JACKSON STATE UNIVERSITY | COLLEGE OF PUBLIC SERVICE | SCHOOL OF SOCIAL WORK

Conference Proceedings

Mississippi Child Welfare Institute

Editors

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2010

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Gwendolyn Spencer Prater and Mario Joaquim Azevedo

Table of Contents

FOREWORD

Historically, it is important to note that the Mississippi Child Welfare Institute (MCWI) began in the School of Social Work at Jackson State University in 2003 with the overarching goal of providing competency-based child and family welfare education and training for social workers and pre-service undergraduate and graduate social work students. The Institute supports the charge to promote the safety, health, permanency, and well-being for children in the child welfare system of care and preparing them for sustainability as they age out of and exit the system. Initial (start-up) funding was provided by the Mississippi Legislature with the strong support of Mississippi House Speaker, Charlie Capps, Democrat-District 28 (now deceased) from the town of Cleveland in the Mississippi Delta. Later, funding was provided from Title IV-E federal dollars through the Mississippi Department of Human Services, Division of Family and Children's Services, with strong support from Jackson State University's administration and the School of Social Work, College of Public Service. The MCWI's precursor was the Child Welfare Training Grant, funded by the Children's Bureau, U.S. Department of Health and Human Services, from 2000 to 2003, which provided tuition, monthly stipends, and professional development through the participation of students and administrative leaders in annual national child welfare and social work education conferences. A total of 26 bachelor-level students in social work were funded, primarily for the final two years of study towards the degree. In addition, with the initiation of Title IV-E support, the education of an additional 17 master of social work students and 16 bachelor of social work students were funded at Jackson State University from 2003 to 2006. Thus, a cadre of professional social workers was educated and made available for child and family service work in public and private agencies in Mississippi. Currently, the Mississippi Child Welfare Institute (MCWI) is supported by foundation funds and State and private partners, both national and local, that have a strong commitment to improving the plight of our most vulnerable children and families by ensuring their safety, health, well-being, and permanence in loving and protective families, whenever feasible.

Since 2003, the Institute has sponsored an annual child welfare conference. This year, we wish to welcome the publication of selected peer-reviewed articles written and delivered by research-scholars, scholar-administrators, and scholar-practitioners at several of the Mississippi Child Welfare Institute conferences held between 2007 and 2010. The opening article, by William Bell, consummate administrator and advocate for children and families, which he delivered as the luncheon keynote address, shares his extensive knowledge, insight, and vision for the well-being of America's children with special attention on meeting the needs of his home state's vulnerable children—foster children in Mississippi. Administrator Bell presents the challenge and provides elements required for success in this noble quest, including 7 necessary areas of focus: Political will, competent executive and mid-level leadership, clear plan of action with principles and standards, consistent and reasonable investment in frontline supervision and social workers, strong cross-systems partnerships, data-driven accountability and transparent reports of outcomes, and time. Mr. Bell concludes with the Casey Family Programs' 2020 Vision and how we, together, can ensure that "all the children are well." Doctoral student Michelle Salvaggio, discusses the very important issue of disproportionate representation of African American children in child protective services. The article explores parental mental

health evaluations, race, and placement decisions in protective services' cases, shares implications for policy, and argues for a firm stance by social workers in support of the rights of vulnerable families and children in the child welfare system. Dr. Irma Gipson's article follows with a focus on the plight of the homeless, convicted felons, society's role, and the impact on families and children, particularly those served in the child welfare system. Gibson also discusses trends and strategies for primary and secondary prevention, including the use of family and drug courts.

The article written by Professor Michael Weuste reports the findings of a research study conducted on the critical incident stress for child welfare workers. His study concludes that workers do have significant stress symptoms when experiencing critical incident stress or vicarious trauma while exposed to traumatic events occurring in their relationships with the clients they serve. The author suggests that there is institutional resistance to external assistance in normalizing the critical incident response and accepting the need for debriefing. The author discusses his perceptions of the "closed child welfare system" and the reasons for the resistance to "outside" influences and intervention. He also provides implications for the need to change the culture of the organization to include more supportive supervisors and other workers and increased agency openness to the inclusion of outside resources.

The "Art and Science of Effective Direct Practice Supervision" article focuses on the importance of effective practice supervision in the education of social work students. It emphasizes the need to translate theory into practice in a supportive supervisor-student relationship and positive agency environment. Clinician Barbara Smith and Professor Gwendolyn Prater further discuss the significance of incorporating adult-student learning styles, the learning goals and agreement, including specific activities and tasks, weekly individual (set-aside) time for supervisory meetings with the student, and on-going evaluation for effective direct-practice student supervision. Constructive approaches to supervision and evaluation along with responsibilities and rewards conclude the manuscript.

Professor Marian Swindell discusses the innovative approach to using equine therapy with at-risk children as an effective intervention program and notes that this is an untapped resource for social workers in practice. Swindell reviews research studies that indicate the profound effect of therapeutic riding with a variety of sub-groups of children, including those with attention deficit hyperactivity disorder (ADHD) and fetal alcohol syndrome (FAS). Among the benefits are improved self-esteem and better school performance. The author advocates that equine therapy be considered by helping professionals who wish to offer effective intervention programs to their clients.

Professors Tom Osowski and Carolyn Hester provide an interesting secondary data analysis of the impact of trauma on college student academic attainment following one of our worst natural disasters, Hurricane Katrina. The study reviews trauma theory and summed grade-point averages (GPAs) to determine if there is a difference in student GPA scores pre-disaster compared with post-disaster. Although the study's findings did not show statistical significant results, it did imply, consistent with other findings, that students, at least those pursuing undergraduate studies, were negatively impacted by human-caused traumatic events. The last article, written by Consultant Dorothy Adamson Holley, shares the author's personal reflections on self-care. Holly indicates that self-care is often a neglected topic, especially for social workers who have a strong tradition of caring for others' needs and problems while, too often,

neglecting their own. The author discusses the physical, intellectual, emotional, and spiritual dimensions of self-care and concludes with boundary and job-burnout relative to self-care.

It is our hope that the views of these distinguished authors will encourage social workers and our other professional partners to reflect on their roles as professional practitioners, administrators and academicians, always remaining life-long learners who are mindful of the need for empirical and practice-based research. It remains our continuous responsibility to ensure the translation of our best research knowledge into usable and effective best-practice for the individuals, families, groups, communities, and organizations we serve.

We would be remiss if we did not our current community partners: Children's Defense Fund, Mississippi Department of Mental Health-Bureau of Alcohol and Drug Use, Social Work prn, Another Chance Enterprise, Jackson Medical Mall Foundation, Mississippi Department of Health—Office of Child/Adolescent Health, Patient's Choice Medical Center, and, of course, our own, Jackson State University. We especially appreciate the Casey Family Programs and the Marguerite Casey Foundation that have graciously and generously supported the Mississippi Child Welfare Institute and the publication of these articles, in support of best and promising practices with our vulnerable children and families.

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"MISSISSIPPI, ARE ALL OF YOUR CHILDREN WELL?"

William C. Bell, MSW

Abstract

The following essay focuses on the plight of foster children not only in Mississippi but in the nation and argues that America, a country able to send man to the moon, and produce the fastest travel and the fastest Internet, can do better and significantly reduce the current number of 500,000 foster children. The author then suggests a seven-fundamental component to achieving this goal, namely: Political will, competent executive and mid-level leadership, clear plan of action and clearly articulated principles, application of reasonable and continuous standards, reasonable and continuous investment in frontline social workers, strong cross-systems partnerships, data-driven accountability and public reports on outcomes and time. The last section discusses the goals of the Casey Family Programs, which include the pivotal role of education and employment and attention to mental health care, all of which could reduce the rate of children in the foster care system by 50% by year 2020.

Greetings/Introduction

Good afternoon. It is indeed an honor and a pleasure to be asked to address you today. It is always a pleasure to be back home among family and friends. And it's an honor to address you on this occasion – Jackson State's fifth annual child welfare conference – a historically black university that has, for nearly 130 years, been on the frontlines educating and preparing African American leaders in just about every arena, from pro sports to education, science and national politics.

This is all the more fitting as Jackson State, the sponsor of this gathering, has as two of its core values: service and responsibility. That, after all, is ultimately what brings us all together in this room. Our common denominator – our common cause – is service to children and a shared sense of responsibility to ensure that all the children are well.

So, I ask, "how are we doing in our shared cause?" Mississippi, are all of your children well? Are all of your children well?

It is customary for the people of the Maasai ethnic group of East Africa to greet each other with "Kasserian Ingera?" Which means: "And how are the children?" Warriors and even the childless exchange this greeting. For it is understood that every one of the Maasai people, regardless of one's station or standing in the ethnic group, has a responsibility to the ethnic group's future – its children. Imagine the power of that greeting. Not "how are you?" But "how

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are the children?" It's indicative of the high value the Maasai place on the well being of their children. They know that if you take care of the children, society will flourish.

In the tradition of the Maasai people of East Africa, that's the question I ask you today. Mississippi, how are all of your children? Are all of your children well?

Setting the Context; Painting the National Picture

America currently invests more than $15 billion a year in its children's services system – a lot of money, but you'd be horrified at what we get in return for that investment.

The 15-year rate of return on that investment is:

- 14 million children confirmed as victims of child abuse and neglect;
- 9 million children entering the foster care system;
- 300,000 young adults aging out of the foster care system, mainly unprepared to live as stable productive adults, and
- 22,500 children dying as a result of child abuse and neglect.

Painting the Picture in Mississippi – 15-Year Return

Although Mississippi doesn't register in the top 10 or 20 on many of these issues, conditions are no less critical here. According to the Child Welfare League of America's fact sheet on Mississippi, the State of Mississippi spent $56.8 million on child welfare services in 2002. That includes federal, state and local dollars.

Despite notable progress in Mississippi's Program Improvement Plan, if things continue according to as-is – if nothing changes – in the next 15 years:

- 60,000 children in Mississippi will be confirmed as victims of abuse or neglect;
- More than 26,000 children will enter Mississippi's foster care system;
- 1,100 youth and young adults will age out of foster care, most of them unprepared and ill equipped for adult life; and
- 105 of Mississippi's children will die as a result of child abuse and neglect.

The Challenge

How come we can't get it right? We certainly know how to raise children. All in all, we've been doing a pretty decent job of it since humans first appeared on the earth. When you consider all the generations of billions of people over time, there's no doubt we've learned a few things about raising children. We know children flourish in loving, stable and nurturing environments. We also know what it takes to prepare youth for a successful transition into adulthood. Many of us in this room have dedicated nearly a lifetime ensuring that families are as sound and healthy as they can be.

How come, then, with all the resources we have available to us – even with all the resources, heart and good intentions in this room – we can't do better by this nation's half million youth in foster care?

How can this be the case in a nation of plenty, wealth, and even excess?

A nation that blazed the trail in developing instant communication and ready access to information via the Internet, cell phones, and satellites?

A nation that led the way in high speed jet travel so that I could leave Seattle yesterday — and be here with you in Jackson in a matter of hours?

A nation that put man on the moon and regularly flies man to outer space to build a space station that will be able to sustain human life in outer space?

How can we do all this, yet fail half a million innocent children in the foster care system?

Solution: Elements Required for Success

Like all the accomplishments and successes this country has ever achieved, improving foster care will require bold, daring vision and action. It may require that we work differently with each other and approach the work in a different way. Business as usual isn't cutting it. We have to be innovative, bold and courageous in redefining solutions for success.

If we are to create meaningful solutions, we must address the full spectrum of foster care – the front end and the back end. Our ultimate goal has to be to strengthen all families. Otherwise, we're just spinning our wheels, expending lots of energy, but getting nowhere – staying in the same place. We have to work together to invest in the front end – in vulnerable families – if we want to permanently reduce the number of youth growing up in foster care and leaving the system at age 18 without any family connections, skills and support structure.

Looking at the big picture in this manner – approaching foster care from a holistic, systems viewpoint – requires that all of us work together. Building strategic partners that will deepen the work and impact – working together strategically, in a coordinated fashion, leveraging each other's strengths, and approaching the issue from all angles – is the only way we'll create a more promising future for our youth.

In preparing for this talk, I went to the Mississippi Department of Human Services' web site and am well aware of your Program Improvement Plan and the challenges you face implementing it and other improvements.

As a native of this state and as president and CEO of Casey Family Programs, on behalf of the entire Casey organization, I extend an offer to work with you to improve Mississippi's foster care system. I extend an open invitation to meet with the Director of Family and Children's Services and the staff to discuss how we can work together to bring about the necessary changes.

This is much too big for either one of us to tackle alone. With an issue as complex as foster care and keeping families healthy, we need everyone's ideas, contributions and connections to create a more promising future for foster youth – and to build a better system of care in Mississippi.

The children of Mississippi are depending on us at so many levels – to be their advocate; their guardians; their protectors; to step in, step up to the plate and make things better for them.

There are seven foundational components that I believe must be in place for significant change and improvement to occur in the child welfare system. Each one of us should be able to see him or herself as a leader or agent of change in at least one of these seven areas.

First, **there must be a commitment of the political will necessary to sustain change.** The child welfare system must have the consistent, powerful and focused leadership of the chief politicians (whether it is the governor, a county elected official, or the mayor) to keep driving improvements forward. Child welfare must be treated with the same level of support and attention as crime, public safety, and education.

We must elevate the issue of child welfare. We need to change the discussion at the national level. We have to become the consciousness of the government. We need to have courageous conversations with lawmakers that will inform them and lead to well thought-out policies – policies that pave the way for developing a better system of care across this nation; policies that serve to align our work from the national level on down to the state, community and family or direct service levels.

I call special attention to public policy because of the far reaching impact it has on child and family welfare. Public policy sets the stage or platform upon which we can build foster care improvements and reform.

All three branches of government play a critical role in responding to the needs of vulnerable children and youth. Although, each branch – the executive, legislative and judicial – has a different function and area of responsibility, all three must work together as one to respond in a comprehensive, singularly focused, collective and meaningful manner.

For example, there can't be two parents with divergent philosophies on how to raise children without there being some degree of confusion, disharmony, disunity, and even dysfunction in that home. The two parents have to be in lockstep with each other, on the same page, and work together as one – as a whole.

The same is true of the government. All three branches, with their own defined niche or area of responsibility, have to work together and be in concert with one another.

All three have to see children and families as a priority.

All three have to be made aware of the needs of children and youth in foster care.

All three have to commit to improving the foster care system.

All three have to commit to making life better for this nation's foster care youth.

All three have to say enough is enough; mean it; and do something about it.

Government has responded to big, complicated issues in the past – the space race, the war on terror. Why can't our government respond to half a million youth in foster care in the same manner – with that same fervor, commitment, energy and focus?

I don't deny that much is being done. What I'm saying is that a piecemeal approach creates a system that, by its very nature, isn't set up to produce successful outcomes for youth in its care on a continuous and consistent or reliable basis.

This is not our best. The youth and children, who are in foster care through no fault of their own, deserve our best thinking – the best solutions we can offer.

We need a unified, systems-wide response from all three branches of the government, working together as one unit; and working with those of us at the state or county level of service provision.

Secondly, **there must be competent executive and mid-level leadership.** If you want to improve outcomes on the front lines of our child welfare system, those in leadership positions must have the experience and expertise to ensure that strategies and vision can be translated into action.

Third, **there must be a clear plan of action and clearly articulated principles and standards to guide the work.** Everyone – from the top of the organization to the frontline

caseworkers – must have a clear understanding of the plan, processes and desired outcomes. This creates a culture of trust, of consistency, of action and, most importantly, of accountability.

Fourth, **there must be a reasonable and continuous investment in frontline supervision and frontline caseworkers.** There must be a culture of support and success created with the people who are responsible on a daily basis for the health and well-being of the children in foster care. These frontline supervisors and caseworkers must know that they have the confidence and backing of leadership in doing their work.

These are the people responsible for connecting foster youth to strong, stable, loving, and permanent families as well as engaging youth, and whoever they consider family, in planning and exploring permanency options. This includes family-centered practices; safety-based services delivered in the home; reunification; and kinship care, which may or may not lead to legal guardianship and adoption.

The family and child are our first line of response in improving services and outcomes. If our business is about strengthening families, then families must be part of the solution. For who better to inform us than the families and youth in the child welfare system? Child welfare has to be about the children and their families.

Fifth, **we must develop and demand strong cross-systems partnerships.** Child welfare systems cannot do this work alone. The system must work in tandem – with local communities, law enforcement, education, community-based organizations, philanthropic organizations and others – to build comprehensive programs that improve the lives of children in foster care.

This includes having neighborhood or community-based services and safety nets in place to ensure all families are taken care of. It's about having the appropriate amount and mix of community resources to respond to families who are in, or are about to be in, a crisis situation. These are situations that could ultimately result in children being removed from their homes. Non-profit, faith-based and philanthropic organizations – and many other community service-based institutions, such as healthcare facilities and schools – play key roles. These organizations need to fully embrace the idea of building stronger communities by committing to strengthening families; and working together to provide a complementary array or a continuum of services and resources, at an adequate level, to families who may be in or near crisis.

If our work is all about families – keeping them strong and healthy – then we have no choice but to work toward creating communities and neighborhoods that have a wide range of health, mental health, developmental, educational, and social services to meet the diverse needs of its families and children. Without strong, stable, healthy families, there are no strong, stable, healthy communities.

Sixth, **we must create and enforce data-driven accountability, and publicly report on our outcomes.** We must have accurate systems to measure child welfare outcomes and hold us accountable for improving the lives of children in foster care.

And seventh, **we need time.** Systems don't improve overnight. We need time to get the right people in place, time to get the right resources aligned, time to test and make sure that we have the right systems and processes in place, time to form the right partnerships and collaborations, and time to see what is and isn't working.

Casey's Response-2020 Vision

Before I leave you today, I want to share with you Casey's vision of the future, what we are doing – working with others, including national, state and county government bodies – to ensure a better future for youth in foster care and those at risk of entering the system.

At Casey Family Programs, we're aggressively focusing on what we call our 2020 vision. In essence, in 15 years – by the year 2020 – we want to reduce the number of children in foster care by 50%, and we want to improve the safety and well-being of children in care by effectively addressing their educational, employment and mental health needs.

Education

We have to get better at helping youth in foster care do better in school. Education remains the **number one** path to improving one's life.

If we do a poor job of educating youth in foster care and neglect to take into account their unique educational needs, how can we expect their lives or the foster care picture in America to change for the better?

