Drug Abuse 2004 Meth Policy Brief](#)

[Division of Alcohol and Drug Abuse Services](#)

[National Alliance for Drug Endangered Children](#)

[Coalition Against Drug Abuse](#)

Chapter Memoranda History: (prior to 01-31-07)

[CD05-43](#)

Memoranda History:

28: Physical Abuse

Physical Abuse:

1. **Definitions Of Physical Abuse** - Any physical injury inflicted on a child other than by accidental means by those responsible for his care, custody, and control except that discipline including spanking, administered in a reasonable manner shall not be construed to be abuse.
2. **Physical And Medical Indicators Of Physical Abuse** - The indicators of child abuse and neglect vary. No child or caretaker will exhibit all of the physical or behavioral indicators listed, and some of the indicators are contradictory. The behavior of an abused or neglected child and other family members may be sporadic and unpredictable. Indicators should be used only as a general guide. The presence of multiple indicators or the pervasiveness of any one behavioral indicator warrants close scrutiny by the worker.

Surface Skin Marks

Location: The location of the injury is a significant criterion which can aid identification of its origin. Injuries to the thighs, calves, genitals, buttocks, cheeks, earlobes, lips, neck and back are more likely a result of abuse than injuries to the elbows, knees, shins and hands, which are frequently incurred accidentally. In the younger child, bruises over the bony parts of the child's body (i.e., chin and forehead) are common sites for falling injuries. However, bruises to any infant should be particularly suspect given his or her limited mobility and opportunity to harm himself or herself.

Objects Causing Skin Marks: The shape of a surface skin mark or patterns of skin marks provide other clues to origin. Bruises or welts which have distinct configurations, appear in clusters, form regular patterns, or which resemble instruments should be immediately suspect. Examples of objects which cause distinct surface skin marks include:

- belts, belt buckles, ropes and straps;
- electrical cords;
- hands (palms and fists), feet, knees and elbows;
- mop or broom handles, sticks or other pieces of wood;
- wire or wood coat hangers;
- hair brushes and combs;

- cooking utensils (i.e., spatulas);
- knives, scissors;
- hot liquids;
- electric appliances (i.e., irons, heating coils);
- radiators; and/or
- lighted cigarettes, matches or lighters;

Marks encircling the child's wrists, ankles or neck may be the result of being tied or restrained. Multiple bruises extending out and/or downward from the corners of the child's mouth may indicate that the child has been gagged. The child who has been grabbed around the torso by another person's hands may show fingerprints in a pattern that clearly denotes the pressure applied - eight fingerprints on one side of the torso and two thumb prints on the other side.

Bruises, Lacerations And Abrasions: Multiple bruises on various parts of the body and in various stages of healing should receive particular attention. One way to determine the approximate age of a given bruise is by the color. The following table¹ lists the color of bruises and associated age.

<u>Age</u>	<u>Color</u>
0-2 days	red and bluish and swollen, tender
0-5 days	red, blue, purple
5-7 days	green
7-14 days	yellowish
2-4 weeks	clear

The worker should be aware that skin surface redness, which is not swollen and tender, does not always represent the early stage of a bruise. Red marks should be assessed in relation to the reported time of injury.

In addition to color differentiation, injuries incurred at different times will reveal older and newer scars. Bilateral eye and facial injuries (both eyes or cheeks) are of suspicious origin because only one side of the face is usually injured as a result of an accident.

¹Richard D. Ruddle, "Missouri Child Abuse Investigator's Manual." Juvenile Specialist Program, Institute of Public Safety Education, College of Public and Community Services, University of Missouri and University Extension Division, May, 1981, p. 42.

The worker should be aware that certain birthmarks, in particular "Mongolian spots," can be mistaken for bruises. "Mongolian spots" are present at birth and generally disappear by the time the child is five years old. These spots are grayish blue, do not change color with time and are commonly located on the buttocks and back. Incidence of the discoloration varies for groups of different abuse:racial descent.

The presence of a bruise(s), inflicted upon a child during the course of discipline and/or behavior management, should not always result in investigative conclusion of "Preponderance of Evidence". An investigative finding by "Preponderance of Evidence" that physical abuse exists will be based on the worker's judgment after considering all the evidence including the description of the incident causing the bruise provided by the child, alleged perpetrator and witnesses. The following factors should be considered when evaluating whether a bruise represents physical

- How bruise was inflicted (open hand, paddle or instrument);
- Location of bruise;
- Severity of bruise;
- Age of child;
- Child's behavior posed a risk to himself or others.

Each incident of bruises inflicted upon a child as the result of discipline/behavior management must be carefully assessed based on: evidence, observations and the above factors.

Bite Marks: In many cases bite marks should be suspected as the product of abuse or neglect. Although the opinion of a physician or dentist will be needed to firmly identify their origin, workers should be able to make preliminary identifications. A bite will be evidenced by a mark the shape of the cutting edges of the teeth. It may be seen alone or in conjunction with other marks, including a suck mark and/or a thrust mark. The suck mark ("hickey") is a result of the skin being pulled into the mouth by pressure. The thrust mark is caused by a tongue pushing against the skin trapped behind and between the teeth. Bite marks are egg shaped, and clear or contain the suck or thrust mark in the center.

Human bite marks differ in a number of ways from those of animals (including dogs, cats and rodents), which are the bite marks most commonly seen by investigators. In general, animal bites have a narrower arch form (shape) than human bites, leave deeper and narrower marks, and tend to have a ripping rather than crushing effect. Severe animal bites may resemble surgical incisions.

Whether human bite marks are inflicted by an adult or a child can be determined by a trained medical or dental examiner by the size of the impression made by the cutting edge of the teeth. Time is an important factor in accurately diagnosing these marks, so workers should immediately secure medical opinions for this type of injury.

Mouth Injuries: Workers may observe the results of trauma to the child's mouth, including broken teeth, lip injuries or tears to the frenum (the fold of skin under the tongue). The latter may be the result of the forcing of an object (i.e., spoon, baby bottle) into an infant's mouth.

Although it is possible for a toddler to accidentally incur such an injury after beginning to walk, infants less than six months old are unlikely to experience such accidental injuries. Children between the ages of two and five are not likely to accidentally tear the frenum because they move about more steadily and are less inclined to fall into objects (i.e., furniture) in a manner that would cause such a tear. Lip injuries can be accidental but can also be the result of a forcible blow to this area with an object (i.e., hair brush). Similarly, teeth may be broken accidentally or as the result of a blow to the mouth with an object (i.e., fist, stick).

Burns

The extent and characteristics of burn injuries reflect the way the injury occurred. For example, cigarette, match tip, or incense burns produce circular lesions with blisters and ulcers. A lesion is an injury to the body from any cause that results in damage or loss of structure or function of the body tissue involved. Old burns are seen as pigmented scars. The palms, soles, torso and buttocks are the most common sites of these burns.

Dry Contact Burns: Dry contact burns from forced contact with devices or instruments which conduct heat (i.e., irons, heating coils, radiators) usually produce second degree burns which do not form blisters. The injury resembles the contour and shape of the instrument. It is unlikely that an accidental fall against one of these objects will cause an injury of this severity because the child would not remain in contact with the device for more than an instant.