What chances for a stable, productive adulthood does a young child in foster care have when he or she is being shuffled from foster home to foster home; from neighborhood to neighborhood; from school to school?

Sadly, for whatever reason, this is what is happening to too many of our youth in foster care. Is it any wonder then, that at age 18, when they must leave the system, ready or not, they struggle to find jobs, housing or enter an institution of higher learning?

Casey's focus during the next 15 years is to:

- Work closely with those in early childhood education,
- Increase the high school graduation rate for youth in care,
- And increase the number of youth who earn two- and four-year vocational or college degrees.

The majority of teens in foster care – 70% – say they want to attend college. The sad reality is that about half that – 35% – actually do, and only 3 percent graduate. Recognizing the positive impact education can have on one's life, we must change that statistic.

Employment

Hand-in-hand with education is employment. The more education you have, the better the employment opportunities available to you; and the more work experience you gain, the more marketable you become for higher paying and more challenging employment opportunities.

Casey's focus in the next 20 years is to increase the employment experiences for youth in care and after they have transitioned out of care.

Youth aging out of the foster care system are often unemployed or underemployed in low-income jobs. Our Northwest Alumni Study, published two years ago, bears that out. The study data showed that:

- One-third of the alumni in foster care had household incomes at or below the poverty level. That's three times the national poverty rate.
- One-third had no health insurance – double the national rate for people 18 to 44 years of age.
- And more than one in five alumni experience homelessness after leaving foster care.

I find those statistics outrageous. And they should outrage you too. The more preparation and training young people receive through education and pre-employment skills development, the better equipped they will be to achieve economic success.

Strategies supporting the employment of youth exiting foster care must combine traditional employment and training programs with support services, such as counseling, peer support, child care, and transportation assistance.

We know that youth in care with minimal or no job experience may benefit from collaborations that blend social services with workforce development. We can and must do a better job of connecting foster care youth to these programs, and we need to start in the early teen years, so young people have opportunities and experiences to systematically develop strong work skills and habits.

Reducing the Numbers by 50 Percent/Prevention

Reducing the foster care population by 50% in 15 years is a mighty order. It's easier said than done, but it can be done. It must be done.

In most states, the data are already trending downward, but not fast enough. In Mississippi, the number has been fluctuating up and down over the years, but has shown a net decline since 1998. Regardless of this downward trend, the numbers must change. By all accounts, half a million children in foster care across the United States and more than 2,600 children in Mississippi are too many. This is not a satisfactory situation. We all should be discontented with those numbers; discontented to the point of doing something about it.

Reducing the foster care population means we have to draw a web of support and services around our communities' most vulnerable families – to help those families address the crises and stress they're in that, if left unattended, can overwhelm families, push them to the edge and put them at risk of having their children taken out of their homes.

Reducing the numbers also means placing youth in out-of-home care in permanent, loving and safe homes in a more timely manner so they aren't languishing in the system, moving from foster home to foster home. This includes timely, permanent, safe placements with relatives, guardians, adoptive families, and birth families.

Dollars saved through prevention efforts, should be strategically reinvested in the system to fund programs and services aimed at helping families stay intact.

Mental Health

The fourth component of Casey's 2020 vision is mental health.

It is absolutely critical that we address the mental health needs of our foster care youth for several reasons. Many youth end up in the foster care system because:

- Their birth parents may be experiencing mental health issues;

- Many are taken out of their homes because of abuse and neglect, which often manifest into mental health issues later on;
- It's a traumatic experience to be taken from your birth home;
  And many youth experience instability and insecurity while in foster care.

Our Northwest Alumni Study found that, compared to the general population, a disproportionate number of foster care alumni suffered mental health disorders. In fact, we found the proportion of foster care youth with Post-Traumatic Stress Disorder to be double that of U.S. war veterans. This statistic should remind us of the significant challenges these children face as well as serve as an incentive for us to ensure they have a healthy transition into adulthood.

Overall, children in foster care often suffer from poor health and have much higher rates of chronic physical disabilities, birth defects, developmental delays and serious emotional and behavioral problems than children from the same socioeconomic background who are not in foster care.

Many young adults, upon leaving foster care at age 18, enter jobs that do not provide health insurance or pay sufficient wages to allow them to purchase coverage independently.

In addition, there is a national shortage of qualified providers who can help young people with the unique developmental, mental health and substance abuse issues some foster youth face when transitioning from care.

Although federal budget cuts have resulted in additional challenges on this front, it is vital that each of us advocate for federal policies that give states the flexibility to connect youth leaving foster care to existing health programs such as Medicaid.

During the next 15 years, Casey will work to:

- Increase access to mental health services for youth while in foster care;
- Increase the number of youth with health insurance coverage, up to age 25 or, at a minimum, to age 21; and
- Decrease the number of youth who suffer from mental health disorders.

New York City Examples

I, in my heart, believe this is doable. I truly do. I would not be standing here before you if I thought we were in a hopeless situation.

While I was commissioner of New York City's Administration for Children's Services, we did what many thought was impossible. But we dared to not give up on the children; we dared to dream and believe that we could change the system and that we could positively change how youth experienced out-of-home care.

- At the end of 2003, New York City had 28,000 fewer children in foster care than in 1991.
- During the two-year period ending in December 2003, we saw a 22% reduction; 14% in 2003 alone – the largest yearly decrease in history.
- Our reductions in New York City drove reductions in the State of New York and contributed significantly to decline in the national numbers.

- We achieved these impressive numbers despite budget cuts, and while increasing the quality of services.
- In fiscal year 2003, discharges exceeded admissions by more than 3,000 children; one which was of the greatest positive differences ever.
- This is prevention and permanency at its best. These numbers highlight the success we achieved in reducing the foster care population through keeping families together safely, when possible; and completing adoptions by caring families when a return to a parent wasn't possible.
- In 2001, a critical milestone in New York's Children's Services was reached when, for the first time, more children were served by in-home preventive services than were in foster care.
- Nearly 34,000 children received preventive services in December 2003; that's about 12,000 more children than were in foster care.
- This is an indicator that New York successfully improved the quality of case practice, training, and supervision for child protective staff who are on the frontlines making the decisions to keep families together when safe and appropriate.
- We also worked with contract agencies and other partners to increase the availability of an array of preventive services; and to create a thoroughly integrated system of child protective and preventive services.
- During the two-year period, from 2002 through 2003, we reduced caseloads to half what they were in 1996.
- At the same time, we vastly improved the timeliness of our investigations, eventually getting to a point where we were able to complete almost 99% of all investigations due within 60 days.

This is just an example of what we can make happen when all of us make the safety and well-being of children a priority.

We can create the change in Mississippi. We can create the change I, and all Casey staff, envision for this country in 2020.

We can, and we must.

A Standard of Our Own

The current foster care picture is unacceptable. The future picture, if nothing changes, is unacceptable. If one of our own children or grandchildren or niece or nephew, were to be included in that picture, there's not a single one among us who would find that acceptable. We should find it equally unacceptable for someone's child to be included in that number.

We must hold ourselves accountable to do what we've been entrusted to do. These youth deserve the same opportunities and experiences that we'd like our own children to have. Through no fault of their own, they are starting out in life behind many of this nation's youth, with the gap continuing to widen the longer they stay in foster care. This should not be the case.

We–the administrators, practitioners, foster parents, guardians, policy makers, community leaders, family-interest organizations – must use the standard of our own.

An alumnus of foster care, Estakio Beltran, who is now a staff member for U.S. Sen. Maria Cantwell, from Washington State, spoke at our annual meeting last year. His remarks left an indelible impression on our 400 staff members. What Estakio said was this:

- He doesn't believe in resilience; he believes in you and me.
- He believes in our commitment to children in our communities, and he believes in our ability to make positive change happen for children in foster care.
- He said our children don't belong to a state government agency or a county – they belong to you and me.
- And most important of all, he said, "we are all your children, and we all need your help."
- And then he made one request: When it comes to children in foster care, he said, you must apply the "Standard of Your Own Children." And that standard is simply this: "If it's not good enough for your kids, it's not good enough for me."

At the end of the day, the litmus test should be if it's good enough for my own – for my children – if it meets the same standards I have for my own family; then and only then is it good enough for the children and youth in foster care. Anything less is unacceptable.

Closing

I began my talk by asking "Kasserian Ingera?" Mississippi, how are the children? When asked that, the Maasai respond to their fellow brethren with the words, "Sapati Ingera." Meaning "all the children are well."

It means that safety and peace prevail, that the priorities of protecting the young, the powerless, are in place. That Maasai society has not forgotten its reason for being, its proper functions and responsibilities. "All the children are well" means that life is good. It means that the daily struggles of existence, even among poor people, do not preclude proper caring for the children.

It is my hope that when I ask, "Mississippi, Kasserian Ingera? How are all the children? You will be able to reply, "Sapati Ingera." "All the children are well." "All the children are well." That is my hope for the entire nation. I want to get to that place where all the children are well.

Thank you, God Bless.

An Exploration of the Relationship Among Parental Mental Health Evaluations, Race and Placement Decisions in Child Abuse and Neglect Cases

Michelle Salvaggiois, MSW

Abstract

As a social problem, child maltreatment in the United States has commanded public attention and concern through an emphasis on the horrific reality of severe physical abuse and child deaths. Over half of all families currently involved with child welfare services have been the subjects of previous reports for child abuse and neglect. Among African American families, children are disproportionately represented among those affected by child protective services. This article explores the relationship among parental mental health evaluations, race and placement decisions in child abuse and neglect cases. It includes a systematic review of research on this topic, recognition of current gaps in the literature, and implications for policy. It argues that the social work profession must make a firm stance in support of the rights of vulnerable families to be treated in a fair and just manner in the child welfare system.

Introduction

Determining whether and when it is appropriate to reunify families that have been separated due to child maltreatment is a significant challenge to those involved in the decision-making process. In monitoring the family, child welfare workers must consider whether they believe the parents will maltreat their children in the future and if the children will be safe once returned to their families. Criteria for establishing when parents are fit to be reunified with their children vary among cases. Two fundamental concerns germane to determining parental capacity are the degree to which the child is at imminent risk of harm and if the caretaker exercises a minimally adequate degree of care (Benjet, Azar, & Kuersten-Hogan, 2003). Due to the inherent difficulty in defining such nebulous concepts, referring parents for mental health evaluations is one method of assessing parents' capacity to care for their children.

This illuminates how mental health evaluations have been utilized in the placement decision-making process. An ongoing assessment of competence must occur as to whether the parents have addressed the circumstances that precipitated the children's placement into foster care. In particular, this analysis will explore the effect of race on this process. This will include a systematic review of available research on this topic, recognition of current gaps in the literature and implications for policy.

Scope of the Issue

In considering the most recent child maltreatment statistics of 2007, the Child Abuse and Neglect Data System (NCANDS) reported that approximately 3.5 million children have been

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subjects of child protective services (CPS) investigations, and 794,000 children were estimated to have been victims of abuse or neglect. With regard to maltreatment type, neglect is by far the most common, comprising 59% of reports to State Central Registries. Eleven percent of children were determined to be physically abused, 8% were sexually abused, 4% were psychologically maltreated, and 13% were victims of multiple forms of maltreatment. An additional 4% of children experienced abuse coded as "other" depending on statewide classification systems. Circumstances such as abandoning or threatening to harm the child would meet such criteria (U.S. Department of Health and Human Services, 2007).

Impact of Race and Bias

Although African-American children comprise 15% of the U.S. childhood population, they make up 34% of the number of children in foster care (U.S. Government Accountability Office, 2007). Despite the racial disparity, research has illustrated no racial differences with regard to a child's risk of being abused (Ards, Myers, Chung, Malkis, & Hagerty, 2003). Once they are involved with the child welfare system, African-American children have poorer outcomes than White children. Rivaux et al. (2008) found that although risk scores for Caucasians were higher than for African-Americans, Anglo-Americans were more likely to have family-based treatment, and African-American families were more likely to have children placed into foster care. Once in care, African-American youths are likely to remain for longer periods of time than their Caucasian peers (McRoy, 2005). They are less likely to be reunified with their biological families (Connell, Katz, Saunders, & Tebes, 2006), and they have fewer chances of exiting foster care to adoption than Caucasian children (Barth, 1997; Potter & Rothschild, 2002; McRoy, 2005).

What research has illuminated is how various types of bias have affected African-American families' experiences with the child welfare system. Garland and colleagues (1998) examined the placement ratios of African-American children in California counties. The authors found evidence for the "visibility hypothesis" in that children are more likely to be placed into foster care when residing in an area where they are less representative compared to other ethnic groups. Labeling bias involves the differing perceptions of individuals and their increased propensities to seek out or presume abuse among particular groups of individuals. An incident of physical discipline could be interpreted as child maltreatment depending on the individual's perspective of that family (Ards, et al., 2003). Reporting bias indicates professionals' failure to inform the authorities of suspected abuse; their decision may be affected by variables such as a family's level of income. After the case has been reported, substantiation bias reflects circumstances in which child welfare workers establish findings based on inappropriate variables such as socioeconomic status or race (Drake & Zuravin, 1998).

Surbeck (2003) explored how child welfare workers assess children's attachment to their mothers and foster parents while in foster care. When considering race, results indicated that Caucasian caseworkers perceived African-American mothers as significantly less attached to their children. Workers reported that they observed mothers to have low occurrence of affection, acceptance and approval of their children. Furthermore, Caucasian workers were found to give Caucasian mothers more favorable assessments than African-American mothers. The author declared that individual characteristics of workers such as their cultural background, socioeconomic status, gender and sexual orientation influence how they perceive attachment in the parent-child relationship. Furthermore, differences in cultural identities of workers and

parents may indicate conflicting perspectives regarding expressions of attachment and the value given to specific behaviors such as signs of affection and tone of voice (Surbeck, 2003).

Impact of Poverty

Poverty has been established as a significant correlate in the child maltreatment literature (Faulkner & Faulkner, 2004). In the Third National Incidence Study of Child Abuse and Neglect, results indicated that families earning less than $15,000 per year were 22 times more likely to experience an incidence of child maltreatment than those with household incomes above that level (Sedlak & Broadhurst, 1996 as cited in Smith & Fong, 2004). Currently, more than 13 million American children reside in families with incomes below the federal poverty level, which is approximately $21,000 for a family of four. The number of children living in poverty is on the rise as there has been a 15% increase between 2000 and 2007. Minority children are disproportionately represented as approximately 34% Black, 29% Latino, 13% Asian, and 10% of White children live in poor families according to 2007 data (Fass & Cauthen, 2008).

The overrepresentation of the poor among families affected by the child welfare system raises questions about the relationship between income level and child maltreatment. The statistical discrepancies between socioeconomic groups may indicate differences in identifying and recognizing child abuse rather than its actual occurrence. Wealthier families may be capable of concealing maltreatment due to greater access to resources and less involvement with social services organizations (Downs, Moore, & McFadden, 2009). Conversely, indigent families are more likely to encounter public officials to have their concrete needs met. Due to mandatory reporting requirements, interactions with public employees place the family at increased risk of being reported to the State Central Registry (U.S. Government Accountability Office, 2007).

Legal Context/Family Court

With the passage of the Adoption and Safe Families Act in 1997 (ASFA, PL 105-89), the role of family court has significantly expanded in the context of child welfare practice (Hardin, 2005). This federal policy's core principle is the timely attainment of legal permanency for foster children; options include family reunification, adoption and legal guardianship by relatives. With regard to reunification with family, the law specifies that 'reasonable efforts' must be made to support this goal. States are to conduct the child's first permanency hearing within 12 months after placement. If the child has been in foster care for 15 of the most recent 22 months, court proceedings must be initiated for termination of parental rights (TPR). Mandatory TPR proceedings can be prevented if an exception exists. This includes children in relative kinship care, if the state agency has demonstrated evidence why TPR is not in the child's best interests, or if the parents were not provided with resources to complete services as described in the reasonable efforts requirement (Klee, 2002).

Though ASFA's goal of expediting permanency is laudable, the policy does not provide a clearly articulated framework of how family courts will adhere to these new timeframes. With limited resources, many jurisdictions have struggled to manage the legal responsibility for an increasing foster care population (Hardin, 2005). Families engaged in mandated service plans frequently experience delays to locate and participate in programs, long adjournments between court dates, and child protective workers' lack of organization. Workers are often not present for court nor prepared to discuss the family's status. From the parents' perspective, "child welfare

practice is received commonly as a police power function, controlling poor parents' lives, setting needless obstacles in their path, and unnecessarily delaying or thwarting progress" (Guggenheim, 2007, 508). Furthermore, there is considerable disparity in the legal representation of children and parents. In New York, there is the Juvenile Rights Division of the Legal Aid Society where lawyers attend an intensive training program and have a consistent impact on the formation of public policy. In contrast, parents' lawyers are members of panels with large caseloads and few resources (Guggenheim, 2007).

Mental Health Issues and Stigma

Child welfare and legal professionals are appealing to clinicians for parental competence assessments to guide the reunification decision-making process. Mental health experts, however, have called attention to the field's inadequacy of determining what qualities demonstrate a minimum threshold of parenting skills. Current models of assessment and standardized instruments are individually focused and less appropriate to evaluate the parent-child relationship and parenting skills (Azar, Lauretti, & Loding, 1998). Although parents may be initiating mental health services for the first time, in typical clinical practice clients must have a diagnosis of mental disorder in order to demonstrate both a rationale for treatment and to obtain third-party reimbursement for the service provided. The diagnosis of mental illness carries a stigma and that label triggers damaging, culturally stereotyped images (Rosenfield, 1997). Depending on the diagnosis assigned, parents may be perceived as being deficient in their ability to provide a basic standard of safety and care for their children. In addition, there is a lack of clearly defined, professionally validated criteria on which to interpret such reports, and mental health evaluations are open to a wide variety of interpretations (Benjet, et al., 2003).

Parental Mental Health Evaluations

Clearly the type of mental health evaluation and who is conducting it are essential in establishing its suitability for determining parental fitness. Different disciplines have varying conceptual frameworks that structure the assessment approach. A psychological evaluation traditionally utilizes a clinical interview and battery of intellectual and personality tests in an effort to assess cognitive functioning (Budd, Poindexter, Felix, & Naik-Polan, 2001). Therefore, it is crucial that the evaluation's principal objective is clearly stated, so the professional is gathering information relevant to determining parental fitness (American Psychological Association, 1999). In addition, a psychiatrist evaluates a client's mental status with regard to mood, presence of psychotic symptoms such as delusions or hallucinations, impulse control and need for medication to manage mental disorder. A parenting assessment team (PAT) evaluation involves extensive exploration of the functioning of parents and their children by a team comprised of a child development specialist, psychiatrist and psychologist. Such evaluations have been designed specifically for parents with a preexisting mental health diagnosis and utilize observation of interactions between parents and their children, clinical interviews and multiple sources of information (Budd, et al., 2001).