Scalding: Scalding burns are a result of dipping a child into hot liquid or pouring it over the skin. The burn appears uniform in those areas which were exposed to the hot substance with a line separating the burned area from the unburned skin. "Stocking" burns refer to the injury that results when the child's feet are submerged in a hot liquid. "Glove" burns are caused when the child's hands are forcibly submerged in a hot liquid. Another type is a "dunking" burn, in which the scalding injury is to the feet, buttocks and perineum (i.e., the area between the anus and the posterior part of the external genitalia) corresponding to the child's posture during submersion. Splash marks may not be evident because the child's movement has been constrained. On occasion, an area of skin within a submersion burn will show no injury. This can happen when the submerged part

of the child's body is pressed against the bottom or side of the container (i.e., tub).

These burns are often associated with discipline for "accidents" during toilet training. The degree of injury will vary with the temperature of the liquid and the length of time exposed to it. For example, prolonged exposure to bath water (105°-110°) will not cause burns, while exposure to 158° water, even for one second, will produce third-degree burns.

Burns From Cigars, Cigarettes, Or Flames: Cigar or cigarette burns may appear separately or in a series. These circular burns are usually inflicted on the palms of the hands, the arms, the soles of the feet, or the scalp. Burns from matches or gas stoves may result from holding the child's hands, feet or other body parts over the flames.

Chemical Burns: Caustic burns may result from chemicals, such as acids, being splashed or poured on the child.

Hot Needle Burns: Burns resembling tattoo marks of initials, words or pictures are usually inflicted with a hot pin, needle or other sharp and pointed object.

Burn Classifications:

- First Degree - The burn is limited to the outer layer of skin;
- Second Degree - The damage extends through the outer layer of the skin into the inner layers. Blistering will occur within 24 hours;
- Third Degree - The skin is destroyed and the damage extends into underlying tissues, which may be charred or coagulated;

Infected burns may indicate a delay in seeking treatment.

Head Injuries

Violent pulling of a child's hair may cause bleeding under the skin surface, swelling of the scalp, and the simultaneous loss of hair resulting in bald spots or patches.

Subdural hematoma, bleeding between the brain and the skull, is caused when the vein bridging the two is torn. This injury can result from a direct blow to the head or violent shaking. Although medical examinations and x-rays are needed to diagnose all symptoms, the presence of swelling and bruises to the scalp, bleeding of the eye, vomiting, seizures, coma or loss of consciousness should alert the worker to the possibility of this injury. Finger-tip encirclement bruises around the torso, or bruises to the skin located over the center of the shoulder bone (back) and the center of the collar bones (both sides) and the absence of a

skull fracture with the above listed symptoms may indicate that the harm resulted from violent shaking.

Internal Injuries

Blows (i.e., punches, kicks) to the child's chest or abdomen may cause internal injuries. Diagnosis of these injuries will require medical examination but can sometimes be detected by the worker. Tenderness or swelling of the skin or vomiting may signal the presence of these injuries. The child with internal injuries may appear pale, have an anxious expression, be cold, semi-comatose and perspiring freely. The child may report having experienced intense pain which may diminish over time.

A variety of fractures can result from trauma to the child's bones. Medical and x-ray examinations are necessary to diagnose these injuries. Observable symptoms include swelling, tenderness, the child's inability to move a limb, or protrusion of the bone(s) through the skin surface.

There are many types of fractures, the most common being:

- Simple - the bone is broken, but there is no external wound;
- Compound - the bone is broken, and there is an external wound leading to the site of fracture, or fragments of bone protrude through the skin;
- Complicated - the bone is broken and has injured some internal organ, such as a broken rib piercing a lung;
- Comminuted - the bone is broken or splintered into pieces;
- Spiral - twisting causes the line of the fracture to encircle the bone in the form of a spiral.
- Skeletal injuries that may indicate abuse include:
 - Spiral fractures - fractures that wrap or twist around the bone shaft
 - Corner fractures of the metaphyseal (long bones) -splintering at the end of the bone
 - Epiphyseal separation - a separation of the growth center at the end of the bone from the rest of the shaft, and periosteal elevation - a detachment of the periosteum (i.e., surface layer of the bone and membrane of connective tissue from the shaft of the bone with associated bleeding). These injuries may be caused by twisting or pulling.

Poisoning

A child may be neglectfully, accidentally or intentionally poisoned from the ingestion, inhalation, injection or absorption of substances which interfere with the body's normal physiological functions. In addition to dangerous chemicals (i.e., cleaning fluids), almost all substances can be poisonous if consumed in sufficient quantity. An excessive dosage of even common substances, such as aspirin or alcohol, can be poisonous. A medical opinion should be obtained to confirm this diagnosis.

Disciplinary Actions

A variety of disciplinary techniques utilized by parents and caretakers may, by the standards of the worker, appear inappropriate. Other disciplinary techniques are considered bizarre by most any community's standard, i.e., locking a child in a closet or tying a child in a bed for extended periods of time. The worker should carefully evaluate each incident of inappropriate and/or bizarre discipline to determine if it resulted in abuse or neglect and if so, which category of abuse or neglect. The following factors should be considered when evaluating reported incidents of abuse or neglect resulting from disciplinary actions:

- The age and physical/psychological/emotional development of the child;
- The frequency and/or duration of the disciplinary action;
- The physical/psychological/emotional effect the discipline had on the child's safety and well-being;
- Ethnic and cultural standards and practices of the family.

3. Behavioral Indicators Of Physical Abuse - Behavioral indicators of physical abuse may exist independently or in conjunction with physical indicators. Behavioral indicators of physical abuse in the child include:

- Reacts with fear or aggressiveness to being touched, whether the touch is playful, supportive or restraining;
- Appears wary of adult contact;
- Appears to be or states that (s)he is frightened of the parents or other persons;
- Appears to be afraid to go home or to another familiar location;
- Seems to feel deserving of punishment;
- Demonstrates apprehension when other children cry;

- Behaves provocatively and appears to push encounters to the point where others physically maltreat him or her;
- Behaves manipulatively to get attention;
- Indiscriminately seeks affection;
- Appears to have a poor self-concept;
- Appears to have a vacant or frozen stare;
- Remains very still while visually surveying the surroundings;
- Responds to questions in monosyllables;
- Seems capable of only superficial relationships;
- Exhibits behavioral extremes, including extreme aggressiveness or extreme withdrawal;
- Is physically aggressive with no provocation;
- Exhibits assaultive behaviors (physical assaults or homicide attempts);
- Is involved in fire setting, compulsive lying, compulsive stealing, compulsive destruction of property or vandalism, or other delinquent acts;
- Runs away and appears reluctant to return home when found;
- Exhibits precocious maturity;
- Wears long sleeves or other cover-up clothing to hide injuries; and/or
- States that he or she has been physically abused.

Behavioral Indicators Of A Physically Abusive Caretaker Include:

- Seems unconcerned about the child;
- Perceives the child as "bad," "evil," a "monster," a "witch," or "different";
- Offers an inadequate or illogical explanation or has no explanation for the child's injury;
- Gives different or contradictory explanations for the same injury;

- Attempts to conceal the child's injury or to protect the identity of a person the caretaker says is responsible;
- Takes an unusually long time to obtain medical care for the child;
- Takes the child to a different doctor or hospital for each injury;
- Does not visit the child in the hospital;
- Does not ask about follow-up care;
- Disciplines the child too harshly considering the child's age, condition, or what the child did;
- Abuses alcohol or other drugs; and/or
- Has a history of physical abuse as a child.

4. Types Of Evidence - Evidence is collected by law enforcement personnel, Children's Division (CD) and multi-disciplinary team members and used as both physical and credible verbal evidence to document the worker's investigative conclusion. Evidence for reports of physical abuse may include any one or all of the following:

- Child's statement;
- X-rays;
- Photographs;
- Witness statement;
- Licensed medical practitioner's statement;
- Police reports;
- Worker's observation;
- Instrument/object used to inflict injury (to be obtained by law enforcement personnel); and/or
- Perpetrator's statement;

Chapter 210, RSMo requires the investigator to conduct a thorough investigation. To that end, investigators are allowed to contact anyone with information relevant to the CA/N report without the knowledge and/or consent of the subjects. This includes interviewing the child without the knowledge and/or consent of the

parent. When the child is seen without parental consent, every effort should be made to involve the parents as quickly as possible.

Visible Signs

Visible signs are those observations made by the worker during the course of the investigation. Visible signs include, but are not limited to: the size, shape and location of an injury, behavioral indicators of family members, and physical condition of the family home.

- 5. Operational Definitions - Preponderance Of Evidence:** A finding that physical abuse has occurred or is occurring, founded on the observation of visible signs, physical and/or credible verbal evidence provided to the investigator by the child, perpetrator or witnesses in accordance with the definition of physical abuse and which is supported to a degree of evidence that is of greater weight or more convincing than the evidence which is offered in opposition to it or evidence which as a whole shows the fact to be proved to be more probable than not.

Related Subject: Section 2, Chapter 4, Attachment L: Preponderance of Evidence
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Unsubstantiated-Preventive Services Indicated: A finding of Unsubstantiated-Preventive Services indicated is appropriate when insufficient visible signs, physical and/or credible verbal evidence exist, but where the investigator determines that indicators are present which if unresolved, could potentially contribute to child abuse/neglect.

Unsubstantiated: A finding of unsubstantiated is appropriate where insufficient physical or credible verbal evidence exists and where few or no indicators are identified and the worker has not identified a specific threat exists for the child.

Investigative Conclusion: This is determined after collecting and reviewing all evidence and/or indicators obtained during the course of the investigation. If there is a finding by a "preponderance of evidence" that child abuse and neglect exists the investigative conclusion will be "Preponderance of Evidence." If the evidence is inconclusive, but there are sufficient indicators to suggest a potential for abuse/neglect to a child, the investigative conclusion (determination) will be "Unsubstantiated-Preventive Services indicated." Lacking evidence and sufficient indicators, the investigative conclusion will be "unsubstantiated."

Priority Status: This is to be determined based on the degree of risk to the child and the immediacy of the treatment needs. In a large part, this is based on the investigator's judgment and knowledge of the family situation.

Investigative Recording: Shall be completed in a summarized narrative style on the CPS-1. It should be written in a clear, concise, easily understood manner and include but is not limited to the following components:

- A chronological listing of who, when, where each subject and/or collateral was contacted and the content of the interviews;
- A brief description of all credible verbal and/or physical evidence provided to the worker during the investigation;
- A statement justifying the investigators investigative conclusion i.e., Preponderance of Evidence, Unsubstantiated-Preventive Services indicated or unsubstantiated;
- A brief description of "reasonable efforts" used by the worker to prevent removal of the child; and/or
- Documentation for the reason services were not provided when a child is placed in emergency alternative care.

Chapter Memoranda History: (prior to 01-31-07)

[CS03-51](#), [CD04-79](#), [CD05-35](#)

Memoranda History:

29: Sexual Abuse

The Definition of Sexual Abuse Includes:

- The use, persuasion, inducement, enticement or coercion of any child under the age of 18, to engage in, or having a child assist any other person to engage in, any sexually explicit conduct by those responsible for the child's care, custody and control; or,
- Sexual exploitation, which is the sexual use of a child under the age of 18 by those responsible for his/her care, custody and control for the purpose of the individual's personal satisfaction and/or gain. Sexual Exploitation includes, but is not necessarily limited to, pornography and prostitution.

1. Indicators/Characteristics of Sexual Abuse:

The indicators of child abuse and neglect vary. No child or caretaker will exhibit all of the physical or behavioral indicators listed and some of the indicators are contradictory. The behavior of an abused or neglected child and other family members may be sporadic and unpredictable. Indicators should be used only as a general guide. The presence of indicators alone does not establish that sexual abuse or exploitation has occurred. The presence of multiple indicators or the pervasiveness of any one behavioral indicator warrants close scrutiny by the worker.

Physical Indicators in Child:

- Genital or anal bleeding or lacerations;
- Bruises;
- Pain or itching in genital area;
- Lacerated hymen;
- Semen in clothes or genitals;
- Genital or anal infected lesions;
- Vaginal infections/discharge;
- Venereal disease/oral or genital;
- Difficulty in walking or sitting;
- Pregnancy; and/or

- Bruising in or around mouth area.

It should be noted that physical indicators are present in only a very small percentage of sexual abuse cases. Therefore, the absence of physical indicators should not be considered conclusive evidence that the allegations are unsubstantiated.

Behavioral Indicators in Child:

- Child displays bizarre, sophistic or unusual knowledge of sex;
- Acts out sexually;
- Child displays confusions over sexual identity;
- Victim has fear of men or women;
- Extreme curiosity about sexual parts of body;
- Excessive masturbation;
- Excessive sexual activity with other children;
- Victim affectionless or extremely affectionate;
- Role reversal with same sex parent;
- Refuses to participate in physical education activities;
- Difficulty in sitting or walking;
- Child feels destroying parents' marriage;
- Night terrors;
- Deviant sexual activity;
- Runs away;
- Withdrawn;
- Aggressive;
- Depressed;
- Enuresis;

- Regressed;
- Retreated into fantasy world;
- Poor peer relationships;
- Sudden school problems;
- Fire setting;
- Emotional instability;
- Delinquent;
- Extreme changes in behavior such as loss of appetite;
- Child has episodes of self-mutilation;
- Cruelty to animals;
- Low self-esteem;
- Defiance;
- Lying;
- Sleep disorders;
- Speech disorders; and/or
- Self-destruction (i.e., head banging, drug abuse, obesity, or anorexia).

Familial/Parental Characteristics:

- Authoritarian father - ineffectual mother;
- Sexual problems in marriage;
- Role reversal between mother and daughter;
- Religious beliefs (father's duty to teach daughter about sex);
- Over protection of the daughter;

- Isolation -- geographic isolation -- lack of social or emotional contacts with people outside family;
- Poor self-esteem in family members;
- Repression and denial as coping mechanisms;
- Alcohol/drug problems - other addictions;
- High stress - unemployment, physical disability, etc.;
- Past sexual abuse in family;
- Poor sexual boundaries;
- Extreme passivity of the father;
- Power, father tries to control wife, child, etc., but has no impulse control;
- Prolonged absence (emotionally and/or physically) of one parent from the home;
- Loss of one parent through death or divorce;
- Severe overcrowding in the home, especially in sleeping arrangements
- Marital problems causing one spouse to seek physical affection from a child rather than from the other spouse
- Multi-generational pattern of incest/history of sexual abuse;
- Cultural standards in a family which determine the degree of acceptable bodily contact;
- Physically isolated in community;
- Family roles are rigid;
- Family members are socially fearful, placating, or blaming ;
- Family members have difficulty expressing feelings;
- Attitudes regarding sexuality repressed or confused;
- Mother passive/poor self-image;

- Parents claim victim is "seductive";
- Parent sexually abused as child;
- Child may mention subtle or veiled threats;
- May be evidence of "conditioning" process – including favoritism;
- Denial of non-abusive parent; and/or
- Perpetrator uses abuse victims serially and one at a time.