Identifying the core concepts and questions necessary to make a judgment regarding parental fitness represents one challenge for such decision-making. The identification of risk and protective factors offers one possibility for a conceptual framework to determine a parent's fitness. Risk factors occur at the individual, family, community and societal levels and function

as a hindrance to emotional well-being (Waller, 2001). At the individual level, risk factors include being socially isolated, demonstrating inadequate impulse control, poor self-esteem, difficulty managing parenting responsibilities, having unmet dependency needs with one's own parents, lacking empathy and having inflexible, inappropriate expectations regarding children's behavior. Furthermore, at the familial level, single-parent families comprised of adolescents that lack connections to extended family also pose significant risk for child abuse and neglect (Popple & Vecchiolla, 2007). In contrast, protective factors refer to those individual, familial and community aspects that function as a safeguard against the risk factors and their subsequent impact on an individual's well-being. Some examples include a solid sense of an individual's cultural identity, family cohesion and a firm positive relationship with family members' vocational/educational settings (Waller, 2001). Oyserman, Mowbray, Meares, & Firminger (2000) emphasize the importance of assessing the parents' capacity to be nurturing and receptive to their children's needs and whether they demonstrate the ability to manage their children's behavior in a developmentally appropriate and consistent manner. How the child responds offers insight into the quality of the relationship between parent and child. For example, does the child show affection towards her parent or appear fearful (Budd, Felix, Sweet, Saul, & Carleton, 2006).

Extant guidelines provided by the American Psychological Association provide an organizing framework for those engaged in parental evaluations to inform the placement decision-making process. Such criteria include the following: The best interests and emotional health of the children are of primary importance, the evaluation must address psychological issues relevant to the episode of abuse or neglect, that mental health professionals maintain a neutral perspective, use of various sources and methods to gather information regarding the case and that workers caution against making conclusions not sufficiently corroborated by the information gathered (American Psychological Association, 1999). Additional recommendations state that child protective and legal professionals provide evaluators with comprehensive data regarding case status and that the specific objective of the evaluation is clearly articulated. For example, the evaluator must be aware of what information is being sought about the parents' functioning, what are the context and circumstances that led to these concerns, and an understanding of how the assessment will impact case status (Beyer, 1993 as cited in Budd, et al., 2001).

In an effort to identify current trends, one study utilized a sample of 190 mental health evaluations randomly selected from three providers including the Department of Children and Family Services and the Juvenile Court Department of Clinical Services of Cook County, Illinois. The sample was predominantly African-American single mothers. The inquiry addressed which professionals are conducting evaluations, what are the procedures utilized, what referral concerns are addressed, how is this information used to assess parental traits and how do those attributes impact parenting capacity. With regard to who was conducting evaluations, the majority of evaluators held a Ph.D. (32%), Psy.D.(22%), or M.D.(15%); 8% of evaluators listed no credentials. Assessments were categorized as psychological, psychiatric, parenting assessment team (PAT), substance abuse, bonding/parenting and other evaluations such as those with a social worker or neurologist.

The overwhelming majority of assessments were psychological evaluations that occurred in an average of one office session. Conversely, PAT evaluations occurred over the course of at least 2 to a maximum of 18 sessions. The most frequently utilized procedures were projective and objective personality tests; there was significant usage of written records across all

assessment types except for psychological evaluations. Parent-child observations occurred infrequently across all evaluation types except for PAT assessments. Although descriptions of presenting problems were clearly stated in less than half of all reports, the most common issues addressed included family reunification, adoption and termination of parental rights. Furthermore, of interest is that one or more parental weaknesses were emphasized more frequently than strengths across all evaluation types. Currently, there are no formal standards that have been instituted for the purpose of evaluating the adequacy of parents' assessments in a forensic context. Therefore, the criteria represented in this investigation await validation by other researchers to evaluate the representativeness of these results (Budd, et al., 2001).

Assessment Tools for Psychological Evaluations

The Minnesota Multiphasic Personality Inventory-2 is one of the most commonly utilized instruments in psychological evaluations and is routinely employed in forensic assessments of parents involved in child abuse and neglect cases. The measurement tool has been found to be reliable and valid such that normative data scores have been documented. For parents involved in family court cases, the concept of self-presentation bias has been asserted as a concern among psychologists. In their efforts to regain custody of their children, caretakers are clearly motivated to portray themselves in the most positive manner (Medoff, 1999 as cited in Carr, Moretti, & Cue, 2005). Validity scales within the instrument assess individuals on the following domains: the L scale indicates a propensity to disagree with the presence of minor issues; the K scale implies slightly defensive responses toward questions; and the F scale suggests exaggerated expressions of symptoms, inadequate comprehension and hasty responding. In one study that examined the test results of a sample of 91 biological mothers, 48 biological fathers and 25 stepfathers, predominantly of European descent, the researchers found enhanced self-presentation on L or K scales, thus threatening the validity of about 60% of participants' profiles. It is the recommendation of this researcher, that prior to evaluation, parents are informed of the validity scales designed to identify positive self-presentation and that untruthful responding will be detected. Also, other researchers have suggested that courts are informed as to the possibility for parents "faking good" during the assessment process in an effort to regain custody of their children (Carr, et al., 2005).

With regard to the availability of reliable and valid assessment tools, the area of child maltreatment is in early development. The Child Abuse Potential (CAP) Inventory (Milner, 1986 as cited in Haskett, Scott, & Fann, 1995) represents one possibility for determining risk for physical child abuse. One study explored the instrument's level of external validity (i.e., generalizing the study sample's findings to a larger population) as the tool has been criticized due to previous testing with non-clinical groups of parents and college students. The sample was comprised of 41 parents (34 mothers, 7 fathers) drawn from a multifamily intervention group for abusive or high-risk parents. Sixty percent of the sample was African-American, and 40 percent were Caucasian. Scores on the CAP Inventory abuse scale were compared to parents' conduct during encounters with their children as well as the presence of individual risk factors correlated with abusive behavior. High risk correlates included level of parental distress, support of harsh disciplinary strategies, inappropriate expectations of children's behavior and poor problem-solving skills. Correlational analysis revealed a large effect size between CAP Inventory scores and observed parenting style as well as statistically significant results which support the construct validity of the instrument. Significant relationships were found among some (e.g.,

parental perceptions of internalizing, externalizing problems) but not all risk factors (e.g., poor problem-solving skills and belief in the value of corporal punishment) as noted by Haskett, et al., 1995.

Model for Functional-Contextual Parenting Assessment

Budd (2001) outlines three core aspects of assessing parental capacity in a clinical practice model. First, the evaluation should be entirely focused on parenting and quality of the parent–child relationship. An adult's individual qualities and characteristics need to be connected to particular features of parental capacity and incapacity, by demonstrating how they create a risk or protective factor, respectively, or how they facilitate or inhibit the parent from benefiting from rehabilitative services. Furthermore, the assessment should include a functional component that emphasizes actual parenting skills and activities of daily living. Evaluation encompasses a constructive process of recognizing skills and strengths as opposed to focusing on deficits. Finally, the author proposes the application of a minimally adequate standard of parenting. This definition is more consistent with the previous discussion as to how workers in the legal system seek to establish whether parents are able to provide a basic level of safety and care to the child instead of comparison to an optimal level of functioning. Furthermore, this necessitates careful consideration of what qualities are indicative of the minimum threshold of parenting skills essential to protect a child's well-being, given the context of the family's strengths and risks to the child (Budd, 2005). For example, maternal conditions such as mental retardation or depression pose potential risks to parenting capacity and child safety. These risks may be mitigated by factors such as the mother's understanding regarding challenges, treatment compliance and a supportive family network (Benjet, et al., 2003). Individual circumstances of the case must be considered when making assessments about minimally acceptable parenting competence (Budd, 2005).

Collaborative Programming

In an effort to explore the collaborative relationship between mental health clinics and family court, one study investigated the impact of mental health evaluations on judicial outcomes in child abuse and neglect cases. The study sample included 59 evaluations of single mothers considered to be of elevated risks with significant rates of family instability, domestic violence and substance abuse. Assessments were conducted at the Family Court Clinic (FCC) of Toronto. Located within an urban psychiatric hospital, the FCC performs court-ordered evaluations of the parents and children to inform the placement decision-making process. With regard to placement, study findings indicated significant correlations among dispositions recommended by child protection workers, the FCC and the judicial system with regard to preserving the family and parental rights (Butler, Atkinson, Magnatta, & Hood, 1995).

When there were discrepancies among evaluation dispositions, the researchers discussed the difference in roles of the three systems. Child protective workers (CPS) are frequently in open conflict with the interests of the parent as the child's interests are paramount; CPS workers are concerned with the potential for continued abuse. Conversely, mental health clinicians engage families as an objective worker assessing what is in the child's best interests with less emphasis on the child's imminent safety. Incongruities between child welfare and FCC proposals tended to revolve around the issue of whether or not to preserve the parent-child relationship. Disagreements among the judicial system and the other organizations were

potentially impacted by theoretical differences between mental health practice and the law, differential influence of the court's concerns and parental rights, and the presence of additional information being available to judges when they make their ruling (Butler, et al., 1995).

Models that actively promote collaboration in child welfare decisions exist in a number of states. In Kentucky, the Comprehensive Assessment and Training Services Project has been instituted. This calls for the participation of child welfare workers, court personnel and clinicians in the service of systematic court-mandated, forensic evaluations. The multidisciplinary team makes use of a triangulated methodology so that multiple individuals conduct evaluations at the family's home, in the office, and at the child's school (D'Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005). Also, team members review documentation such as standardized assessments of functioning and family history. The finished document is provided to CPS workers prior to court hearings to enhance judicial decision-making and expedite permanency. Eligible families are those coping with an indicated case of child maltreatment. The researchers present an intriguing collaborative service model that has yet to be comprehensively analyzed to understand potential effects on permanency for children in foster care (Sprang, Clark, Kaak, & Brenzel, 2004).

A similar initiative was evaluated in Chicago's Cook County Juvenile Court. A three-year, longitudinal study compared this pilot clinic service with two existing providers of forensic evaluations for parents involved with family court proceedings. The researchers analyzed the ability of each program to systematically conduct evaluations that include characteristics from the forensic literature (i.e., multiple sessions, settings and sources) and whether clinical information was delivered in a timely manner on a consistent basis. The pilot clinic delegated responsibility among four different departments of clinical coordination, education and resources, administration, and program evaluation. The education unit had responsibility for training court and clinic personnel on the procedural aspects of the program such as services offered and protocol for assessment. Program evaluation provided a system of accountability that documented client outcome. The researchers found that the pilot clinic providers completed evaluations substantially faster than the other treatment providers. Assessment of whole family functioning was limited, however, because parents were the only family members evaluated under this model (Budd, et al., 2006).

In North Carolina, the Durham Family Initiative (DFI) is a comprehensive system of care for families. The program's main objective is to reduce the community's child abuse rates by 50% over a 10-year period from 1999-2009. One of the core objectives is to screen every pregnant woman in Durham for risk of child maltreatment as a primary prevention effort. The measure considers domains of functioning such as parents' ages, employment, quality of their relationships, substance use, presence of physical or mental health issues, level of social support, family structure, and previous involvement with CPS (Dodge, et al., 2004).

According to preliminary data, the program is currently screening pregnant women at two gynecological clinics that serve a predominantly low-income population, and this protocol is utilized to link women to appropriate services such as mental health treatment or parenting skills training. In addition, DFI is incorporating a home visitation program targeting pregnant women deemed at risk for maltreatment due to low level of social support, stress or other factors. Professional family support workers utilize an educational model that focuses on parents' development of skills to nurture child development, provide information regarding health and safety, and attachment. Furthermore, in a tertiary prevention effort, the DFI Parent-Child Support Program works with families with a history of CPS involvement. The goal is to prevent

recurrence of abuse or neglect by strengthening the parent-child relationship with the assistance of a licensed therapist. As of 2006, findings have indicated that the rate of substantiated child maltreatment in Durham has decreased by 37% percent. This is in comparison to 5 other counties that have demonstrated a 14% decrease, and in considering the entire State of North Carolina, there has been a 21% decrease (Dodge, 2006). As there could be many spurious explanations for the decrease in substantiated child maltreatment rates, it is essential that the researchers rigorously evaluate the mechanisms by which this phenomenon is occurring.

Due Process and Implications for Social Policy

It is essential for mental health professionals working in conjunction with the family court to make a firm stance supporting the rights of vulnerable families. The concept of due process refers to the procedures that impact decision making in the forensic context. Fox (1997), as cited in Fondacaro, Slobogin, & Cross (2006), describes it thusly:

> It is a delicate process of adjustment inescapably involving the exercise of judgment by those whom the Constitution entrusted with the unfolding of the process…. The precise nature of the interest that has been adversely affected, the manner in which this was done, the reasons for doing it, the available alternatives to the procedure that was followed, the protection implicit in the office of the functionary whose conduct is challenged, the balance of hurt complained of and good accomplished – these are some of the considerations that must enter into the judicial judgment (pp. 968-969).

The creation and implementation of a standard of care of forensic mental health assessments is a critical step toward ensuring due process for families involved in the child protective system. To have a standard of care in existence certifies that workers are adhering to minimally adequate standards of professional behavior. Furthermore, individuals would have a point of reference to hold forensic mental health professionals accountable in a court of law and have a recognized procedure for filing malpractice claims for inadequate care. Conversely, the standard of care would safeguard forensic mental health professionals from unfounded assertions of misconduct (Heilbrun, DeMatteo, Marczyk, & Goldstein, 2008).

In the discussion of due process, it is vitally important for professionals to validate and facilitate a dialogue regarding the inherent imbalance of power in the child protection system. In discussing the social problem from a conflict perspective, for example, child maltreatment arises in the context of the oppression and exploitation of particular groups. Individuals and groups in positions of power manipulate their location in the stratified, societal structure and create poverty, prejudice, subjugation and delinquency in the process. The real issues are rooted in the implications of being a member of an exploited group that is being manipulated by those in positions of power. Social issues result from individuals being deprived of a sense of control over their lives, an inability to assign meaning to one's own constructive efforts and not being a participant in the creation of change but only being subjected to the consequences of the changes (Widdison & Delaney, 2001/2002). Therefore, under the guise of protecting vulnerable children, the child protective system is utilized as an instrument of the state to exert power over exploited groups (e.g., the poor, women, individuals of color) and to maintain them in their subjugated position. This is but one quite radical perspective, however, but one need only consider

anecdotal experiences of parents discussing what it feels like not to have a voice in this process. Despite how the parent may feel about mental health evaluations or other recommended services, she must demonstrate that she will do whatever is necessary to regain custody of her children.

In the absence of standardized guidelines, it is essential for judges to be educated on the strengths and limitations of mental health evaluations. For example, the judge could interpret assessments in consideration of their adherence to recommendations in the forensic literature. It is absolutely critical that aspects such as the reason for referral, number of sessions, credentials of the evaluator, procedures utilized, use of collateral sources and description of how emotional functioning is related to parenting capacity are clearly stated for the judge to critique the utility of the assessment (Budd, et al., 2001). Furthermore, expansion of programs such as the court-based clinic model delineated in Budd, et al. (2006) warrants a closer examination as to how the forensic evaluation process can be streamlined in the child welfare context. Furthermore, such a model holds the potential of enhancing compliance of parents with services as referrals are centralized to specific locations. Parents seeking their own services are at the mercy of their insurance company since a mental health diagnosis is required for service reimbursement.

On an individual level, there is much that mental health professionals can do to improve clinical practice with families involved with the child welfare system. In consideration of the racial disparity of children in foster care, it is essential that workers receive ongoing training in an effort to become culturally competent. For example, workers could become more well-informed in the culturally normative child-rearing practices of the different racial/ethnic groups encountered in practice. They could gain knowledge regarding demonstrations of affection, discipline and more general forms of communication, including nonverbal interactions. A clinician's continuous development and recognition of personal biases is crucial to inform as objective an assessment as possible.

There must be recognition of the severe damage that has been inflicted as a result of the often toxic relationships between families and child protective services. Transparency is one possibility to demystify the process of mental health evaluations. Clinicians must conduct psychoeducation with participants as to why the court is making the referral (if known) and the procedures of the assessment such as asking questions in a clinical interview, administering standardized measures, or observing parent-child interactions. Also, clients should have access to their records so as to be aware of what is being documented and how the information is organized. Furthermore, it is my opinion that the family courts, particularly, take notice of evaluations from workers serving therapeutic roles with the family. Although this suggestion is in stark contrast to guidelines published by the American Psychological Association (American Psychological Association, 1999), this researcher believes that a therapist with an existing relationship with the family is strategically positioned to offer insight as to parents' capacity. Over time, a therapist is able to view many aspects of the parents' functioning that is not possible in several office sessions. The therapist is able to track attendance to and priority given to treatment, parents' ability to respond to therapist's suggestions for improvements, how parents and children interact with one another, and motivation for change. It is the prospect of whether parents can change their behavior that determines the likelihood that they will be reunified with their children.

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The Plight of the Homeless, Convicted Felons and Society's Miscarriage of Justice: It's a Family Affair

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Abstract

There is a critical need to explore the issue of homelessness from a systemic and contextual perspective in hopes of decreasing the literature gap that presently exists particularly in regards to African-American males and homelessness. This paper will address the precipitating factors of homelessness, the plight of convicted felons, and how these major issues have a direct economic and social impact on the children and families who are affected by poverty and served by the child welfare system. Innovative trends and strategies geared towards primary and secondary prevention utilizing family and drug courts are also briefly referenced.

Introduction

When President Lyndon Johnson declared a "war on poverty" in 1964, the homeless did not appear in the nation's vocabulary, except perhaps as "bums" or "hobos." The visibility of homeless people increased during the late 1960s and early 1970s, when nearly a half-million hospital beds were closed nationwide in state-run mental hospitals, and their occupants were shipped for community care to neighborhood-based institutions. Unfortunately, a great many of the evicted wound up without shelter on city and suburban streets (Marciniak, 2001). Ever since that de-institutionalization, the number of homeless (both the mentally ill and others) has continued to increase, according to the National Law Center on Homelessness and Poverty (1999). The U.S. Department of Housing and Urban Development has provided more than $1 billion yearly to fund programs for them (Marciniak, 2001).