Pedophile Characteristics:

- Usually perceived as a caring person and forms caring relationship with child;
- Rarely uses force; uses manipulation and coercion;
- May marry woman with children of "appropriate" ages;
- Takes inordinate number or inappropriate pictures of child;
- Feeling of inadequacy;
- Immaturity;
- Vulnerability;
- Helplessness;
- Isolation;
- Lack of nurturing as a child;
- Conflicting relationships in the family of origin;
- History of own abuse;
- Family of origin was repressive and punitive around issues of sexuality;
- Large amount of inferiority, more so than incest;
- Poor social/sexual peer relationships;
- Compulsive and obsessive behaviors;

- Feelings of powerlessness;
- Sexual dysfunction in adult relationships; and/or
- Males are at higher risk than females to be victims.

The Fixated Pedophile:

- Child like, identifies with the child;
- More likely to pick a male child;
- Single, isolated, has little contact with people of own age;
- Not as likely to abuse drugs or alcohol;
- Involved with multiple victims;
- Assaults are premeditated; and/or
- Have character and personality disorders.

The Adolescent (Age 12-17) Offender – Characteristics:

- There is a wide variety, some sophisticated, others very immature;
- Detached relationship with dad;
- There is a favored child in the family who is not the offender;
- Loners;
- Does not excel in any one thing;
- Has no positive role models;
- Early onset of sexual experiences; and/or
- Has inadequate sexual information.

- 2. Types of Evidence:** Evidence is collected by law enforcement personnel, Children's Division (CD) and multi-disciplinary team members and used as both physical and credible verbal evidence to document the worker's investigative

conclusion. Evidence for reports of sexual maltreatment may include any one or all of the following:

- Doctor's statement;
- Rape kit evidence;
- Clothing;
- Linens;
- Police report;
- Pornographic pictures;
- Pornographic videotapes;
- Diagnostic videotapes;
- The child said it happened;
- Witness' statement; and/or
- Perpetrator's statement.

Chapter 210 requires the investigator to conduct a thorough investigation. To that end, investigators are allowed to contact anyone with information relevant to the CA/N report without the knowledge and/or consent of the subjects. This includes interviewing the child without the knowledge and/or consent of the parent. When the child is seen without parental consent, every effort should be made to involve the parents as quickly as possible.

Visible Signs

Visible signs are those observations made by the worker during the course of the investigation. Visible signs include, but are not limited to: the size, shape and location of an injury, behavioral indicators of family members, and physical condition of the family home.

3. Operational Definitions:

Preponderance of Evidence: A finding that sexual maltreatment has occurred or is occurring based on observation of visible signs, physical evidence, and/or credible verbal evidence provided to the investigator by the child, perpetrator or witnesses in accordance with the definition of sexual abuse and which is supported to a degree of evidence that is of greater weight or more convincing

than the evidence which is offered in opposition to it or evidence which as a whole shows the fact to be proved to be more probable than not.

Related Subject: Section 2, Chapter 4, Attachment L: Preponderance of Evidence
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Unsubstantiated-Preventive Services Indicated: A finding of Unsubstantiated-Preventive Services indicated is appropriate when insufficient visible signs, physical and/or credible verbal evidence exist, but where the investigator determines that indicators are present which if unresolved, could potentially contribute to child abuse/neglect.

Unsubstantiated: A finding of unsubstantiated is appropriate where insufficient visible signs, physical and/or credible verbal evidence exists and where few or no indicators are identified and the worker has not identified a specific threat exists for the child.

Investigative Conclusion: This is determined after collecting and reviewing all evidence and/or indicators obtained during the course of the investigation. If there is by a preponderance of evidence that child abuse or neglect exists the investigative conclusion will be "Preponderance of Evidence". If the evidence is inconclusive, but there are sufficient indicators to suggest a potential for abuse/neglect to a child, the investigative conclusion will be "Unsubstantiated-Preventive Services indicated." Lacking evidence and sufficient indicators, the investigative conclusion will be unsubstantiated."

Priority Status: This is to be determined based on the degree of risk to the child and the immediacy of the treatment needs. In a large part, this is based on the investigators judgment and knowledge of the family situation.

Investigative Recording: Shall be completed in a summarized narrative style on the CPS-1. It should be written in a clear, concise, easily understood manner and include but is not limited to the following components:

- A chronological listing of who, when, where each subject and/or collateral was contacted and the content of the interviews;
- A brief description of all credible verbal and/or physical evidence provided to the worker during the investigation;
- A statement justifying the investigators investigative conclusion i.e., reason to suspect, Unsubstantiated-Preventive Services indicated or Unsubstantiated.

4. Interviewing Victims Of Sexual Abuse

As in all types of abuse and neglect, interviewing children who have been sexually abused involves professional skill, judgment, and expertise. The nature of the allegations, the impact on the child and family, and the physical and behavioral indicators are such that creative and effective interviewing techniques are needed.

The following is meant to serve as a guideline in providing questions that may be asked of children. These questions are phrased in such a way that they will help elicit the needed information in a non-threatening way. When appropriate, the information gathered can be used in a juvenile and/or criminal court proceeding. This information is not a substitute for worker's judgment and creativity as each child will need to be assessed based on the interviewing technique that is most appropriate (depending on such factors as age, personality, verbal skills, etc.). Props, i.e., anatomically correct dolls, puppets or drawings may be used to elicit information from the young or non-verbal child.

Arrange a Safe Setting for Interview: Careful consideration should be given to the choice of setting for this interview. If at all possible, children should be seen away from the alleged perpetrator and in an environment the child would consider "safe," and familiar to the child--i.e., school or child care center. Whether or not to include a parent during this interview will depend on such factors as the relationship of the alleged perpetrator to the family and where the report originated. It is important to remember that sexual abuse is a private, secret affair and there may be many reasons a child would hesitate to reveal information.

Establish Rapport: Give your name and simple definition of what you do; i.e., someone who helps children when there are problems; I get calls sometimes when someone is concerned about a child -- I got a call about you:

- Establish that the child knows the difference between a lie and the truth;
- Express interest in child as a person, but don't ask superficial questions -- kids usually know why you're there. Ask things like -- who is in the home, who cooks meals, etc. This should help the child relax, yet provide information;
- Empathize with the child;
- Go as slowly as needed, letting the child set the pace and style;
- Redirect the interview as needed -- things may get too tense. Let the child know that you talk to a lot of children;
- Let the child know you can be reached if he/she needs to talk to you;

- Be sure you understand the child's language terms. Answer all his/her questions candidly; and
- Let the child know that you appreciate him/her talking about the incident.

Things to Avoid:

- Making promises;
- Showing displeasure or appearing upset;
- Using technical jargon;
- Bringing up the alleged perpetrator's name first, let the child do that;
- Staring at the child continuously, direct eye-to-eye talk may not work;
- Saying, "Did someone hurt you" or "Did somebody do bad things to you?" Use instead, "Did someone touch you in a way you didn't like or make you uncomfortable?";
- Asking leading questions;
- Asking questions that can be answered yes or no;
- WHY questions;
- Excessive congratulation or praise of a child on or off videotape.

Time is A Relative Factor: Most people measure time in relation to other factors in their lives. Children are particularly tuned to this both in long-term and short-term time frames. It is frequently helpful to use such factors in assisting the child in establishing a time frame; i.e., long term -- was it hot or cold outside, during the school year, around Christmas or other specific holidays; close to some specific occurrence -- trip to grandma's; when a friend spent the night, etc. (such things should be verifiable with some checking); short-term -- in the morning after Mom leaves for work, while Dad goes bowling, during a specific TV program.