In the healthcare for homeless veterans program at the Atlanta Veterans Affairs Medical Center, the astonishing number of African-American males who repeatedly sought shelter and services was disturbing. It was this phenomenon that motivated the dissertation study: An Analysis of Precipitating Factors Among Homeless African-American Veterans. Many of those who sought services were in need of more than the basic necessities of life. Because homelessness signals deeper problems in many cases, persons who qualify as homeless, often times need more than just housing. The analysis of the precipitating factors research is just the beginning of what appears to be a critical need to explore the issue of homelessness from a systemic and contextual perspective in hopes of decreasing the literature gap that presently exists particularly in regards to African-American males, homelessness, and child and family welfare.

Paradoxically, current public policy at the city and state levels actually generates homelessness. For example, 16% of the nation's mentally ill are likely to be imprisoned, according to a U.S. Department of Justice study released in 1999. Only a minority of those imprisoned are given treatment. Furthermore, upon release, they are seldom referred to local

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institutions for medical or mental health treatment. Many become homeless, deteriorate, are re-arrested and then return to jail. Unless this predicament changes dramatically, no decline in the number of persons without shelter can be expected (Marciniak, 2001).

"We have done a terrible job in this country since we de-institutionalized [the mentally ill] in the 70's," says Dean Wright, a homeless expert at Drake University in Des Moines, Iowa. "We just did not provide care to the people that needed care, whether
it be medical care, mental health, or substance abuse treatment; and without it, people end up right back in prison or out on the streets" (Marks, 2000).

Homelessness is a very complex and challenging social problem that has not enjoyed widespread popularity as a topic of interest among social scientists and policy analysts. Included among the reasons for this limited concern is the continuing debate about how to define homelessness and which enumeration methodology best ensures an accurate count and description of the affected population (Dail, 2000).

The expression "homeless individual" does not include any individual imprisoned or otherwise detained pursuant to an act of congress or state law. This definition primarily targets the literal homeless and those in urban areas; it is legitimately questionable when considering rural homelessness, which tends to be characterized by overcrowding due to doubling up with other family members or living in substandard housing because nothing else is available in the rural community (Dail, 2000).

According to Marks (2000), many believe it is time for a new approach to address the root causes of the problem. Reports estimated that on any given night in America, anywhere from 700,000 to 2 million people are homeless. Homeless statistics show the number of homeless has remained [persisitently] high. Homelessness in America persists in part because many urban areas remain economically depressed, housing costs have risen rapidly in the past decade, and wages for lower skilled workers have remained stable (Burt, Aron, and Lee, 2001).

The most proximate cause of homelessness in America is poverty. Statistics show between 20%-30% of homeless families surveyed in 1996 said they had gone without food for part of the previous month (Burt, Aron, and Lee, 2001). The homeless also face persistent deprivation and constant threat of harm. They spend more time in the hospital and in jail than their poor counterparts. The majority are victims of violent crimes, and one fourth lack needed medical care (Burt, Aron, and Lee, 2001). Children in homeless families do worse in school and have lower attendance and more long-term absences (National Alliance to End Homelessness, 2001).

Although single men constitute about 60% of the homeless population, families make up about one-third of all homeless and are the fastest-growing group of homeless. The homeless elderly will also be an important group as America ages in the next decades (Rosenheck, Bassuk, and Salomon, 2001; Burt, Aron, and Lee, 2001). Although about 70% of the homeless live in central cities, rural homelessness is a hidden problem. The rural homeless are more likely to be families that are homeless for shorter periods of time, often as a result of domestic violence (Singleton et al., 2002). One of the hardest groups to reach, however, is the one-fourth of the homeless who have been homeless for at least five years (Burt, 2001).

According to Schwartz and Carpenter (1999) in most cases, the stated causes of homelessness are superficial. Homelessness, in reality, is strongly correlated to structural factors such as employment opportunities and the availability of low-cost housing. African Americans tend to be disproportionately affected by such structural inequalities. Thus, ethnic or racial status may be a proxy for economic vulnerability to homelessness (Whaley, 2002).

Regarding the political response to homelessness, the Stewart B. McKinney Homeless Act (PL100-77) was the first and remains the only major federal legislative response. Since the passage of the McKinney Act in 1987, the McKinney Act programs have been expanded, and funding has significantly increased. However, McKinney programs now face new challenges as homelessness continues to persist unabated across the country (National Coalition for the Homeless, 1999).

The McKinney Act has created valuable programs that have saved lives and helped hundreds of thousands of Americans to regain stability. However, evaluations of the program have found that the resources allocated to the McKinney programs are insufficient to meet demand, and that lack of adequate funding limits the programs' success. While inadequate funding clearly impedes the effectiveness of the McKinney Act programs, the McKinney Act's greatest weakness is its focus on emergency measures. It responds to the symptoms of homelessness, not its causes (National Coalition for the Homeless, 1999).

The McKinney Act was intended as a first step toward resolving homelessness; in the absence of legislation containing farther reaching measures, homelessness has only increased as a result. It was and remains, landmark legislation. The programs created by the McKinney Act are needed now more than ever, as homelessness shows no signs of abating. However, after many years of an emergency response to a long-term crisis, it is clear that only by addressing the root causes of homelessness including lack of jobs that pay a living wage, inadequate benefits for those who cannot work, lack of affordable housing, and lack of access to health care, will homelessness end (National Coalition for the Homeless, 1999).

Finally, according to a December 2000 report of the U.S. Conference of Mayors, single men comprise 44% of the homeless, single women 13%, families with children 36%, and unaccompanied minors 7%. The homeless population is about 35% white, 12% Hispanic, 2% Native American and 1% Asian and 50% African-American. The largest numbers of the homeless are concentrated among single men and African Americans.

Results

Research confirms that the social and economic status of the African-American male has deteriorated over the past quarter century. It is well documented that their rates of school failure, joblessness, homicide, incarceration, and other antisocial behaviors far exceed those of their white, Hispanic, and Asian male counterparts. In fact, the magnitude of these problems has led some researchers to characterize the African-American male as an endangered species (Johnson et al., 2000).

Forces that promote overt and covert discrimination in employment, housing, and access to health care resources marginalize their health status and reinforce the endangered species hypothesis. The increasing scarcity of African-American men and the imbalance in their ratio to African-American women severely threaten the vitality of the African-American family (Braithwaite, 2001). Homelessness is often accompanied by the aforementioned comorbidities. Furthermore, these factors have some direct implications for children and families, particularly those who are being serviced by the welfare system. Homelessness is a devastating experience for families. It disrupts virtually every aspect of family life, damaging the physical and emotional health of family members, interfering with children's education and development, and frequently resulting in the separation of family members.

The purpose of the author's initial study (2004) was to analyze precipitating factors among homeless African-American veterans. The primary focus of the study was to explore secondary factors associated with homelessness among a population of veterans. Specific family of origin factors as well as social support and family preservation factors and those pertaining to the veterans' individual resilience and problem-solving abilities were investigated. The goal was to determine how these factors might influence the social phenomena of homelessness among African-American veterans, including the duration and the number of episodes of their homeless experiences. One hundred twelve (112) survey participants were selected for the study utilizing non-probability convenience sampling. The survey participants were composed of consumers who sought services during the quarterly homeless service day sponsored by the Atlanta VAMC Healthcare for Homeless Veterans Program. The survey questionnaire consisted of 36 items that solicited demographic data, a military profile, psychosocial data, a homeless profile, family of origin, family/social support and individual resiliency data that were utilized on a four point continuum Likert scale. As a result of bivariate analysis utilizing multiple regression analysis (MRA), the findings indicated that homelessness among African-American veterans in this study did not appear to have a statistically significant relationship to an unstable childhood, a supportive family or individual resiliency. However, the data indicated that significant, although minimal relationships do exist between the independent variables of family/social support and family of origin and also individual resiliency and family/social support.

The final results from this study prompted the author to further explore the possibility of additional factors that appear to disproportionately affect the homeless status of not only African-American veterans, but the overall homeless population in general. Upon reviewing additional literature, the variable pertaining to the criminal status of the homeless appeared to be of interest. In a study by Benda et al. (2003), crime was studied among 188 homeless persons who were in a Veteran Affairs Medical center program for substance abusers. The purpose of the study was to find out: (a) what proportion committed crimes and (b) what other problems, relational factors, and other personal attributes predict crime. Data indicated that 27% of these homeless veterans committed nuisance offenses, and 41% had committed crimes in the past year. The study found that physical and sexual abuse before 18 years of age increases the odds of committing crimes, whereas self-efficacy, ego integrity, and resilience decreased these odds. The literature frequently referenced legislative, economic, historical and other disadvantages and barriers faced by the African-American male that reveal serious miscarriages of justice and are possibly perpetuating the difficulties and challenges already faced by those who have been convicted of felonies, served their time and repaid their debts to society. Could this issue have a direct correlation to the high numbers of homeless among the African American population? Could this be correlated to the high numbers of children of color that are represented in the child and family welfare system?

The Felony Factor and the Impact on Children and Families

According to Bontrager (2006), the convicted felon label brings forth a host of personal and legal limitations that restrict an individual's ability to participate in social life. On a personal level, the label has the potential to stigmatize the individual and reinforce the criminal identity, both of which influence future criminal behavior (Lemert, 1967; and Lofland, 1969 as cited in Bontgrager, 2006). There are also many barriers faced by convicted felons because state and federal law rescinds many of the rights and privileges that they enjoyed prior to conviction.

Additionally, the impact of race, ethnicity and gender on adjudication withheld has very practical consequences – both for those who do and do not receive this beneficial sentencing decision and for society – as well as theoretical implications. In practical terms, those who have adjudication withheld are able to avoid all of the "collateral consequences" associated with the label "convicted felon," despite the fact that they have been found guilty of a felony offense by a judge or jury. As Bontrager's (2006) research has shown, it is whites and women who are most often able to escape the "disabilities" of formal adjudication. These individuals are more likely than blacks, Hispanics and males to retain the right to vote, to carry a firearm, and hold or keep professional licenses and certifications. They can also legally assert that they have not been convicted of a felony on job and loan applications and other legal documents. On the other hand, men, Hispanics and blacks, are more likely to experience the "invisible punishment" associated with losing these rights and privileges, effectively eliminating their ability to participate in governance, get a job or acquire professional certifications or licenses within specific states. In fact, she states that convicted felons in the State of Florida lose all of their civil rights and suffer all of the stigmatization associated with this labeling event. It is highly possible that the laws in other states are representative of this stance also.

In addition to the "collateral consequences" for males, blacks and Hispanics, there is also a possibility that the stigma associated with the label of convicted felon may increase offenders' chances of recidivism. There have been few studies that assess, as this research has shown, that it is disproportionately blacks, Hispanics and males that are subjected to these costly personal and practical consequences (Bontrager, 2006). Bontrager's (2006) research further states that there are also potential social costs associated with excessively labeling blacks and Hispanics as convicted felons. Some theorists, including Bernburg and Krohn (2003), suggest that the penalties of labeling may be more salient for people with certain characteristics. Specifically they point to race and social class as attributes that may differentially impact a person's ability to resist a label and its consequences. If this is true then the "collateral consequences" of being labeled "convicted felon" may be more severe for blacks and Hispanics. In addition, both blacks and Hispanics are already at a greater social disadvantage with higher rates of poverty, single headed households and unemployment. These are risk factors that may increase one's susceptibility to homelessness.

Labeling someone a convicted felon increases impediments including the exclusion of drug and violent offenders from welfare assistance, food stamps, public housing and educational loans. These additional "disabilities" impede economic and personal success for many offenders and continue the cycle of poverty and deprivation that is common for many blacks and Hispanics in society. These social conditions not only impact those that must deal with them directly, but society as a whole (Bontrager, 2006). Additionally, and equally important, is the direct impact that this public health problem has on the child and family welfare system.

Homelessness severely impacts the health and well-being of all family members. Children without a home are in fair or poor health twice as often as other children, and have higher rates of asthma, ear infections, stomach problems, and speech problems (Better Homes Fund, 1999). Homeless children also experience more mental health problems, such as anxiety, depression, and withdrawal. They are twice as likely to experience hunger, and four times as likely to have delayed development. These illnesses have potentially devastating consequences if not treated early.

Often, children are separated from their parents when families become homeless. This poses serious risks to the safety of the children and the stability of the families (Doerre and Mihaly, 1996). In the absence of adequate resources to combat family homelessness, communities are faced with unwise and expensive interventions such as placing homeless children in foster care. Thus, the child welfare system comes into play and as research indicates, children of color are disproportionately represented in the system. The implications are cyclic in nature. Case and point: Children from homes with housing problems are more likely to be in foster care than children without housing problems (46% vs. 27%). These children are more likely to be "long stayers" in care compared to children from adequately housed families (U.S. Dept. of Health and Human Services, 1997). In terms of reunification, income and housing status are more important than substance abuse in determining whether children will remain with their families. (Jones, 1998 least 30% of children in foster care could return home if their parents had access to housing (Doerre and Mihaly, 1996.) If housing subsidies were provided for those families, federal, state, and local governments could save $1.94 billion annually (Harburger and White, 2004). However, research has shown that history has a way of repeating itself with homeless families whose children's adult experiences tend to lead to homelessness all over again. It is a family affair.

The saga continues. Currently, Blacks make up about 14% of the population, but they represent roughly one third of ineligible individuals unable to vote because of criminal convictions. There is great variance from state to state on this matter. Currently, 48 states practice felony disenfranchisement. The two who do not are Maine and Vermont (Massachusetts and Utah recently passed disenfranchisement into law through referendum). Of those 48 states (as well as the District of Columbia), 36 of them prohibit felon parolees from voting and 31 of those prohibit felon probationers from voting. Nine states allow voting for ex-felons after a waiting period. Lastly, there are seven states (three have limited restoration) that prohibit ex-felons from voting for the rest of their lives. Overall, there are approximately 4,700,000 Americans who are currently not allowed to vote because of such law (Bontrager, 2006). The implications of these laws impact the American society, they impact communities and they cut through the very fiber of what the basis of the family structure represents, stability and an early foundation that leads to the production of healthy adult citizens.

During the 1970s, African-American men were labeled an "endangered species." Thirty years later, African-American men face a multitude of health, sociopolitical, and psychological issues, and thus, they continue to be an "endangered species." One factor that could account for their increasing scarcity and absence from family life is that the number and percentage of black men in prison is higher than it is for any other racial or ethnic sub-group (Braithwaite, Hammett, & Mayberry, 1996, as cited in Braithwaite and Taylor, 2001).

Almost 2 million of the 72 million minor children in the United States have a parent who is currently incarcerated. Ninety-three percent of the incarcerated parents are fathers. Black children are nine times and Latino children are three times more likely to have an incarcerated parent than are white children (U.S. Department of Justice, 2000). According to Manza, 2002, (as cited in Hattery and Smith, 2007), the impact of incarceration can affect every aspect of the children's world. They are often emotionally traumatized. Physically, they are affected by economic changes. The spillover of incarceration affects the children's school performance, behavior, peer relationships, sense of self, and feelings about the future. Statistically, they are five times more likely to be incarcerated than other children. It is truly a family affair.

Social and Economic Implications

According to Braitwaite and Taylor (2001), although African-American men make up approximately 6% to 7% of the total U.S. population, they represent more than 60% of the two million persons under correctional supervision. African Americans are imprisoned at seven times the rate of whites. Thirty-three percent of black men between the ages of 20 and 29 are either in jail, on probation, or on parole (Whitehead, 2000 as cited in Braithwaite & Taylor, 2001). The research indicates that after being released from prison, because of systemic and contextual factors, many times convicted felons are sometimes forced to take on a life of homelessness, helplessness and hopelessness. Missing from this equation, in regard to the political solutions, is the impact that this problem has on children and families and the child and family welfare system.

A state representative of Texas, Terri Hodge, stated that many convicted felons get released and after leaving prison and serving their sentences they are cast back onto the street without a support system to help them make a transition back into society after years behind bars. With the greater concentration of former inmates ending up in major cities without support, many are homeless, unemployed and often end up in neighborhoods or environments that do not encourage law-abiding behavior. Coupled with these factors are the fear of failure, the requirements and pressures of paying probation fees and fines, and the problem of finding housing, employment and assistance without basic information assistance and support services. "We must find a way to curb and change these trends," she said. "It makes more sense to reexamine the current system and distribute the money better for treatment and services rather than continue to pay for more years of incarceration." Hodge added that each time an inmate returns to jail, it adds an extreme burden to an already taxed criminal justice system (African American News and Issues, 2007).

Speaking from an experienced legislator's viewpoint, Hodge further stated that for African-Americans leaving prison, it is an uphill struggle. Many are faced with the stigma of being a former convicted felon and end up living on the street or in a half-way house because of the lack of support from family and inability to rent an apartment or hold a job. "Time works against these men and women," Hodge added. "Many end up giving up and going back in to the system because it is easier to go back and get three hot (meals) and a cot than it is to make it on the outside." According to Hodge, support, treatment and recovery options offer hope and can help break the cycle by offering ways for former African-American inmates to rebuild their lives and family relationships. (African American News and Issues, 2007) this will be expounded upon in the conclusion.

Another perspective according to Hattery and Smith (2007) relates to the human capital concept. The prison problem means that an enormous amount of human capital is lost with the incarceration of African American men during their most productive years. These men learn few transferable skills while they are in prison, and when they are finally released, they are often useless to themselves and to others. One of the most obvious and devastating outcomes of incarceration on human capital is seen in the labor market. Protected by law, employers are allowed to ask prospective employees if they have a record of incarceration. Lack of stable and meaningful employment results in lack of crucial child support funds and other means of financial support for our children who are faced with being raised in single-parent families often under conditions of poverty. It is a family affair.