Workers should take into account that a child's concept of time is not literal in terms of minutes or hours. The child's perception of the length of time an incident lasts may be skewed by emotions, etc. A child's description of an unrealistic time frame does not necessarily mean he's lying.

Description of a Specific Incident: Has someone done something to you which you didn't like or which made you feel uncomfortable? What happened? Who? Where and when? Children may vary greatly on which of these things is

easiest to reveal first. If such a broad question reveals information of other kinds of "uncomfortable" occurrence, you may need to be more specific, i.e., I understand that someone touched your private parts -- (establish what private parts are). It will be important to establish information as specific as possible regarding what happened.

After the child has told you what happened in his own words, you may need to ask some specific questions. Some questions that may help (depending on age, emotional state, maturity, communication skills) might include:

- Did someone touch you and can you show me where;
- Did someone make you touch him/her? Where? How? (With hand, mouth);
- Did he/she kiss you or make you kiss him/her? Where;
- Did someone put something inside your body? Where? When;
- Did anything come out? Describe it;
- What were you wearing -- what was he/she wearing;
- Were your clothes taken off;
- When he/she did this, did he/she say anything to you? Did he/she say something after he/she stopped;
- Did you say anything;
- Did he/she offer you anything or threaten you? (get specifics);
- Who did this to you? (Make sure you know who the child names -- if its Daddy and there is a stepfather, natural father, grandfather, be clear on exactly to whom the child is referring). **Don't assume**;
- Did he/she take off his/her clothes? Pull down or unzip his/her pants;
- Did he/she touch you inside or outside your clothes? Where? How;
- How did you feel when he/she touched you;
- Where were you when this happened;
- What's that room/place like? Child may find it easier to draw a diagram of house - show room and other specifics - on bed, in chair in living room, etc.;

- Where was your Mommy/Daddy? Siblings, etc.;
- How do parents and others show affection;
- Was it dark or light when this happened;
- Has this happened more than once with named person;
- About how often? Did it happen other places or always same location? (Get specifics);
- Did other things happen at other times besides the one you already told me about? (Go through the same specifics as outlined earlier so that you have a good sense of all the times and places molestation might have occurred.) Location is important as it might change the criminal jurisdiction;
- Did he/she ever take any pictures/videotape of you. Did you have your clothes on or off;
- Have you told anyone about this happening to you? Who, when, what did you say (try to get specifics)? What did that person say? What did that person do;
- Has anyone else ever touched you in this sort of way? (If the answer is yes, advance to "go" and start over!)

How do You Tell if a Child is Not Telling the Truth?

Children (pre-adolescent) "lie" for two reasons:

1. To get out of trouble; and,
2. To prevent trouble.

Given this information, the interviewer should also be aware of the following points of information:

- If a child has been "coached," the child may be able to visually describe the incident. However, information on touch (what did it feel like?), taste, and smell can not usually be "faked." Gear your questions toward these sensations and look for the degree of detailed knowledge that the child may possess;
- Listen carefully to words used to describe the incident. Are they age-appropriate? For example, the three year old who reports to you that she

has been "raped" or "molested" has used phrasing that is beyond the usual norm vocabulary one would find at that age;

- What is the child's motivation in reporting the incident. (Is there a custody dispute occurring?);
- The child's affect should be carefully observed and documented:
 - How does the child present himself/herself during the interview? (Nervous, shy, etc.)
 - Body language/eye contact/voice tone;
 - Non verbal cues from another adult in the room;
 - Are re-tellings of the incident(s) to other co-investigators consistent down to the last detail; and never changing in the slightest detail? This MAY be unusual in that some blurring of the incident is normal.

Questions to Ask the Child to Assess Risk to Child:

- What will happen? (This is the child's opinion of what will happen in the family when you leave, if he/she is returned to his/her home, etc.);
- Who will be on your side? (This is the child's opinion of who will support his/her story, protect him/her, etc.);
- Are there any guns in your house? Who uses them? Where are they? What kind? (These questions explore potential violence, reprisal, etc.);
- What do people in your household do when they're in a fight? (This question explores violence, reprisal, etc.);
- What will happen when worker talks with parents? (child's perception)

End Interview: Ideally, this interview will take place in cooperation with the appropriate law enforcement personnel. However, there may be occasions when worker will conduct the interview alone. In such cases, the child needs to be prepared for the fact that he/she may need to give this information to someone else.

In any case, try to tell the child things that might happen. This will differ according to local policy, but may need to include such things as role of the police (may come to school in uniform -- child is not in trouble); possibility of foster care placement (include a little of what foster homes or shelters are like); possibility of

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criminal action -- (adult has done something against the law -- judge will decide what should happen).

Questions regarding what is going to happen next must be handled honestly, but to the extent possible, in a way that relieves the child of responsibility for any action that takes place.

Results of this interview should be closely documented in the case record.

Chapter Memoranda History: (prior to 01-31-07)

[CD04-79](#), [CD05-35](#)

Memoranda History:

CD11-42

30: Neglect

Neglect:

1. **Definition Of Neglect** - Failure to provide, by those responsible for the care, custody, and control of the child, the proper or necessary support, education as required by law, nutrition or medical, surgical, or any other care necessary for the child's well-being.

Proper or necessary support is defined as including, "adequate food, clothing, shelter, medical care, or other care and control necessary to provide for the child's physical, mental, or emotional health or development."

2. **Indicators/Characteristics Of Neglect** - The indicators of child abuse and neglect vary. No child or caretaker will exhibit all of the physical or behavioral indicators and some of the indicators are contradictory. The behavior of an abused or neglected child and other family members may be sporadic and unpredictable. Indicators should be used only as a general guide. The presence of multiple indicators or the pervasiveness of any one behavioral indicator warrants close scrutiny by the worker.

Child's Physical Indicators:

- Consistent hunger, poor hygiene, inappropriate dress
- Consistent lack of supervision, i.e., child participates in dangerous activities or is unsupervised for long periods of time
- Abandonment
- Often tired or listless
- Lack of adequate clothing
- Illnesses associated with excessive exposure and poor hygiene (home or personal--EXAMPLE-persistent scabies, bacterial infections, persistent head lice)
- Persistent diaper rash or other skin disorder
- Chronically dirty or unbathed
- Developmental delays (EXAMPLE-three-year old that doesn't verbalize)
- Consistently low blood count

- Improper growth patterns, low weight or weight loss

Physical Condition In The Home:

- Exposed wiring, frayed electrical cords, dangerous electrical outlets
- Inadequate heating
- Broken windows and/or screens over the windows
- Unsanitary housing conditions
- Exposed heating elements or fan blades
- Absence of railings on stairs, broken stairs, or open windows
- Chemical substances or dangerous objects (knives, guns) improperly stored and within reach of children
- Human or animal feces or garbage which has been inappropriately disposed
- Inoperative indoor or outdoor bathroom facilities
- Inadequate, insufficient, or unsanitary sleeping provisions (EXAMPLE-not enough or clean enough beds, cots, mattresses, and blankets for all, including an infant's sleeping place which does not have sides to prevent falling out
- Infestation by rodents or vermin
- Vicious or uncontrolled animals in the home
- Inoperable electricity and heating in the home in cold weather, and lack of proper ventilation in summer and winter
- Inadequate space to provide some privacy to family members of various ages/sexes
- Small objects that can be swallowed if left within the reach of the child
- Objects lying about the home that the child might fall over or be injured by

- Insufficient quantity of nutritious and edible food that meet the child's needs (food that is not rotten, moldy, insect-infested, or in any other way contaminated)
- Inadequate equipment and provisions for cooking and refrigerating food
- Inadequate or unsafe water supply
- Inadequate or unsafe sewer system
- Fire hazards (EXAMPLE-piles of clothing or paper, flammable materials improperly stored i.e., gasoline)

Although many of these conditions will be apparent through the worker's observations, the worker should discuss conditions with the caretaker. In particular, the worker should find out what precautions the caretaker has taken to protect the child from potentially harmful conditions.