Although the inquiry of a felony record is legally justified, in some states and in some industries, it is noted that employers can also ask about misdemeanor records as well as arrest

records (with a conviction). In order to examine the impact of felony records on employment (Mukamal, 2004, Pager, 2003) as cited in Hattery and Smith, 2007), designed an experiment to test the effect of race and incarceration history on the likelihood of getting a "call back" after submitting a job application. The research results were terribly disturbing. In her study, which included only men, whites were more likely than blacks to be called back for an interview regardless of incarceration history. White men without a felony were, not surprisingly, the most likely to be called back of all groups. But the shocking finding from her research is that whites *with* a felony record were more likely to be called back than African Americans *without* a felony record. Less than 5% of African American men with a felony record were called back (compared to 15% of whites with a felony record). Incarceration is problematic for anyone, but the effects are devastating on the employability of African American men (Hattery and Smith, 2007). We must wake up America.

Strong families build strong communities and strong communities impact society in positive ways. Yet, research demonstrates that homelessness frequently breaks up families that may be separated as a result of shelter policies which deny access to older boys (age 12) or fathers. Many shelters are not able to accommodate intact families and have to separate families in order to house them (Wilder Research, 2003). Also, families who have experienced homelessness have much higher rates of family separation than other low-income families (Culhane et al., 2003). Twenty-two percent of homeless children are separated from their immediate family (Better Homes Fund, 1999).

Separations may also be caused by placement of children into foster care when their parents become homeless. In addition, parents may leave their children with relatives and friends in order to save them from the ordeal of homelessness or to permit them to continue attending their regular school. The break-up of families is a well-documented phenomenon: in 56% of the 27 cities surveyed in 2004, homeless families had to break up in order to enter emergency shelters (U.S. Conference of Mayors, 2004).

According to the report by the U.S. Conference of mayors (2004), it is cheaper to help families access affordable housing and provide supportive services in order to keep them together rather than placing their children in foster care. Sadly, many separated families are never repaired. Worse still, their children simply "age-out" of foster care never having been formally adopted; never having found a place to call home. Convicted felons, the disproportionate numbers of children of color who are being serviced by the child and family welfare system and the deterioration of the solid black family structure are factors that should be examined in the wake of addressing the plight of the homeless. Felony convictions and incarceration are a part of the equation that has been overlooked. It's time to seriously redo the math, rethink and revise the strategies and address these issues from a 21st century perspective. What does this mean?

Clemmons (2007) indicated that it is apparent within modern society that a severe and subtle issue, which has been ignored for decades, should now be brought to light and addressed. The matter is simple, yet so complicated in context and solution. It postures itself by and through the support of government demographics and statistical data, showing a disproportionate trend in the sentencing terms of African Americans, who have committed specific criminal offenses, to be more severe than those of all other races. This disproportionate abomination of the law has also fueled the already exacerbated, racial and ethnic disparities within the African American community. To determine an answer for this unjust trend requires a detailed answer to the fundamental question; What are the origins of this disproportionate sentencing system? An even

deeper question is when will the powers that be of the American society recognize the error of their ways? Until these questions are sincerely addressed, homelessness will continue to be a public health problem and it warrants further research in the area of the criminal justice system at a minimum.

Additionally, Mitchell (2007) conveys an interesting and valid viewpoint also. He states that, "When ex-felons have finished their time, they should have all of their rights automatically restored." "Now, my detractors would say, 'Does that mean if someone is convicted of a sex offense crime, they should be allowed to hold a job in an education-related field?' No ... there are conditions; however, a greater relationship between the nature of the offense and the restrictions being applied should exist." In examining the issue, Mitchell said his goal was to explore the "entire notion of citizenship and what it really means to be a United States citizen." He concluded the restoration of a cadre of rights is just as important as the right to vote. Restrictions only limit the quality of life and impede the successful reentry of individuals attempting to re-establish themselves in their communities.

Recommendations and Conclusion

More than 800,000 African American men are currently incarcerated in prisons or jails in the United States. Most of these men leave prison ill prepared to return to society as workers, or to reintegrate into family settings. Returning from prison is complicated by struggles in the housing and job markets. Exploration of drug laws and disproportionate incarceration rates, homelessness, and joblessness are factors that are crucial to understanding these numbers. Data from a community-based, qualitative study of African American men following incarceration provides a discussion of how incarceration influenced their return to family situations and supports the findings by earlier studies on the effects of homelessness and joblessness on individuals and families (Cook, 2005).

Effective action is urgently needed in the areas of housing, health care, employment, and education. It is truly a family affair whose affects have far reaching implications that have not been sufficiently addressed during the past. Entire families including our most precious resource, children are impacted, from their earliest stages until adulthood. Deep poverty and housing instability are especially harmful during the earliest years of childhood; alarmingly, it is estimated that almost half of children in shelter are under the age of five (Homes for the Homeless, 1998 as cited in Cook, 2005). School-age homeless children face barriers to enrolling and attending school, including transportation problems, residency requirements, inability to obtain previous school records, and lack of clothing and school supplies.

Parents also suffer the ill effects of homelessness and poverty. One study of homeless and low-income house families found that both groups experienced higher rates of depressive disorders than the overall female population, and that one-third of homeless mothers (compared to one-fourth of poor housed mothers) had made at least one suicide attempt (Bassuk et al., 1996). In both groups, over one-third of the sample had a chronic health condition. The alternative of continued social disintegration will have great consequences for the national health and welfare and makes this a problem which cannot be ignored. Only with policies aimed at providing the means and specialized programs necessary to attack these public health problems and their root causes will society's miscarriage of justice be contextually and adequately addressed.

Homelessness has now been on the American policy agenda for two decades. In 1989, when the Urban Institute published *America's Homeless* (Burt & Cohen, 1989), policymakers and the public may have expected, or hoped, that the crisis of homelessness could be resolved relatively quickly. The decade of the 1990s has not fulfilled that expectation. Programs and services to help homeless people expanded dramatically in the 1990s, just as they did in the 1980s. At the same time, visible homelessness in many American communities does not seem to have diminished. How are we to think about the persistence of homelessness at the end of a decade of unprecedented prosperity, and at the dawn of a new millennium (Burt et al., 2001)?

Because it is a public health issue as well as a social problem that is directly intertwined with the problems of incarceration and the child welfare system, homelessness will remain a complex matter; therefore, this aforementioned question is a complicated one that cannot be answered in simple terms. Given that homelessness stems, at base, from an inability to afford housing, the structural conditions of the economy, housing markets, labor markets, and related factors that influence people's ability to afford housing, must be considered. People's individual characteristics as well as ways in which the United States has chosen to address homelessness from the federal level must be examined also (Burt et al., 2001).

If innovative ways of serving the homeless is the key to making a difference in preventing future homelessness, an overhaul of the current way of providing assistance may be needed. This includes the implementation of needs assessments and serious program evaluation to determine if the measures that are in place are truly beneficial or just a band-aid solution to the problem and serves no purpose except to resolve short-term crises. Social workers and other advocates for justice will need to be equipped with knowledge and resources that create an environment which results in effective interventions and halts these visible political, social and economic injustices. Thus, effective clinical interventions and program evaluations cannot be implemented at a successful level without the support of policy makers. Support from those officials who are responsible for passing down the laws of society and for appropriating the funds that sustain these programs are crucial. Additionally, they must understand the effects that failing to provide assistance will have on the society as a whole.

In reference to convicted felons and how homelessness is impacted by this factor, there is a wide range of sanctions used by the criminal justice system to punish criminal offenders including death, imprisonment and community supervision. All of these sanctions involve a social institution exerting direct social control over an individual either through loss of life or liberty or via constant supervision. And even after a prison sentence or community supervision term has ended there are continuing penalties, for while a prison term may be completed, the label of "convicted felon" last a lifetime. The indirect consequences associated with a criminal label remain even after an offender has "paid their debt to society" because at every turn they are met with the obstacles created by being forever branded a felon (Bontrager, 2006). In the meantime, the homeless continue to suffer as well as their families, communities and society as a whole.

The historical nature of homelessness, in general, is a typical example of how ineffective funding, practices and interventions can affect the outcome of any attempts to decrease this public health and social problem. Policies to end homelessness must include jobs that pay livable wages. In order to work, families with children need access to quality childcare that they can afford, and adequate transportation. Education and training are also essential elements in preparing parents for better paying jobs to support their families. But jobs, childcare, and transportation are not enough. Without affordable, decent housing, people cannot keep their jobs

and they cannot remain healthy. Affordable housing is a key component to resolving family homelessness. Preventing poverty and homelessness also requires access to affordable health care, so that illness and accidents no longer threaten to throw individuals and families into the streets.

In conclusion, for unique populations such as veterans, felons and other incarcerated persons, the implications for failing to overhaul the criminal justice system and for failing to provide specialized assistance in the form of innovative programs such as drug courts, family courts and mental health courts that provide alternatives to jail and focus on rehabilitation, are only aggravating a problem that has grown bigger and more complex than anyone could have anticipated. Hodge and others want the emphasis changed from building more prisons to looking at rehabilitation options that would offer treatment alternatives and drug court monitoring to ease the burden on the system and allow non-violent offenders the opportunity to rebuild their lives (African American Issues and News, 2007). Additionally, funding of these unique and innovative interventions is crucial to longevity and success. Only concerted efforts to meet all of these needs will end the tragedy of homelessness for America's families and children.

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Critical Incident Stress For Child Welfare Workers: Does It Exist And What Can Be Done?

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Abstract

This article is a report of the findings from a formative study of 32 child welfare workers who identified themselves as having experienced a critical incident event related to their professional practice as child welfare workers. Workers received an inventory related to stress symptoms and an inventory related to styles of coping with stress. An interview was conducted related to these experiences. It was found that workers did have significant stress symptoms relative to these experiences and that they relied on avoidant coping strategies. It is suggested that, while a critical incident debriefing would be helpful, educating the child welfare culture through all levels of the organization, with particular attention to direct line supervisors, is equally important.

Introduction

Currently, little research has been conducted to address the particular experience, means of coping, and solutions to assist those who experience critical incident stress in child welfare. This paper is the result of a formative study regarding child welfare workers who had experienced a self-identified critical incident. The intention is to examine existing knowledge and theory regarding critical incident stress and expand the knowledge and techniques of critical incident debriefing to child welfare providers. Solomon (1986: 11) defined critical incident as "any situation in which one feels overwhelmed by a sense of vulnerability and/or lack of control over the situation."

Review of the Literature

Experiencing a critical incident may result in symptoms of critical incident stress for these workers. Workers can experience symptoms such as poor health, decrease in job performance, and violation of professional boundaries as a result of such incidents. Psychological distress in persons who are typically healthy and able to carry out daily functions and self-care may also result from such experiences.

Since the middle 1980s, there has been increasing awareness, development of interventions, and research devoted to the psychological effects of traumatic events on the individuals exposed to them. The resurgence of this interest is fueled by the same motivations reported by Rapport (1970): limited resources to provide treatment, greater demand for services, and need for briefer interventions. There has also been an increasing concern and need for interventions with those whose profession or occupational roles might expose them directly to such traumatic events. Two national events that brought focus to critical incident stress and debriefing involved the Oklahoma Federal building bombing on September of 1995 and the

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terrorist attacks of September 11, 2001. Lane (1994) noted that concern about critical incident debriefing for traumatic stress finds its beginnings primarily in the history of concern with post-traumatic stress disorder (PTSD) within the military. This military concern with war related stress dates back as far as the Civil War (1861-1865). Lane noted that some recognition of PTSD occurred on D-Day and rudimentary debriefings took place on the beaches of Normandy. By the 1960s, police psychologists had recognized the syndrome in the police force after the death of a fellow officer, and began to employ strategies of debriefing borrowed from the military. This interest continued in articles published in the 1970s with concerns that negative psychological consequences were occurring among emergency rescue workers as secondary responders to a traumatic incident (Lane, 1994).

The field of debriefing for critical incidents is heavily influenced by the evolving concepts of post-traumatic stress syndrome and, more recently, by concepts of acute stress disorder. The diagnostic criterion for acute stress disorder is found in the DSM-IV. It includes six major categories of symptoms:

A. The person has been exposed to a traumatic event in which both of the following occurred.
   1. Event or events that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others
   2. The person's response involved intense fear, helplessness, or horror
B. The event is persistently re-experienced in one (or more) of the following ways.
   1. Recurrent distressing recollections of the event, including images, thoughts, or perceptions
   2. Recurrent distressing dreams of the event
   3. Acting or feeling as if the traumatic event were recurring
   4. Intense psychological distress at the exposure to internal or external cues that symbolize or resemble an aspect of the event
   5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness as indicated by three or more of the following.
   1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
   2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
   3. Inability to recall an important aspect of the trauma
   4. Markedly diminished interest or participation in significant activities
   5. Feeling detachment or estrangement from others
   6. Restricted range of affect
   7. Sense of a foreshortened future
D. Persistent symptoms of increased arousal as indicated by two or more of the following.
   1. Difficulty in falling or staying asleep
   2. Irritability or outbursts of anger
   3. Difficulty concentrating
   4. Hyper-vigilance

5. Exaggerated startle response

E. Duration of the disturbance is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning DSM-IV (pp. 431-432).

Mitchell (1983) differentiated the experience of PTSD and critical incident stress (CIS). The reaction of PTSD is attached to those who are participants in the actual event while CIS refers to those who respond to the needs of the event. The primary concern regarding this dimension of critical incident stress refers to the experience and resulting symptoms for those Mitchell called "secondary responders." By secondary responders, Mitchell meant those individuals exposed to a critical incident because of their occupational role. Mitchell and Everly (1995: 271) defined a critical incident as "any significant emotional event that has power, because of its nature or because of the circumstances in which it occurs, to cause unusual psychological distress in healthy normal people."

Since the September 11, 2001, terrorist attacks, an increasing number of studies has begun to show a mixed sense of the effectiveness of debriefings for those experiencing a critical incident. In addition, soldiers who returned from the peacekeeping assignment in Somalia in 1994 were found to have not necessarily benefited from the use of such debriefings (Litz, 1997). Some evolving criticisms stemming from the use of debriefings after the September 11 attacks and the experience of such interventions with soldiers in Kosovo since the 1990s have been that such debriefings actually can induce symptoms by suggestion. In non-voluntary group situations, the intervention is thought to actually create a contagion effect or secondary crisis for those not directly involved in the events of the critical incident (Walling, 2003). Another criticism notes that a one-time intervention may not be adequate for all individuals and that more and alternative interventions may be necessary for some people. As a result of such criticism, it is now recommended that debriefings be voluntary and that assessment of the need for follow-up and alternative intervention be determined.

Various researchers report that not everyone is vulnerable to critical incident stress and that those who went through more training regarding reactions to trauma seemed to cope better (Harbert, 2003). In studies of the Oklahoma City bombing, however, 23% of civilians and 13% of firefighters suffered from critical incident stress (Walling 2003). These same studies indicate a need for scrutiny as to who might be most vulnerable to critical incident stress to address their needs more readily (Van Emmerick et al., 2002). The effect of a critical incident can be mediated by such variables as the objective and subjective severity of the incident, the temporal duration of the incident, and characteristics of the victim (perceived similarity of the victim to a significant other or self). Other influences can be personality of the helper, viability of coping strategies, ethical and spiritual concerns, and the depth of the relationship formed pre-critical incident (Lane, 1994.

Methods

In this study, several workshops were held throughout the state to educate workers about critical incident stress and the use of critical incident debriefing. Feedback from the workshops compelled many workers to volunteer to participate in the study. Participants were given two inventories. One was for the measurement of stress and another for coping strategies. The participants were also interviewed regarding their experiences.

In the study, the first measurement used was the Trauma Symptom Inventory (TSI by Briere (1995). The TSI is a well established measurement instrument in post-traumatic research literature and is the predominant measurement used. In other studies researching critical incident stress with service providers, the TSI has been the chosen instrument (Schauben & Frazier, 1995). While several other measures exist, Briere (1995) noted that this scale expands from the other scales that use only one or two general constructs of trauma to achieve several scores and adds a subscale for measuring dissociative symptoms. It also includes three validity scores, which is an improvement over other such instruments. The TSI is an expanded version of the Trauma Symptom Checklist developed by Briere and Runtz (1990). The scales include the following:

- Anxious arousal,
- Depression,
- Anger and irritability,
- Intrusive experiences,
- Defensive avoidance,
- Dissociation,
- Sexual concerns,
- Dysfunctional sexual behavior,
- Impaired self-reference, and
- Tension reduction behavior.

In addition, the inventory provides three validity scales of response level.

The measure used for the second dependent variable was the Coping Responses Inventory (CRI) developed by Moos (1995). This is a brief self-report inventory that identifies cognitive and behavioral responses individuals may use to cope with a recent problem or stressful situation. Moos (1995) identified both engaged and avoidant styles of coping as two major classifications of coping with stress. The four scales for the engaged coping style include:

- Logical analysis- Logical analysis measures cognitive attempts to understand and prepare mentally for a stressor and its consequences.
- Positive reappraisal- cognitive attempts to construe and restructure a problem in a positive way while still accepting the reality of the situation
- Seeking of guidance and support- behavioral attempts to seek information, guidance, and support
- Problem solving- behavioral attempts to take action to deal directly with the problem or stressor.

Moos (1995) also identified four scales for the avoidant coping style:

- Cognitive avoidance- not thinking realistically about a problem.
- Acceptance or resignation- the attempt to react to a problem by accepting it
- Seeking of alternative rewards- behaviors attempting to get involved with substitute activities and create new sources of satisfaction.

- Emotional discharge- expressing negative feelings.

With both inventories, respondent answers were recorded and converted from raw scores to test scores or what the authors labeled t-scores. The inventories allow participant scores to be plotted into a profile for each participant. With these inventories a score between 40 and 60 for each of the scales represents a normal score. Participants, then who place one standard deviation from the score of 50 (either below 40 or above 60) are considered to have a significant deviation from the normal scores.

Results

Participants

Participants were recruited over three years and totaled 32. Their age ranged from 25 to 58 years. Thirteen of the participants were male and 19 of the participants were female. The mean age was 38.5, the median was 37, and the mode was 42. Six were African American, 20 European American, 2 Latino, and 4 identified themselves as Other.

The years of work in social services ranged from 1 to 28. The mean years of service were 10.3, the median was 9.5, and the mode was lower, 4 years. Ten participants reported having only an undergraduate degree, and 22 reported having a masters level graduate education. Thirty-one worked full-time and one participant worked part-time. The income levels ranged from $20,000 per year to over $50,000 per year. Twenty-one participants reported income levels between $30,000 per year and $50,000 per year, making up 65.7% of the study.