Behavioral Indicators:

- Child begs or steals food
- Child assumes an excessive amount of responsibility or relies heavily on another child
- Child attends school irregularly, including excessive tardiness
- Child remains at home for extended hours
- Child falls asleep, is fatigued or listless in school
- Child abuses drugs or alcohol
- Child engages in delinquent or status offender behavior or has other contact with Juvenile or other Law Enforcement authorities
- Extended stays in school (early arrival and late departure) or other places where care is provided
- Child states there is no caretaker
- Child unable to form appropriate relationships with peers and adults
- Eating disorders (EXAMPLE-over eating/hoarding food)

Parental/Familial Characteristics:

- Highly stressful family situations
 - Single parent family
 - Several children
 - Recent marital problems
 - Insufficient financial and other resources for child care
- Isolated within the neighborhood
- Mental retardation, character disorders, emotional illness of parent(s)
 - Coldness, inability to empathize with child's needs
 - Alcoholism, drug abuse
 - Loneliness
 - Poor self-esteem, immaturity, dependent, unable to carry continuing responsibility, poor or distorted judgment
 - Depressed
 - Limited intellectual capacity
- Parental history also reflects neglect
- Parents are indifferent, emotionally detached from each other and/or the child(ren)
- Disorganized, inconsistent family life
- Parent(s) is unable to make decisions, passively accepts events, waits for others to solve problems/provide needs
- Parent(s) is unwilling to accept referrals for tangible services
- Parent(s) is unable to give information on child(ren)'s immunizations, illnesses, childhood milestones (EXAMPLE-potty-training, first began talking, walking)
- Parent(s) has long-term chronic illness
- Parent(s) cannot be found

- Parent(s) provides for self before providing for needs of child (Example-coats, shoes, etc.)
- Parent(s) is apathetic, feels nothing will change

Lack Of Supervision: To establish "lack of supervision" there must be evidence that those responsible for the care, custody and control of the child were negligent in their decision making or supervision of the child. Negligence is present if the parent/caretaker ignored or disregarded pertinent information about either the child's behavior history and self-management abilities, or those of the person actually harming the child. (Example: If a parent/caretaker has no knowledge of one child's sexual aggression against other children, and puts this child under that child's supervision, they have not failed to adequately supervise the child. However, if the parent or caretaker is aware of the history and places this child in the setting anyway (s)he has ignored that history and there may be a finding of Lack of Supervision. There are two distinctly different forms of lack of supervision, "inattentive parenting" and "left home alone." The inattentive parent is at home with the child, but likely to be apathetic and detached. Children of inattentive parents tend to be sexually and emotionally maltreated, medically neglected and allowed to participate in dangerous activities. Parents who leave their children home alone are warmer, not apathetic and tend to do so because of lack of financial or child care resources.

Not all reported incidents of children being left alone or given responsibility for the care and supervision of younger children should result in a finding of lack of supervision. The worker should assess each situation based on the individual child's knowledge and maturity level. The following questions are designed to assist the worker in assessing whether a child has sufficient knowledge and maturity to care for him/herself and/or other children.

Ability To Locate Parents And Home:

- What is your name?
- What are your parent(s)' name?
- What's your address and phone number? (If home has no phone, who would you call if you were away from home and needed to call your parent(s)?)

Ability To Telephone For Help:

- Can you use a phone by yourself?
- Tell me how you would call a friend?

- If there was an emergency, could you call someone for help? Who would you call for help?
- Where are emergency numbers?
- What information would you need to give the police, fire department, or ambulance on the phone?
- Do you know how to use a pay phone?
- How would you call for help on a pay phone if you didn't have any money?

Knowledge Of Fire Safety:

- What would you do if you were in the house alone and the house caught on fire?
- What would you do if there were other children in the house and it caught on fire?
- How could you get out of this room? (each room of the house)
- What is the safest way to get out of a building full of smoke?
- Where would you go when you got out of the house?
- Would you try to save your pet dog or cat by looking for them in a burning house?

Knowledge Of Electrical Safety:

- Is it safe to have more than two objects plugged into an outlet?
- Why is it unsafe to have your radio plugged in and setting on the edge of the bathtub?
- What could happen to you if you stuck your finger or an object into an outlet?
- What would you do if you saw someone who is wet, or standing in water, begin to plug something in?

Ability To Protect Self From Strangers:

- Do you know what a stranger is?

- What are some safety rules about strangers?
- What things can you do when you're home alone to protect yourself from strangers?
- What would you do if you were home alone, and you thought someone was trying to break in?
- What would you do if a man came to your house at night and told you he wanted to come in and that he was a policeman?

Knowledge Of Cooking Safety:

- Can you cook?
- What kinds of things can you fix to eat?
- What safety rules do you know about cooking? (EXAMPLES-never leave pots unattended, turn handles to inside of stove, clean up spills, watch out for little kids, etc.)
- What would happen if you left a chicken cooking in water and forgot it?
- What could happen if you put water on hot grease?
- How do you put out a grease fire?

First Aid Knowledge:

- What would you do if a little hot grease popped on you or someone else?
- What would you do for a little cut or scratch?
- What would you do for a big cut with lots of blood pouring out?
- What would you do if a child you were watching got hit by a car and just laid there?
- What would you do if someone's clothes caught on fire?
- What can you do to help someone who has a nosebleed?
- What would you do if you saw a little kid drink something poison?
- What would you do if you saw someone drowning?

Storm Safety Knowledge:

- What is the safest thing to do if a tornado is coming?
- What does a tornado sound and look like?
- What would you do if you were home alone and the lights and heat went out?
- What if it started getting very, very cold?

Caring For Other Children:

- What would you do if two children you were babysitting for got into a fight?
- How old should a kid be before he can take a bath by himself?
- What would you do if one child you were watching ran off?
- Tell me some things you think are important to keep little kids safe?

Long Absences:

- What would you do if your parents left and didn't come back when they said they would?
- What would you do if they didn't come back all night?
- What if they didn't come back by dinner time the next day?

Child's Ability To Deal Emotionally With Parent Absences:

- Do you like to stay alone?
- Are you scared when you're home by yourself in the daytime? At nighttime?
- What do you do when you're home alone and get scared?

3. Types Of Evidence

Evidence is collected by law enforcement personnel, Children's Division (CD) and multi-disciplinary team members and used as both physical and credible verbal evidence to document the worker's investigative conclusion. Evidence for reports of neglect may include any one or all of the following:

- Photographs;
- Witness' statement;
- Licensed medical practitioner's report;
- Law enforcement reports;
- Perpetrator's statement;
- Fire Marshall reports;
- Health Department reports;
- School reports;
- Workers Observation;
- Child statements.

Chapter 210 requires the investigator to conduct a thorough investigation. To that end, investigators are allowed to contact anyone with information relevant to the CA/N report without the knowledge and/or consent of the subjects. This includes interviewing the child without the knowledge and/or consent of the parent. When the child is seen without parental consent, every effort should be made to involve the parents as quickly as possible.