Among participants, 17 reported being married, 7 reported being single. Seven were divorced and one reported living with a partner. Among the participants, 12 had no children, 6 had one child, 11 had two children, and 3 had three to five children. In other words, 12 of the participants had no children and 20 had children. These demographics imply that the participants came to the research with a very varied range of life experiences and relationships.

Type of Critical Incidents Identified

First, this study attempted to understand better what participants, as social service providers, identified as a critical incident. A content analysis examined what the workers identified as a critical incident. In this study nine participants reported the death of a client as the preceding critical event. These reported incidents could be categorized as:

Death of a Client. One of the deaths was considered natural, another was related to a chronic illness. Three involved the violent death of a child by someone related to or known by the child. Two of the deaths were the suicide of an adult parent. Two were the suicide of a child client.

Clients Perpetrating Violence. Five of the participants reported working with adult clients who had participated in violent activities ranging from assault to murder. All the acts of violence were directed towards family members who were also clients of the participants. Nine participants reported incidents in which clients had made a serious threat to commit violence against the worker. Five of these workers had actually experienced violence inflicted by the client.

Child Pornography. One participant reported the arrest of an adopting parent for making child pornography of a client.

Client Trauma Similar to Worker Trauma. Two participants reported that the incident that brought them to the study were client trauma issues that were dramatically similar to experiences in their own life.

Personal Trauma. Two came to the study due to a recent family incident that was affecting them in their work.

Conlict with Child Welfare System. Finally, four participants reported conflict with systems within the institution for which they worked. Three involved intense negative experiences in the courtroom and one was a conflict with an administrator.

Inventory Results

The symptoms found to be significant on the TSI were anxious arousal, depression, anger and irritability, intrusive experiences, defensive avoidance, dissociation, tension reduction behavior, and inconsistent response. The areas in which no significant difference existed between the participants and the normative scores were sexual concerns and dysfunctional sexual behavior (Table 1).

Table 1

One-Sample Test Comparing Participant Symptom Scores to Normative Scores

	N	Mean	Sig. (2-tailed)	Mean Dif.
Anxious Arousal	32	60.9063	0.000*	10.9063
Depression	32	58.0000	0.000*	8.00
Anger and Irritability	32	58.0938	0.002*	8.09
Intrusive Experiences	32	60.0938	0.000*	10.09
Defensive Avoidance	32	57.1875	0.002*	7.18
Dissociation	32	62.6875	0.000*	12.68
Sexual Concerns	32	51.5313	0.395	1.53
Dysfunctional Sexual Behavior	32	51.7188	0.386	1.71
Impaired Self-Reference	32	61.5313	0.000*	11.53
Tension Reduction Behavior	32	58.3125	0.000*	8.31

Note: * p. < 05, two-tailed.

Participants scored significantly different from the normative scores in the areas of cognitive avoidance, seeking alternative rewards, and emotional discharge. They did not differ from normative scores in the areas of logical analysis, positive reappraisal, seeking guidance and support, problem solving, and acceptance or resignation. The mean scores for cognitive avoidance, emotional discharge, and seeking alternative rewards were higher than the normative scores. This would indicate that participants were utilizing these avoidance coping behaviors to a greater degree (Table 2).

Table 2

T-Test Between Coping Scores and Normative Coping Scores

	N	Mean	Sig. (2-tailed)	Mean Dif.
Logical Analysis Pretest	32	49.4375	0.810	-0.560
Positive Reappraisal Pretest	32	48.6563	0.451	-1.340
Seeking Guidance and Support Pretest	32	52.7813	0.120	2.780
Problem Solving Pretest	32	51.2500	0.436	1.250
Cognitive Avoidance Pretest	32	57.1563	0.007*	7.150
Acceptance or Resignation Pretest	32	50.7500	0.583	0.750
Seeking Alternative Rewards Pretest	32	53.0620	0.023*	3.060
Emotional Discharge Pretest	32	59.2188	0.000*	9.210
Response Level Pretest	32	50.1563	0.946	0.156
Atypical Response Pretest	32	51.6875	0.327	1.680

Note: * p. < 05, two-tailed.

Discussion

Events Are Extreme

The question of what could be seen as an extreme event in child welfare was raised from the inception of this study. At the time of the design of the study, many said that these workers see terrible events every day. Parents hurting and neglecting children, parents experiencing the removal of children from their care, children losing their parents and becoming dependent on a bewildering group of strangers are examples of occurrences that these workers face on a daily basis. How could one expect them to identify an event as extraordinary or critical if it is

something they experience with frequency? However, these expressed initial concerns were atrocities the social worker felt went beyond their daily experiences in child welfare.

Often, workers reported that they had either never had such an experience over several years of service or that their previous experiences of this nature had happened long ago. While this study presents extreme incidents, it is a given that within the child welfare community such extreme events happen with some frequency. This is why so much time, money, and effort are spent trying to protect clients from such events. Yet, while such events occur with frequency within the system, they do not appear to happen with frequency in the career of each individual worker. This supports the conclusion that these are indeed critical incidents for these workers and are not just a part of the day-to-day job. When they occur, the results for the worker can be devastating.

An example illustrates this point. After investigating and providing services for a family after a parent tortured and murdered his/her child, an agency team requested a critical incident debriefing for team members individually and, later, as a group. One worker involved had been on the job for just one week. Another worker, already seasoned, had just returned to child welfare work after several years of absence. This worker noted that this was precisely the type of experience that had made her ambivalent about returning to child welfare. A third worker, who had been with the department for several years, commented, "I have never seen anything this terrible." The new worker stated that, during her interviews for employment, she had asked about such incidents and expressed fears about having to be exposed to such events. She was told that they rarely happened and, yet, she was exposed to such an event her first week of employment. In this particular case, it was severe enough that, even though the workers had not established a relationship with the family, it was heinous enough to create severe critical incident stress for several team members. While noble and intense actions are taken to prevent such events, the predictability for the individual worker's exposure is difficult to establish. Being virtually impossible to prepare for, these events can be identified as extraordinary for the worker.

Critical Incidents and Critical Incident Stress Did Occur

Despite initial resistance, some child welfare workers came forward to report their experiences and to seek assistance. They reacted to the extreme experiences of violent deaths of clients and clients' perpetrating excessive violence towards others. They experienced children being victims of severe violence, heinous murders, and child pornography. These events typically were at the hands of those in positions of trust for the children. Additionally, some workers themselves experienced real threats or actual violence from clients.

Workers described symptoms of critical incident stress reported in critical incident theory and trauma theory. They felt guilty, overly responsible for the events, and incompetent. Somatic reactions were identified, not only in the objective testing but also in self-reports. Problems with sleep, eating issues, headaches, and a bodily sense of restlessness were reported as symptoms. In reviewing the content analysis, participants reported other symptoms of critical incident stress identified in the literature such as constricted thinking, shock, disbelief, disorientation, and isolation (Arthur, Brende, & Quiroz 2003; Mitchel, 1995).

The sense of isolation reported by the workers was an important and significant symptom of stress. This isolation seemed to result from multiple factors. One factor was the worker's personal sense of guilt and feelings of incompetence related to the incident. Often these feelings were attempts to gain control or understanding regarding the incident. If they could blame

themselves for the event, then they could understand how such a terrible event happened. Thinking in these terms, however, certainly does not encourage one to share such thoughts with others. This internally motivated isolation is also a part of the depressive feelings and shock after being involved in such an event. The workers often felt that no other person could possibly understand the tragedy they had experienced as a child welfare worker. These notions also contribute to a sense of loneliness and further isolating behaviors.

Not surprising was that support persons outside of the helping professions could not comprehend the workers' experiences and therefore could not assist them in coping with the critical incident. Often, people outside of the field did not want to hear about these incidents. Workers feared the effects hearing about the incidents might have on themselves. In the defense of their usually supportive relationships, workers questioned how they could expect spouses and close friends to really understand or even wish to hear about such awful events that happen to people? In fact, there was often an expressed and realistic fear that such sharing would traumatize others, burden these relationships and soon burn the relationships out resulting in more isolation.

Often, supervisors were not available physically for the worker for a variety of reasons. Perhaps this created an unconscious motivation for the workers to seek out the intervention team. In some cases, however, it was probably accurately perceived that other professionals were afraid of learning about the feelings and behaviors of the worker who had experienced the critical incident. These other professionals feared that hearing about these events would increase their own fears that such an event could happen to them. The workers speculated that others were already overburdened emotionally by the job and could not be expected to take on the extra emotional burden of listening to their story. When they noticed that some workers were avoiding them, they thought that these fellow workers feared that listening would bring up unresolved feelings and thoughts about the incidents they had experienced. If these fellow professionals had listened, perhaps it would tap into their fears that, if it happened to this worker, it could happen to me.

Some of the participants, in reflecting on why people at work were avoiding them, speculated that they were seen as incompetent and that associating with the participants would reflect poorly on their own competency. They saw that other workers became very busy with their own cases in attempts to assure that they would not have a similar experience. For many such reasons, the result was that the workers in need were left alone in their experiences. These internal and environmental causes of isolation seem to speak to the need for critical incident interventions being valued, promoted and provided within the child welfare community. The needs of the worker after a critical incident will be addressed neither spontaneously within the child welfare community nor in the natural support systems outside of the work environment.

These workers were overwhelmed and their narratives were disrupted as evidenced by reports of shock and disbelief regarding the events they had experienced. They were uncomfortable with their feelings, perceived themselves as incompetent, and felt disoriented. It was hard to put the incident "together and make sense of it," they reported. Their narratives were not cohesive, comprehensive, or complete.

Conclusion

Child welfare workers do experience critical incident stress or vicarious trauma when exposed to traumatic events occurring in their relationships with the clients they serve. The

present study also gives evidence that these workers experience physical, behavioral, cognitive, affective, and relational symptoms of critical incident stress. A major implication then is that those in child welfare services should be aware that critical incidents exist and need not be denied. Further, these events have a significant impact on workers. Those working in child welfare services should find acceptance of the fact that workers can experience critical incident stress or vicarious trauma when working with at-risk clients. Therefore, they need to promote the understanding that these are normal responses to abnormal circumstances.

An important implication of practice involves the need to address the very culture of child welfare as it operates in a culture of interpersonal violence. The culture of denial that critical incidents exist must be addressed. This involves the denial of individual workers and the organization as a whole. The institutional resistance to assistance in this study was most surprising. Even following educational training on the effects of critical incident stress, the normalizing of critical incident responses and the possible benefits of the critical incident debriefing, a strong resistance to participation remained. While agency directors and upper management were initially skeptical, they seemed to respond to the educational process and see the benefit intervention could have for their workers. It was at the middle-management level of direct supervisors and direct workers where resistance was most evident. It was found that the child welfare agencies were closed systems that were suspicious and resistant to outside influences.

One major reason for resistance to a possible intervention was authority. Whose authority was the research team undermining? Resistors may have been asking themselves the following questions: Would the research team undermine my authority as a supervisor? Would the research team give my workers directions in case management when this is my authority? If I am the union steward and this is an employee benefit, why wasn't I included in the decision to allow the study to take place? Why should I, as the union steward, support this if I wasn't consulted? Concern about turf rather than access to a resource for workers was expressed surprisingly quickly.

Suspicion of the motives of workers was also stated during educational meetings regarding the study. Some workers and supervisors perceived the participants as malingering and that considering an intervention was "coddling" the worker. An attitude pervaded that workers should not be pampered but should be out in the field with clients. The difficulty of the work of child welfare workers was dismissed most often by supervisors. Many perceived workers as children who needed to be prodded into work. A lack of empathy for the difficulty of the work was evident. Even supportive middle managers would secretly relate that workers always complain and that employees would take advantage of such an intervention as a way to "get out of work."

The influence of supervisors on their workers' ability to perform is an important resource. In the end, participants volunteered from agencies in which management and supervisors supported staff to take advantage of such an opportunity. In most cases, when supervisors or other workers promoted the project or the researcher, the participants volunteered.

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The Art and Science of Effective Direct Practice Supervision

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Abstract

This article focuses on the importance of effective practice supervision in the education of social work students. The greatest challenge to supervisors is to teach students how to translate theory into practice in a positive student-supervisor relationship and supportive agency environment. It also includes a discussion of five learning patterns and the importance of both determining and utilizing the adult learning style of the student for most effective teaching. The learning agreement, as a required component of filed education, is also discussed. The significance of the contract to identify the goals for learning and the specific activities and tasks that facilitate the process, in addition to some of the pitfalls, are described. Constructive approaches to supervision and evaluation are included and a summary of the responsibilities and rewards of agency supervision of social work students concludes the article.

Introduction

Educating social work students in the field is both a complex and rewarding experience. It is essential that field work instructors have a clear understanding of the mission of field education and their role in this very important process. Field practicum provides the opportunity for social work students to learn through the practical application of what they have learned through their didactic classroom experiences. It is the place where the focus shifts from the acquisition of knowledge to the application of knowledge (Dettlaff, 2003).

The goal of the field placement is for students to successfully integrate theory into actual practice. It is the job of the field instructor to help students successfully make the link between the two. In so doing, field instructors take on multiple roles and responsibilities as educator-administrator and support person to students. In addition to helping students connect theory and practice, the field instructor helps to: Support and develop their critical thinking skills; model and develop professional values of social workers; develop student self-awareness and capacity to reflect on improving the lives of others; and mentor.

Field work instructors are a "teaching arm" of the academic institution (Waldfogel, 1983). They are social work educators in the field who play an essential role in the professional development of social work students. Research shows that the quality of the field instructor is the most important factor affecting students' satisfaction with their field placement (Dettlaff, 2003). It is this person whose task it is to structure a learning atmosphere and professional

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relationship conducive to learning. To assume the role of field instructor is to position oneself as a role model for social work students anxiously looking for cues about how to interact in the professional setting. It is important that the field instructor be aware of this aspect of supervision as well as other elements that contribute to the effectiveness of the role (Caspi & Reid, 2002). It is essential that field instructors possess motivation, knowledge and experience, ability to impart knowledge to students, patience and understanding, flexibility and maturity, openness to questions and challenges, the capacity to multi-task while committing to supervision and receptivity to the personal and professional rewards of serving as a field work instructor.

The challenge for field instructors is to teach students how to translate social work theory into social work practice; not, how to do a particular job in a social work agency (Dettlaff, 2003). The role of the field work instructor is not only to help students learn how to use social work skills effectively, but also how to use social work knowledge and values to inform their actions and decisions in attempting to meet the needs of the clients they serve. The field work instructor has to determine how to help students engage their clients, how to build rapport, set goals, and develop tasks to reach these goals and the many other aspects of effective practice.

It aids the process of teaching if a field work instructor possesses a vision of the desirable qualities and characteristics they would like a student to have by the end of the placement. One part of this vision needs to focus on the student and the identification of the strengths and skills the student brings to the placement that will need to be activated and applied to the social work setting. The field instructor then needs to turn to self in determining the role he or she is prepared to play in the life and professional development of the student, as it relates to the life and well-being of every client with whom the student comes in contact (Dettlaff, 2003).

The student-field work instructor relationship has far reaching effects on students and is the main instrument in field instruction in which learning takes place. Some reports indicate that students have expressed the opinion that it is the relationship that has the capacity to make or break a placement, thus demonstrating the tremendous influence on a student's overall learning experience. Students look to their supervisors to be supportive, understanding and knowledgeable (Kadushin, 1992). In the context of a positive field work supervisor relationship, students are able to experience growth and development much more easily. The positive relationship prepares students for the challenges they encounter during their training as well as when they enter the world as professional social workers.

Student Learning Styles and the Field Instructor's Role

It is important for field work supervisors to be aware of the individual learning styles of students. Equally as important is the field instructor's awareness of the differences in learning styles among adults from those of children. Adult learning theory suggests that adult learners have specific learning needs that differ significantly from the needs of children (Knowles, 1970). As field work supervisors, it is critical that these learning needs are noted and incorporated into the techniques for training in the field placement.

Common characteristics of adult learners include their need to have a defined purpose for what they are learning along with their wish to participate in structuring their own learning experiences. Adult learners also have the ability to learn by doing. The field instructor assist adult learners to unlearn some of what they know in order to relearn what it is to fully identify with the role of a professional social worker. Adults learn best in environments that promote a

sense of acceptance and support, and provide challenging learning experiences through which students can step outside of their comfort zones (Kadushin 1992).

Determining a student's learning style can be achieved when the field work instructor conducts an educational diagnostic of the student. This entails getting to know the student well enough for the supervisor to ascertain what the student already knows, what the student needs and wants to learn, and how the student desires to learn the material (Waldfogel, 1983). The goal of the educational diagnostic is to study the student in order to determine how, as an individual, the student learns so that the teaching can be more responsive to the unique and specific learning needs of that student. The numerous theories from the classroom setting enlarge and deepen the student's bank of information and provide great intellectual stimulation. The challenge for the field work instructor is to determine how to adapt that knowledge to educational use so that it impacts the student's practice.

The provision of a one-on-one teaching relationship between field work instructor and student, sometimes combined with group supervision, provides an opportunity for supervisors to get to know their students better. In this context they are able to identify personality characteristics and patterns of learning which may impede or enhance the field experience.

It helps, in the supervisory work with students, to be aware of what to look for in trying to recognize learning patterns. Supervisors want to take advantage of every opportunity to build on their awareness of elements that facilitate the learning experience for students (Kadushin, 1992). Key indicators in student learning patterns include determining students:

- Degree of self-responsibility; ability to articulate his/her learning;
- Ability to relate to the field work instructor (e.g., in one-on-one supervision, group supervision, informally);
- Response to supervision; presentation of case material in a well organized, focused manner;
- Level of self-awareness and openness in sharing feelings and responses which might inhibit learning;
- Degree and pace of ability to change feelings and thinking when such changes are noted as needed;
- Use of supervisor's feedback;
- Ability to understand and function within limitations of the agency's structure;
- Adherence to administrative and clerical procedures; and
- Ability to accommodate the demand for learning in areas other than his/her primary interests.

The Jane Addams School of Social Work developed a grouping of five learning patterns that capture the breadth of responses field instructors encounter in their work with diverse groups of students (Jane Addams School of Social Work, 1968). This information remains useful when attempting to understand and respond to student encounters in ways that will facilitate learning. The grouping identifies the different patterns and recommends effective teaching responses to the specific characteristics. The list of patterns includes:

- The Passive–Receptive Pattern: There is minimal activity in pursuing ideas, knowledge and/or relationship engagement. The student learns by conforming, and

accepts the learner role easily. The student feels fine about his or her dependency or about being given to. Hostility from the student is quite low.

Effective Teaching Approach: This student learns best if the instructor is supportive, giving content and directives. The best help from the field work instructor is through the shift of giving credit and praise for independent thinking and action rather than for conformity.

- Passive-Resistive Pattern: This type of student maintains a persistently questioning response to what is presented. The initial presentation is similar to passive receptive. With this student, the initial anxiety seems not to diminish after the first few weeks but rather, it persists. This student seems to"block out" what the field instructor has said. There develops an increasing feeling of "strain" in the instructor-student role which reflects the student's ambivalence about being in the dependent role with the supervisor.

  Effective Teaching Approach: The early and consistent identification by the field work instructor of the problem patterns as they involve learning and the social work activity is required. Such identification is done in the context of a supportive relationship where the field instructor conveys the message of being "for and with" the student while struggling to alter those parts of his or her feelings, thinking, and behavior which interfere with good professional social work performance. The focus needs to remain on the problems as they influence learning and social work activity.

- Assertive-Receptive Pattern: The student with this pattern exhibits marked activity in pursuing ideas, knowledge and/or relationship engagement. The student is active, directive and self-responsible; displays the ability to articulate both what he or she knows and his or her learning needs, shares anxieties and accepts, comfortably, the necessary learning dependent role as a temporary phase. There is a consistent quality to the performance and to the learning progression. This student reflects a level of trust in the supervisor-trainee relationship.

  Effective Teaching Approach: Supervisors should base teaching on an accurate assessment of the student's ability in terms of his or her intellectual prowess, the richness or scarceness of actual life experience, response to present knowledge, and identification of immediate learning needs. A potential problem in working with this type of student is the tendency to set expectations that are too high and/or to inflate the grade because the student is such a pleasure to work with.

- Assertive-Resistive Pattern: With this student, there is an eager outgoing articulated search for knowledge. However, in the student's statements are tones that reflect elements of dogmatism and certitude. The fundamental issue facing the student is the fear of not knowing enough. There is sufficient confidence however to fend against the ambivalence stirred up by taking on the dependent role of student. The student does not submit to this role however, but seeks ways to maintain his or her own integrity and sense of independence.

Effective Teaching Approach: With this student, the field instructor's best course is to allow and encourage intellectual seeking and independent thinking; engagement in intellectual discussions of concepts and support of the student's thinking whenever possible, and making clear one's own rationale for disagreement when it occurs.

- Peripheral Pattern: This student has a persistent inability to comprehend and integrate the intellectual-emotional interrelatedness of concepts and interpersonal relating. The student is agreeable and acquiescent but displays little initial anxiety as is typical of beginning students. This student seems to lack depth in his/her thinking; his/her recorded and verbal presentations show a paucity of material; the student exhibits a superficial quality in the way he/she relates to clients. The student appears not to be resistive or evasive but simply does not seem to get the nuances. As the ways in which the student is not meeting field learning expectations is pointed out to the student, the anxiety level elevates but results in an exacerbation of confusion and bewilderment rather than improvement.

  Instructor's Response: The field instructor may need to consider the question of whether this student is educable for social work. If it is the opinion that the student is not, then the field instructor's efforts should be to identify the steps to convey to the school the concerns and reservations; remaining sensitive to the need to communicate with the student in a manner that will be as non-traumatic as possible.

Direct Supervision

It is necessary for field work instructors, when considering any of these patterns, to be able to distinguish a student's way of relating to new knowledge from that student's way of relating to authority figures. It is also important to remember that students have different ways of learning. Some students learn first by experimenting and then identifying intellectually what has been done while others must have the theory posted first and then the action. Either way can be potentially productive; either way can also be problematic. Both ways fit into the five previously discussed patterns. It is not desirable for a field work instructor to have as a goal to alter the student's basic way of learning; instead, the challenge is to determine how to best work with the particular student's style to enhance the overall learning experience. As field work instructors, it is our responsibility to design the learning experiences we want our students to have. This goal can be achieved by giving careful attention to key aspects of the student's experiences. This process includes the student's acclimation to the setting/agency, development of learning goals, and development of a learning agreement between the student and the field instructor.

C. Knight (2001) noted in her research that students who participated early in activities designed to orient them to the agency reported that these activities enhanced their field experience. Also, students who have positive initial impressions of their field agencies have higher levels of overall satisfaction upon completion of the field placement (Knight, 2001). In orienting students to field placement, the field work instructor should determine the most basic and essential points that need to be covered; recognize that the more clarity there is around what is expected from the student, the less anxiety the student is likely to experience. The following areas are recommended for inclusion in a student orientation:

- Logistics (hour, dress code, absences);

- Organization mission, structure and clientele;
- Policies and procedures;
- Introduction to staff;
- Supervision schedule and expectations;
- Confidentiality;
- Safety;
- Resources within the agency;
- Opportunities to "shadow" staff; and
- Activities to undertake during "down time."

In establishing a learning agreement/contract, the student and field instructor need to identify the goals for learning with the understanding that the agreement may be adjusted, as needed. In the same way the office orientation reduces unnecessary anxiety over what is expected, the learning contract achieves the same goal of clarifying what each person is to expect from the other. It is a performance-oriented document developed between the student and field work instructor that offers concrete, objective statements about needs and goals (Fox, 1983). There should be a description of specific activities that contribute towards the learning goals along with the establishment of criteria for determining when the learning goals have been met. To make the document more effective, action phrases such as "to explore," or "to acquire skill" can be used to further clarify exactly what is expected. The value of this tool can be especially appreciated during the student's evaluation when the field instructor can use it as a reference point for assessing performance.

Supervision of students in the field is seen as the crucial element in establishing the link between academic work and practice. It involves the task of teaching students what they need to know in order to perform as professional social workers. It is considered a process; one that takes place best in the context of a positive relationship (Caspi and Reid, 2002). Supervision needs to be structured, regular, and consistent and case- oriented (Munson, 2002). When these parts are in place, students are better able to contain their anxiety, which otherwise can seriously impede the learning process.

There are numerous issues that can create problems for the supervisory relationship and thus, negatively impact learning. As field instructors, it is important to recognize these issues that can feed into non-productive supervisory experiences. The list below notes some of the main pitfalls field instructors need to remain aware of while planning for supervision with students:

- Unclear or unrealistic expectations;
- Lack of regular or protected time for supervision;
- Resistance to the learner role;
- Avoidance of sensitive issues, issues of diversity or lack of awareness of ethnocentrism;
- Incompatibility of student/field instructor's learning styles;
- Lack of connection between what the student is learning in the classroom and in the practicum;
- Boundary issues;
- Confusion between critical thinking and being critical;
- Student's poor work habits;

- Emotional issues or personal issues that impede learning; and
- Agency turmoil.

In the context of supervision, it is imperative that the field instructor give constructive criticism/feedback to students (Kadushin, 1992). This can be a sensitive interaction which, if not handled carefully, can lead to tension and conflict that may significantly hinder the learning experience. The points offered are suggestions for reducing the risks of this necessary function becoming disruptive to the learning process:

- Focus on the behavior or the event; not on the individual involved;
- Respond to the student's experience of the situation;
- Awareness of the field instructor's own feelings about the student and keep those out of the conversation;
- Provide feedback when the student is ready to hear it and the field work instructor has time to discuss it;
- Consider how the student can learn from the feedback provided;
- Focus on what can be done rather than on what was not done; and
- Separate one's own sense of success or failure from the student's success or failure.

Evaluation

Field work instructors and students view the evaluation as an important tool in social work education that sums up, evaluates and states in an official document the instructor's judgment of the student's field work performance. Evaluation is continuous during the field placement; thus, the final evaluation should be an overview that reflects the feedback/constructive criticism and other input extended to the student over an entire evaluative period. The field work instructor must be aware that the evaluation is a positive and rewarding experience and not one where the student ends up feeling surprised by his or her performance. Otherwise, it can lead to feelings of supervisor betrayal. The suggestions below are offered as considerations for field work instructors around this important part of social work education:

- The evaluation should render no surprises. It should be a review. Ongoing constructive feedback should always precede the summative evaluation;
- The student's strengths as well as his or her areas for improvement need to be identified;
- The student's input should be sought;
- There should be reflection on both the student's and field work instructor's expectations;
- Examples of both gains and areas of concern should be noted;
- Goals for the next evaluation period should be included;
- The evaluation should be viewed as an ongoing process; and
- The evaluation should be conducted in the context of a positive relationship.

Conclusion

In summary, it requires courage and commitment to assume the role of agency field instructor with all of its inherent responsibilities and challenges. Individuals assuming this role find reward and stimulation from the awareness that the students they supervise represent future social work practitioners. By embracing this opportunity to train, mentor and influence social work students, field work instructors are able to have a part in shaping many of the future leaders of our profession.

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Citizen Review Panels: Little-known Leverage for System Improvement

Michael Forster, Ph.D.

Abstract

Creatures of federal legislation, citizen review panels promise a valuable vehicle for child welfare system reform throughout the U.S. While in compliance with law, Mississippi's use of citizen panels has been unnecessarily limited. Recent developments sparked by the settlement of class action litigation, however, suggest the opening of new opportunities for system improvement though citizen engagement.

Introduction/Overview

Citizen Review Panels (CRP) were created by a 1996 amendment to the federal Child Abuse Prevention and Treatment Act (CAPTA), with a general aim of "opening up" public child welfare systems to volunteer citizen scrutiny and input, thereby promoting system improvement and reform.

The legislation required states receiving CAPTA funds to establish at least three panels within two years. Panels were charged, at minimum, with assessing the state child welfare agency's compliance with the state CAPTA plan, coordination with Title IV-E foster care and adoption programs, and review of child fatalities and near-fatalities. A 2003 reauthorization of CAPTA reiterated and expanded CRP charges to include evaluating agency protocols and policies, as well as the practice of child protective services workers, and engaging in "public outreach." Moreover, state child welfare agencies were required to respond within six months to the written recommendations offered by panels in annual reports.

Expectations of the panels are significant, but minimal. CAPTA legislation indicates that the volunteer membership should be broadly representative of the community in which they operate, while including individuals with expertise in the prevention and treatment of child abuse and neglect. Panels are to meet at least quarterly, maintain confidentiality of proceedings, and prepare an annual report of activities and recommendations.

Citizen review panels have to date received limited scholarly attention and remain largely invisible to both the professional human service community and the public at large. Studies by Jones and others (2003, 2004, 2009) have examined factors associated with the functioning of CRPs and their relative success or failure to thrive. A website maintained by the University of Kentucky School of Social Work attempts to maintain a census of CRPs and to track their activities (see www.uky.edu/SocialWork/crp/).

Apparently, however, no studies have assessed the actual impact of CRPs on the child protective system outcomes, or documented the extent to which public systems have adopted panel-recommended measures. In general, one may conclude that consistent with the explicit intent of the CAPTA legislation, CRPs would appear to offer great potential for system improvement, but that the record of achievement is, to date, spotty at best.

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Activities, Achievements, and Obstacles

Under the broad parameters established by CAPTA, citizen review panels possess an extensive scope, should they choose to exercise it. Panels may, for example, examine any component of the child protection system – intake and initial screening; investigations; assessment; case determination; service planning, implementation and monitoring; crisis intervention; service coordination; and/or staff qualifications, training and workloads.

Research by Jones et al. indicates that individual panels across the U.S. have indeed undertaken system reviews through a variety of methods, including the in-depth review of a small number of cases, analysis of statewide data systems, targeted surveys, intensive policy reviews, community forums, focus groups, and interviews with staff and service consumers, among other approaches (Collins-Comargo et al., 2009). In some cases, panel findings have prompted important achievements, such as improved funding (Alaska), new training for mandated reporters (Tennessee), and legislation to reduce child hazards (Indiana).

Dramatic accomplishments appear to be relatively scarce, however, in the face of a rather daunting set of typical obstacles. Clearly, panels function best when the public agency and the panels demonstrate commitment to a mutually respectful collaborative process of engagement; such a process is characterized by frequent communication, staff and logistical support for panel work, an unrestricted exchange of information, and timely feedback regarding panel recommendations. But a healthy collaborative process is commonly undercut by a number of overlapping challenges – including the struggle to gain and retain diverse and non-professional membership; difficulty is establishing sustainable focus and measurable outcomes; disrupted agency relationships in face of high turnover on both sides; difficulty appreciating the complexities of child protection systems; distrust from front-line workers, and inattention from administrators (Jones, 2004).

The Mississippi CRP Experience

The Mississippi citizen review panel experience largely mirrors the mixed record of panels nationwide. To its credit, Mississippi has sustained a positive dialog between its citizen panel and the Division of Family and Children's Services for more than twelve years. Minimum requirements for regular meetings and annual reporting have been met without fail, despite several dramatic shifts in agency administration and turnover of panel membership. Two factors have contributed to a record of relative stability – consistent (if minimal) administrative agency support, primarily in the form of a regular meeting venue, reminders of meetings, and maintenance of meeting minutes; and a relatively stable and reliable core membership of the panel.

The record is dominated by less favorable elements, however. To begin, Mississippi has complied with the letter, but not the spirit, of the three-panel requirement. In addition to the one genuine panel (referred to as the "board"), two pre-existing bodies – a child fatalities review committee, and the foster care review board – were identified as panels as well; moreover, the three bodies never operated with any measure of coordination. Significantly, it appears that "control" of the panel/board was,

until quite recently, the paramount concern of the child protection agency. For most of the panel/board's existence, its mission was pre-defined as review of the agency's comprehensive plan, based exclusively on information provided (rather unevenly and erratically at that) to the panel by the agency. No targeted focus was developed, and no intensive "drilling down" on any focus topic, issue, or concern for reform, was ever accomplished. In perhaps the best illustration of the control emphasis, the panel's by-laws required its membership to be formally approved by the director of the Department of Human Services, parent agency of the child protection agency; recommendations for new members were acted upon extremely slowly. Such centralized oversight of membership combined with the absence of financial support for non-professional members to participate ensured that membership remained small and confined largely to a small group of public and private professionals with long-term interest in the welfare of the system.

Recent developments, however, offer the promise of re-energizing the work of citizen review and expanding the understanding of what constitutes the child and family welfare system. The 2008 settlement of the class-action lawsuit brought against Mississippi in 2004, *Olivia Y v. Barbour*, installed a more progressive administrative team committed to a new regime of openness, engagement and reform.

While more pressing concerns have understandably taken priority, in late 2009 the agency administration accepted a proposal of the panel/board for a rather dramatic restructuring of the state's panels. If carried forward, the restructuring will significantly boost both panel activity and the likelihood of such activity contributing to meaningful system reform, including more extensive citizen engagement with "the system."

The restructuring plan calls for the replacement of the current single "board" with three autonomous regional panels – north, central and south. While autonomous in membership recruitment, setting of priorities, and activities plan implementation, the leadership of the panels will participate in a coordinating council that will include a representative of the child protection agency to ensure appropriate liaison and communication with the public agency. Each panel will, moreover, look to the regional school or department of social work affiliated with the University of Mississippi (north), Jackson State University (central), and the University of Southern Mississippi (south) for administrative and logistical support.

At the time of the Mississippi Child Welfare Institute Conference (2010), the first step in implementing the new arrangement, i.e., recruitment of regional panel membership by lead members of the current panel/board, was underway.

Conclusion

The promise of citizen review panels remains great. Not only do they provide a means of keeping systems open, they create a motivated cadre of advocates for both vulnerable children and the systems charged with caring for them. In addition, and perhaps most significantly, panels help to institutionalize the valuable but frequently neglected recognition that "the system" is not merely the child welfare agency, but the community – the social order – as a whole. In so doing, they underscore the faith that in a democratic society, citizens, and not professionals alone, are central to social well-being.

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EQUINE THERAPY WITH AT-RISK CHILDREN: AN EFFECTIVE AND COST-EFFICIENT INTERVENTION

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Abstract

The purpose of this paper is to provide an overview of animal-assisted therapy, specifically focusing on therapeutic horseback riding. This paper also briefly discusses the appropriate social work client population with whom therapeutic riding intervention programs are effective, prior research studies and their findings, as well as the benefits of employing therapeutic riding as an intervention.

Introduction

Cats, dogs, dolphins, horses, ponies, birds, turtles, and fish are all used in animal assisted therapeutic programs around the world. Social workers have easy access to these animals. Research indicates that animal-assisted therapy is being used around the world with every type of at-risk social work population. Animal-assisted therapy works wonders with war veterans, children who have been sexually, physically, and psychologically abused, neglected children, teens, and young adults, and the elderly who are handicapped, adult inmates, juvenile detainees, cancer survivors, dialysis patients, children with learning disabilities, hospitalized patients, and nursing home residents, just to identify some populations. Therapeutic horseback riding, a specialized kind of animal-assisted therapy, is an especially effective intervention program that is an untapped resource for social workers.

Overview of Animal Assisted Therapy (AAT)

Animal assisted therapy uses animals within a helping setting and addresses a myriad of psychosocial and physical challenges as well as provides the client with additional tools to continue working on the challenge outside of the helping setting. Levinson and Mallon began research on the effectiveness of animal assisted therapy in the 1960s. Their original research in this area focused on employing animals to motivate children towards positive behavior, who otherwise were uncooperative in the helping setting. There are several components to using animals to help humans. Animal Assisted Therapy (AAT) is used by academically trained professionals who have specific goals and objectives to achieve. Animal assisted activities (AAA) and Animal-Assisted Education (AAE) are used by lay people with an overarching and very general goal in mind, either general therapy, general education, or general recreation. AAT actually explores the inner world of the patient with the therapeutic tool being the animal itself.

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Overview of Therapeutic Horseback Riding

Therapeutic riding is a great way to see remarkable changes in social work clients. Many social workers are now looking to alternative methods to assist our clients. One remarkable program that is yielding phenomenal results is therapeutic horseback riding. Research shows this form of therapy works wonders with almost every social work population: Children, teens, juvenile delinquents, physically challenged, developmentally delayed, blind, deaf, and individuals who have experienced all forms of abuse. The explanation for the success rate is simple. A special bond is formed between a child and a horse. Children who have not progressed in a conventional therapeutic setting often excel with therapeutic riding. A child will tell horse things they would never tell a therapist. A child will share secrets, thoughts, failures, setbacks, wishes, dreams, and goals with a horse. And the horse will never tell. Children know this and therefore open up more with horses than with parents, teachers, friends, pastors, and conventional therapists. Children will attempt different physical challenges because they feel the support of the horse underneath them.