Visible Signs

Visible signs are those observations made by the worker during the course of the investigation. Visible signs include, but are not limited to: the size, shape and location of an injury, behavioral indicators of family members, and physical condition of the family home.

4. Operational Definitions:

Preponderance Of Evidence: A finding that neglect has occurred or is occurring as a result of the observation of visible signs, physical and/or credible verbal evidence provided to the investigator by the child, perpetrator, or witness in accordance with the definition of neglect and which is supported to a degree of evidence that is of greater weight or more convincing than the evidence which is offered in opposition to it or evidence which as a whole shows the fact to be proved to be more probable than not.

Related Subject: Section 2, Chapter 4, Attachment L Preponderance of Evidence

Unsubstantiated-Preventive Services Indicated: A finding of Unsubstantiated-Preventive Services indicated is appropriate when insufficient visible signs, physical and/or credible verbal evidence exist, but where the investigator determines that indicators are present which, if unresolved, could potentially contribute to child abuse/neglect.

Unsubstantiated: A finding of unsubstantiated is appropriate where insufficient physical or credible verbal evidence exists, and where few or no indicators are identified and the worker has not identified a specific threat exists for the child.

Investigative Conclusion: This is determined after collecting and reviewing all evidence and/or indicators obtained during the course of the investigation. If there is a finding by a preponderance of evidence that child abuse or neglect exists the investigative conclusion will be "Preponderance of Evidence." If the evidence is inconclusive, but there are sufficient indicators to suggest a potential for abuse/neglect to a child, the investigative conclusion will be "Unsubstantiated-Preventive Services indicated." Lacking evidence and sufficient indicators, the investigative conclusion will be "Unsubstantiated."

Priority Status: This is to be determined based on the degree of risk to the child and the immediacy of the treatment needs. In a large part, this is based on the investigator's judgment and knowledge of the family situation.

Investigative Recording: Shall be completed in a summarized narrative style on the CPS-1. It should be written in a clear, concise, easily understood manner and include but not limited to the following components:

- A chronological listing of who, when, where each subject and/or collateral was contacted and the content of the interviews;
- A brief description of all credible verbal and/or physical evidence provided to the worker during the investigation;
- A statement justifying the investigator's conclusion i.e., probable cause, Unsubstantiated-Preventive Services indicated or Unsubstantiated.

Chapter Memoranda History: (prior to 01-31-07)

[CS03-51](#), [CD04-79](#), [CD05-35](#)

Memoranda History:

CD15-76

31: Medical Neglect

1. Definition Of:

Medical Neglect: The denial or deprivation, by those responsible for the care, custody, and control of the child, of medical or surgical treatment or intervention which is necessary to remedy or ameliorate a medical condition which is life threatening or causes injury. Medical Neglect includes not only serious, but mild and moderate medical neglect as well.

Exception By Reason Of Religious Belief: Failure to obtain specified medical treatment because of the legitimate practice of religious belief on the part of the child's parents, guardian, or others legally responsible for the child, will not be considered to be abuse or neglect. However, the juvenile court may order that medical services be provided to the child in such a situation if such services are necessary for the health of the child.

Medical Malpractice And Negligence: Licensed medical practitioners who through negligence fail to provide adequate care and treatment to a child are not perpetrators of medical neglect. A person must have care, custody and control of a child to be considered a perpetrator of medical neglect.

2. Physical Indicators/Characteristics Of Medical Neglect:

The indicators of child abuse and neglect vary. No child or caretaker will exhibit all of the physical or behavioral indicators listed, and some of the indicators are contradictory. The behavior of an abused or neglected child and other family members may be sporadic and unpredictable. Indicators should be used only as a general guide. The presence of multiple indicators or the pervasiveness of any one behavioral indicator warrants close scrutiny by the worker.

- Untreated serious physical or psychological illness or injury;
- Developmental delays (see Developmental milestones of children chart in appendix);
- Failure to thrive (see failure to thrive in appendix section).

Parental/Familial Characteristics

- Highly stressful family situations
- Single parent family
- Several children

- Recent marital problems
- Insufficient financial and other resources for medical care
- Isolation within the neighborhood
- Isolation from family members
- No community support systems
- Coldness, inability to empathize with child's needs
- Chemical dependency
- Loneliness
- Poor self-esteem
- Immaturity
- Dependent
- Lack of responsibility, poor or distorted judgment
- Depressed
- Parents' histories also reflect neglect
- Parents are indifferent, emotionally detached from each other and/or the children
- Disorganized, inconsistent family life
- Parents are unable to make decisions, passively accept events
- Parents are unwilling to accept referrals for tangible services
- Mental retardation
- Character disorder
- Emotional illness

Other Factors To Consider

- Failure of parent to follow through on a medical professional's advice/instructions

- Failure to seek treatment impairs the child physically or emotionally
- Parent is aware of the child's condition and risk of further harm to the child
- Parent fails to seek adequate treatment despite financial or other reasonable means to do so

3. Types Of Evidence:

Evidence is collected by law enforcement personnel, Children's Division (CD) and multi-disciplinary team members and used as both physical and credible verbal evidence to document the worker's investigative conclusion. Evidence for reports of medical neglect may include any one or all of the following:

- Child's Statement;
- Licensed Medical Practitioner Report;
- Perpetrator's Statement;
- Witness Statement.

Chapter 210 requires the investigator to conduct a thorough investigation. To that end, investigators are allowed to contact anyone with information relevant to the CA/N report without the knowledge and/or consent of the subjects. This includes interviewing the child without the knowledge and/or consent of the parent. When the child is seen without parental consent, every effort should be made to involve the parents as quickly as possible.

Visible Signs

Visible signs are those observations made by the worker during the course of the investigation. Visible signs include, but are not limited to: the size, shape and location of an injury, behavioral indicators of family members, and physical condition of the family home.

4. Operational Definitions:

Preponderance Of Evidence: A finding that medical neglect has occurred or is occurring as a result of the observation of visible signs, physical, and/or credible verbal evidence provided to the investigator by the child, perpetrator or witnesses in accordance with the definition of medical neglect and which is supported to a degree of evidence that is of greater weight or more convincing than the evidence which is offered in opposition to it or evidence which as a whole shows the fact to be proved to be more probable than not.

Related Subject: Section 2, Chapter 4, Attachment L Preponderance of Evidence

Unsubstantiated-Preventive Services Handbook: A finding of Unsubstantiated-Preventive Services indicated is appropriate when insufficient visible signs, physical and/or credible verbal evidence exist, but where the investigator determines that indicators are present which if unresolved, could potentially contribute to child abuse/neglect.

Unsubstantiated: A finding of unsubstantiated is appropriate where insufficient physical or credible verbal evidence exists, and where few or no indicators are identified and the worker has not identified a specific threat exists for the child.

Investigative Conclusion: This is determined after collecting and reviewing all evidence and/or indicators obtained during the course of the investigation. If there is by a preponderance of evidence that child abuse or neglect exists the investigative conclusion will be "Preponderance of Evidence." If the evidence is inconclusive, but there are sufficient indicators to suggest a potential of abuse/neglect to a child, the investigative conclusion will be "Unsubstantiated-Preventive Services indicated." Lacking evidence and sufficient indicators, the investigative conclusion will be "Unsubstantiated."

Priority Status: This is to be determined based on the degree of risk to the child and the immediacy of the treatment needs. In a large part, this is based on the investigators judgment and knowledge of the family situation.

Investigative Recording: Shall be completed in a summarized narrative style on the CPS-1. It should be written in a clear, concise, easily understood manner and include but is not limited to the following components:

- A chronological listing of who, when, where each subject and/or collateral was contacted and the content of the interviews;
- A brief description of all credible verbal and/or physical evidence provided to the worker during the investigation;
- A statement justifying the investigators investigative conclusion i.e., Preponderance of Evidence, Unsubstantiated-Preventive Services indicated or unsubstantiated.

Chapter Memoranda History: (prior to 01-31-07)

[CS03-51](#), [CD04-79](#), [CD05-35](#)

Memoranda History:

32: Educational Neglect

1. Definition Of Educational Neglect:

Educational neglect is the failure by the person responsible for the care, custody, and control of the child to provide an appropriate education and to promote school attendance as required by Missouri Law. Section 167.031 RSMo., requires all children ages 7 up to age 17 to attend school, except that any child who has successfully completed 16 credits toward high school graduation is not required to attend, therefore does not meet the criteria for educational neglect. Children ages 5 and 6 are required to attend school, when they have been enrolled in a public school by their parent or guardian.

Educational Neglect vs. Truancy

Educational neglect must be differentiated from truancy (a status offense).

- When a child is continuously absent from school through intent or neglect of the parent or caretaker, there is **educational neglect**.
- When a child is absent through his/her own intent, this is **truancy** and not reportable as child abuse/neglect.

Related Subject: Missouri Department of Elementary and Secondary Education – Compulsory Attendance and Part-Time Public School Enrollment: http://dese.mo.gov/schoollaw/freqaskques/CompAttend.htm#1

Screening in or Screening Out Educational Neglect Reports

The Child Abuse/Neglect Hotline Unit may take reports of educational neglect for children up to the age of 17, unless there is credible information such as from a school reporter who has verified that the subject child has completed 16 credits toward graduation, the report will be screened out.

It is possible that many callers to the CA/N hotline may not have information available at the time of the call about the child's credit toward graduation. In such cases the call will be screened in as a report; however the family assessment/investigation worker will need to verify the child's academic credit status with the school early in the process in order to determine whether the report meets the criteria for educational neglect.

If a family assessment/investigation worker verifies with the school district that an alleged victim of educational neglect has completed 16 credit hours toward graduation, and there are no other allegations of abuse neglect regarding any child in the household, the report may be concluded as an inappropriate report.

Related Subject: Section 2, Chapter 4.1.11 Inappropriate Report Conclusion Code (G)

The Child Abuse/Neglect Hotline Unit may screen out some calls that based on information indicating it is a case of truancy rather than educational neglect.

Home Schooling

Home Schooling is when a person responsible for the care, custody, and control of a child is educating that child at home. **Home schooling does not constitute educational neglect**, however many times during the investigation/family assessment process CA/N reports accepted as educational neglect reports are learned or found to be home schooling. In such cases the worker will need to rule out educational neglect by verifying that a child is being “home schooled”.

Related Subject: Missouri Department of Elementary and Secondary Education – Home Schooling Information:
<http://dese.mo.gov/schoollaw/HomeSch/homeschool.htm>

Related Subject: Section 2, Chapter 8.3 Educational Neglect Reports Learned or Found to be Home Schooling

2. Indicators / Characteristics of Educational Neglect

The indicators of child abuse/neglect vary. No child or caretaker will exhibit all of the physical or behavioral indicators listed, and some of the indicators are contradictory. The behavior of an abused or neglected child and other family members may be sporadic and unpredictable. Indicators should be used only as a general guide. The presence of multiple indicators or the pervasiveness of any one behavior indicator warrants close scrutiny by the worker.

- A child being held responsible for the care of other children during the school day while the parent works.
- A parent who is unable to get the child fed and dressed in time to attend school.
- Failure of parent to obtain and /or cooperate with special or remedial instruction for the child when recommended and provided by the school and the child is not succeeding in current class placement.

Parental/Familial Characteristics

- Highly stressful family situations
- Single parent family

- Recent marital problems
- Insufficient financial and other resources for child care

Other Factors to Consider

- Parent has been advised by school personnel of child's excessive absenteeism/special educational needs.
- Parent is providing home schooling.
- Parent's religious practices prevent child's attendance in a public school setting.

3. Types of Evidence

Evidence is collected by Law Enforcement personnel, Children's Division (CD), and multi-disciplinary team members and used as both physical and credible verbal evidence to document the worker's investigative conclusion. Evidence for reports of educational neglect may include any one or all of the following:

- Child's Statement
- School Reports
- Academic Records (specifically current credit hours toward graduation)
- Perpetrator's Statement
- Juvenile Court Report
- Witness' Statement
- Interviewing the Child

Missouri State Statute does not require the division or law enforcement to notify the parent of the child prior to interviewing a child when the parent(s) are the alleged perpetrator(s), however pursuant to section 210.145.5 RSMo., **when a parent is not the alleged perpetrator, the division is required to contact the parent prior to interviewing the child.**

Related Subject: Section 2, Chapter 8.1 CA/N Reports Interview with Students at School Setting When Parents/Guardians Named as Alleged Perpetrator
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Visible Signs

Visible signs are those observations made by the worker during the course of the investigation. Visible signs include, but are not limited to: the size, shape, and

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location of an injury, behavioral indicators of family members, and physical condition of the family home.

Chapter Memoranda History: (prior to 01-31-07)

CD05-35

Memoranda History:

CD09-82

33: Emotional Abuse

1. Definition of Emotional Abuse

Emotional abuse is included in the legal definition of child abuse. Under Missouri law, child abuse is defined as, "any physical injury, sexual abuse, or emotional abuse inflicted on a child other than by accidental means by those responsible for the child's care, custody, and control, except that discipline including spanking, administered in a reasonable manner, shall not be construed to be abuse." §210.110(1) RSMo.

Emotional abuse is defined by case law as, "an injury to the child's psychological capacity or emotional stability, which is demonstrated by an observable or substantial change in the child's behavior, emotional response, or cognition, including anxiety, depression, withdrawal, or aggressive behavior." The court also held that the state could use witnesses outside of the mental health profession to present evidence that the child's injury resulted in an observable or substantial change in his behavior, emotional response, or cognition. *State of Missouri v. Moran*, WD 69397 (Mo.App.W.D. 2009).

In order for staff to be able to meet these elements, the record must contain documentation sufficient to answer the following questions:

- What evidence is in the record that shows that the alleged perpetrator had care, custody and control at the time of the incident?
- What evidence establishes that this emotional abuse was caused by the alleged perpetrator?
- What evidence is in the record that establishes emotional abuse?
 1. Is there any evidence of an injury to the child's psychological capacity or emotional stability?
 2. What was the observable or substantial change in the child's behavior, emotional response, or cognition?
 3. Does the observable or substantial change in the child's behavior, emotional response or cognition, at a minimum, include anxiety, depression, withdrawal, or aggressive behavior?
- What evidence is in the record that the conduct was not accidental?
- What evidence is in the record that the emotional abuse was not a form of discipline administered in a reasonable manner? Or, were the actions of the alleged perpetrator such that the discipline exception does not apply?

Staff may use witnesses outside of the mental health profession to present evidence that the child's injury resulted in an observable or substantial change in his behavior, emotional response, or cognition. However, it would be best practice to use a qualified mental health professional if possible.

Related Subject: Section 2, Chapter 4,1,8 Reaching a Conclusion

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