According to the National American Riding for the Handicapped Association (NARHA, 2002), therapeutic riding "uses equine-oriented activities for the purpose of contributing positively to the cognitive, physical, emotional, and social well-being of people with disabilities" (p. 5). Over-activity, distractibility, autism, developmental disabilities, learning disabilities, emotional and behavioral disturbances, and anger management issues are all appropriate problems for therapeutic ridings. There are two types of therapeutic horsemanship: hippotherapy and therapeutic riding. The difference between the two types is that hippotherapy requires a medical professional, such as a physical, speech, or occupational therapist. Therapeutic riding requires a certified riding instructor.

In hippotherapy, riders meet with the therapist one- on- one for about 30-45 minutes. In therapeutic riding, riders usually meet in groups with the certified riding instructor for about 45 minutes. In both types, there are several volunteers, also known as "side walkers" who help the person get on and off the horse and walk beside the horse the entire time to prevent any injury. The side walkers must also complete an intense training course. In addition to riding the horse, the client also is encouraged to complete certain tasks, also referred to as "games." A physically challenged rider may be asked to throw a small ball through a hoop, throw a frisbee into a barrel, or reach and ring a bell. A mentally challenged rider may be asked to count how many times the horse walks around the gate or asked to count how many barrels there are in the arena. All tasks have a specific therapeutic goal which the rider is working to accomplish. Many times, the riders are asked to answer questions aloud as well as get the horse to respond to a verbal command—all simultaneously. This provides both a physical challenge as well as a mental one.

Horses and humans have much in common. First and foremost, the gait of a horse is similar to the gait of a human. The horse's pelvis is identical to a human, but offset by 90 degrees. When a client rides a horse, this motion simulates walking and the rider is able to work on balance, posture, breathing, and coordination. A horse also engages the rider's vestibular system "which runs throughout the body and affects functions like alertness, balance, and digestion" (Killcreas, 2008, p. 2). Social work practitioners should seriously consider animal assisted therapy as a viable intervention when working with any type of population at risk. Many educators and health care professionals have already taken the concept of therapeutic riding and put it into practice (Bland, 1987; Brock, 1989; Crothers, 1994; Cylke & Kurt 1991; Minner, 1983; Potter, 1994; Scheidhacker, 1991, and Spink, 1993) explains that in therapeutic riding, the

focus is on learning to control the horse. The rider actively responds to the directions of the riding instructor by cognitively coding or registering the request, then processes it and attempts to execute the desired positional and/or motor sequence. The three-dimensional movements of the horse stimulates the rider's central nervous system which then stimulates areas of the brain that control specific motor functions and behaviors. In response, various neurotransmitters, such as natural endorphins, are released and can cause a variety of emotional and behavioral effects. These behavioral effects are similar to the effects of the "workout high" or "runner's high."

Several research studies indicate the profound effect of therapeutic riding with a variety of populations. Kaiser, Smith, Heleski, and Spence (2006) found that after completing an 8-week therapeutic riding program, anger in adolescent males significantly decreases and mothers' perceptions of their sons' behaviors improves. Mason's (1988) study revealed enhanced self-concept for people with cerebral palsy after participating in a three-month therapeutic riding program. Emory's (1992) research with emotionally and behaviorally challenged teens found statistically significant improvements in self-concept, intellectual and school status, popularity, happiness, and satisfaction. Scheidhacker (1991) found that people with chronic schizophrenia showed marked improvement in symptom management while participating in therapeutic riding. Crothers (1994) research with learning disabled children found that participating in this type of treatment improves information retrieval and processing. Cummings (1995) found positive changes in riders with both Attention Deficit Hyperactivity Disorder (ADHD) and Fetal Alcohol Syndrome (FAS) at the conclusion of a therapeutic riding program. Therapeutic riding programs are especially effective with attentional disorders because of the areas of the brain stimulated by riding a horse.

The motion of the horses stimulates all aspects of the brain, activating both hemispheres simultaneously. It is also believed that the areas of the brain that control attention, impulsion, and activity levels are directly stimulated by the movement. The neurotransmitters released when riding create an effect that is similar to the one created by stimulant medication. Energy is redirected to different areas of the brain making it possible for the person to concentrate, be active without being overly active, hyperactive, or fidgety, and be less impulsive. Stevens (2007) explains that horses are able to sense certain weaknesses in children with ADHD and respond to them by remaining calm and quiet. As the child pets the horse, the calmness from the horse is transferred to the child. The horse is quiet, the child become quiet or less loud. The child's listening skills become more attuned, their ability to listen to directions and respond appropriately improves, and behavioral difficulties decrease. In therapeutic programs with learning disabled children, certain activities are chosen to specifically decrease negative behaviors. These activities include grooming a horse because the child has to groom from left to right and therefore sequencing is learned. The child must talk softly with the horse during grooming, thus communication skills improve. Self-esteem improves when a child is placed on the back of a horse, as he or she is far above the people standing on the ground. Even as the child rides and masters new skills and becomes aware of his or her horseback riding ability, self-esteem soars (Stevens, 2007).

Children performing poorly in school often thrive in therapeutic riding treatment. Children participate in games and activities that make them point out shapes, colors, sizes, and textures. On a trail ride, children are often to find the red ball hanging from a yellow rope in a green pine tree. Children are learning but they see everything as fun and a game. Through the use of signs placed around a paddock (small riding arena), letters can be taught and the reading of the individual words by word recognition can be learned. Games involving signs for "exit,"

"danger," "stop," "go" help teach important life skills involving reading (Stevens, 2007). Stevens (2007: p. 5) "explains that children learn to count by counting objects around the paddock or arena, the horse's footsteps, or even the horse's ears and legs. Children gain the concept of numbers by counting how many legs the horse has and then comparing that number to the number of legs the rider has. Children are directed to throw large foam dice into barrels or catch them and then add or subtract the dots on the dice. Resistance to learning decreases because the children see these activities as games. Eye-hand coordination, a necessary writing skill, is learned as a child tacks (puts on the saddle) or grooms a horse. Visual and spatial perception improves as children ride around the arena, ride closer or farther from a wall, ride around the blue barrel, riding from the blue barrel to the red barrel and back over to the yellow barrel."

According to Zanin, (1997: np) "many parents of riders enrolled in therapeutic riding programs marvel at their child's newfound skills. The riding center may be one of the first places where the child experiences success and acceptance. The motivating lure of the large, gentle animal, the calm and consistent support of the therapeutic riding team, and the naturally accepting environment of the "stable" provide opportunities for the child to learn and develop. These opportunities may help turn the often disparaging label of the ADD child into a child who is Absolutely Delightfully Driven." Social work students, educators, and practitioners are always seeking effective best practices which can be implemented with their population. It is encouraging to discover new "best practice" programs that are not only cost-effective but that work exceptionally well with the populations with whom we work. The long-term effectiveness of therapeutic riding indicates that this one component of animal-assisted therapy is a formidable intervention to be taken seriously, well-researched and documented to show its effectiveness, and should be considered by every helping professional who wishes to continue to offer the most current, up-to-date intervention programs to their clients.

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THE TRAUMA OF HURRICANE KATRINA AND ITS IMPACT ON STUDENT ACADEMIC ATTAINMENT

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Abstract

This secondary data analysis study looks at the impact of trauma on college student academic attainment following a natural disaster. The study utilizes trauma theory and summed grade point averages (GPAs) to determine if there is a difference in student GPA scores pre-disaster compared with post-disaster. The study reviews pertinent literature related to the topic of trauma and education. The study concludes with the findings from this research.

Introduction

On August 29, 2005 Hurricane Katrina made its third and final landfall on the United States. Hurricane Katrina was a devastating natural disaster impacting much of the Southeastern United States. Media reports from Texas to Florida documented the devastation of this disaster. News media initially focused on human and animal deaths, infrastructure failure, uninhabitable buildings and general devastation. What was not discussed in the news media was the long-term impact on the residents as a result of this disaster. The media did not cover anything related to a return to normal day-to-day activities, or children returning to school. The initial media focus on education was to discuss the number of school buildings destroyed.

In coastal Mississippi, some communities lost up to 90% of all structures directly related to Hurricane Katrina. The loss of structures included homes, businesses, churches, schools and many others. In a matter of a few hours, people went from being homeowners and employed to being homeless and out of work. Students went from being enrolled in a certain school to not having a school to attend. Issues of education and learning become less important when you are fearful of where your next meal may come from, if it comes at all. One cannot focus on education when one is worried about his/her safety at night, because one is sleeping outside. One cannot focus on education when every time the wind blows, or a thunderstorm strikes, one is immediately transported back to the experience of Hurricane Katrina. Education, and the ability to learn, is clearly intertwined with feelings of safety and stability. Following Hurricane Katrina, students did not have feelings of safety and certainly did not have stability. Students who experience trauma are not focused on grades, GPA scores or pursing academic excellence. Students are focused on day-to-day survival.

This study looks at academic attainment, using summed GPA scores, both pre-Hurricane Katrina and post-Hurricane Katrina to address the question: Is there a correlation between GPA scores and disaster for selected university students in South Mississippi?

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As with any academic study, the first place to begin is by looking at what other research has shown on the topic under review. Secondly, the researchers need to have a theoretical perspective developed to help frame the actual research question, and more importantly, how to understand the information gained from the research. The following will be the review of pertinent literature on this topic.

Literature Review

Trauma is a devastating event that is all too common today. War, natural disasters, human caused events, hurricanes, floods, violence, and much more confront us. It appears that we cannot avoid trauma. Trauma can be defined as any event, situation which attacks the psyche and breaks through the defense system with the potential to significantly disrupt one's life, perhaps resulting in a personality change or physical illness if it is not managed quickly and/or effectively. It is "a psychologically distressing event outside the range of usual human experience" (APA, 1987, p. 247). Such events are typically thought to overwhelm one's normal coping mechanisms, (APA, 1994). The traumatic event will engender intense fear, helplessness, or horror (Mitchell, 1997).

Traumatic experience is alarmingly common in the course of human life. Research has indicated that 76% of American adults have reported being exposed to at least one traumatic event in their lifetime (Van der Kolk, McFarlane, & Weisaeth, 1996). Friedman (2000) reports that at least 8% of these individuals will experience distress significant enough to produce impairment in their social, occupational, or other important areas of functioning. Clinically significant "traumas" are defined by the Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition Text Revised (DSM-IV-TR) as involving "direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to the physical integrity" of oneself or another close associate, as well as "the subjective experience of fear, helplessness, or horror" (2000, p. 463). Examples of common traumatic events include military combat, motor vehicle accident, assault, rape, and natural disasters (Kolts, Lombardo, & Faulkner, 2004).

The literature on traumatic stress has overwhelmingly concluded that traumatic events have adverse effects on individual well-being. One of the most debilitating impacts of trauma is Post-Traumatic Stress Disorder (PTSD). PTSD has been shown to negatively impact psychological, physiological, and neurobiological functioning (Shear, 2002).

Multiple or cumulative exposure to trauma is common among those who have experienced a traumatic event. For example, Resnick, Kilpatrick, Danskly, Saunders, and Best, (1993) found 69% of women in their community sample had been exposed to trauma, more than half of those had experienced multiple incidents. In the National Comorbidity Survey, Kessler, Sonnega, Bromet, Hughes, and Nelson (1995), found that 34% of men and 25% of women reported more than one type of trauma exposure. Vrana and Lauterbach (1994) found that one-third of 440 undergraduates had been exposed to four or more events. In an earlier report Green, Goodman, Krupnick, Cororan, and Petty (2000), found that in a sample of college women at least 38% reported exposure to two or more trauma event types. In that study, 80% to 85% of individuals reporting a traumatic event had experienced at least one other traumatic event.

Significant contributions have been made through diverse approaches to the study of trauma, including disaster studies, victimology, learned helplessness, bereavement, stress management studies, crisis theory, and intervention, as well as traditional clinical and sociological

conceptualizations (Bunce & Peterson, 1995). Researchers from a variety of perspectives have examined trauma-related psychological disturbances in such populations as combat veterans (Holloway & Ursano, 1984; Sutker & Allain, 1991; van der Kolk & Greenberg, 1987), prisoners of war (Rahe & Genender, 1983), concentration camp survivors (Davidson, 1967; Eitinger, 1975) and rape victims (Burgess & Holmstrom, 1974; Burnman, Stein, Golding, Siegel, Sorenson, Forsyth, & Telles, 1988).

As Figley (1988) observed, during the 1970s, traumatic stress was discussed largely in terms of severe psychosocial stressors. It is well documented in the clinical and coping literature that survivors of disastrous circumstances typically experience anhedonia, anxiety, depression, guilt, increased startle response, impaired concentration, and sleep disturbances (Horowitz, 1976, 1979, 1982). More recently, however, researchers have found that such traumatic events as rape, child abuse, incest, spouse abuse, violent crime, motor vehicle accidents, natural disasters, and chronic stress can have similar cognitive and emotional consequences (Norris, 1990; Trimble, 1981, 1985).

Research by community and social psychologists, who tend to concentrate on psychological distress and "problem in living," suggest that traumatization can produce long-term changes in personality (Green, 1991). Victims of a flood and of a nuclear power plant disaster reported a variety of symptoms even two years after these events (Gleser, Green, & Winget, 1981; Goldsteen, Schorr, & Goldsteen, 1989). Negative emotional consequences have been documented in rape and incest victims years, even decades after the assault (Riggs, Kilpatrick, & Resnick, 1992; Silver, Boon, & Stone, 1983).

College students represent a population that frequently experiences events that may have traumatic consequences (Hayman, 1999; Vrana & Lauterbach, 1994; Utterback & Caldwell, 1988; Arata & Burkhart, 1996). Prevalence rates regarding the experience of potentially traumatic events in college students have been consistently reported at 80 to 84 percent (Vrana & Laterbach, 1994; Hayman, 1999). Assault, rapes, suicides, hate crimes, intimidations and even homicides are becoming increasingly common on and around college campuses (Utterback & Caldwell, 1988; Arata & Burkhart, 1996).

Due to the prevalence of potentially traumatic experiences in college students, research on how trauma affects this population is critical. Given that traditional college students are young adults who, in terms of adaptive functioning, are engaged in the relatively demanding tasks associated with the higher education process, college students with PTSD may potentially represent a higher functioning sample than has been studied previously in the PTSD-memory literature. Traditional college students with PTSD related to more recent events may represent an adult sample with less chronic PTSD. (Kolts, Lombardo, & Faulkner, 2004).

Lindsey, Fugere, and Chan (2007) conducted a study of 83 college students using the Center for Epidemiological Studies Depression Scale (CES-D). They investigated the moods, perceptions, and behavioral changes among college students during the week following 9/11 and again 11 weeks later. The findings indicated that 9/11 took a heavy toll on immediate psychological and emotional health. Most students' depressive symptoms subsided after 11 weeks.

Following 9/11, at least three major nation-wide studies were conducted to determine the emotional and psychological impact on Americans of the terrorist attacks (Lindsey, Fugere, & Chan 2007). Within one week of the attacks, the Washington-based Pew Research Center had surveyed 1200 Americans from across the country, finding that 71% felt depressed, 50% experienced difficulty concentrating, and 33% experienced trouble sleeping (Pew Research

Center for People & The Press, 2001). Three to five days after the attacks, Schuster and colleagues (2001) interviewed 560 adults, finding that 44% experienced one or more substantial stress symptoms, 14% reported substantial difficulty concentrating and 11% experienced substantial sleep difficulties. One to two months after the attacks, Schlenger and colleagues (2002) administered a web-based survey to 2,273 adults and found that 11% of the New York City dwellers, 2.7% of the Washington, D.C. residents, and 4% of the country overall exhibited probable Post-Traumatic Stress Disorder.

Galea and colleagues (2002) assessed New York City residents five to eight weeks after 9/11, finding that 70.5% reported symptoms consistent with a diagnosis of current PTSD, 9.7% reported symptoms consistent with current depression, 27% reported intrusive memories, and 24.5% insomnia. PTSD was found in 20% of New Yorkers who lived close to the World Trade Center. In a study of Manhattan school children ten months after the attacks, Hoven found 10.5% of public school children in grades 4-12 suffered from PTSD. Agoraphobia, the fear of leaving a safe place or safe person, was found in 15% of pupils (Asch-Goodkin, 2002).

Four to six months after 9/11, Cardenas and colleagues (2003) investigated a volunteer sample of students, for an urban Midwestern university located 600 miles west of New York City, for the prevalence of PTSD, Major Depressive Disorder (MDD), and substance abuse. They found that 5.9% of the students experienced probable PTSD.

Studies of trauma in children have identified likely effects on school performance (Driver & Beltran, 1998). This study focuses on university age students and the impact of trauma on academic attainment. Eth and Pynoos (1985) reported a characteristic decline in school performance for children who had experienced trauma. This is often related to the child's decreased ability to concentrate in class possibly due to the intrusion of memories and thoughts connected to the traumatic event (Driver & Beltran, 1998).

Studies of children's response to traumatic events have focused on the diagnosis of Post Traumatic Stress Disorder and a description of PTSD symptomatology through the use of scales and checklist. Hyman, Zelikoff, and Clark (1988) developed a school trauma survey to describe the pattern of PTSD symptoms in children. The authors identified a subset of symptoms related to abuse in school and proposed that these symptoms are common to the problems of severe stressors in the lives of children. Pynoos and colleagues (1987) studied the acute responses of children to sniper attack using a child PTSD index and Yale and Williams (1990) examined the occurrence of PTSD symptoms in children who survived the Herald of Free Enterprise ferry disaster. These studies concluded that, after extreme traumatic events, a high proportion of children are likely to suffer from PTSD. Common stress reactions include sleep disturbances, separation difficulties, memory problems, intrusive thoughts, heightened alertness to danger, foreshortened future, fears, irritability, guilt, depression, bereavement, anxiety, and panic.

Recent research with college students with PTSD has found that they do not exhibit the memory deficits or cognitive impairments often evident in the adult population (Kolts, Lombardo, & Faulkner, 2004; Twamley, Hami, & Stein, 2004). Other research has indicated that the symptoms of PTSD in college students are not as severe as in community samples (Filipas & Ullman, 2006), and that although students exhibit symptoms of PTSD they may not concurrently report dysfunction in social, occupational, or other areas (Thatcher & Krikorian, 2005). Therefore, college students with PTSD may have a baseline level of coping and adaptability skills that is higher than in a community sample (Bosari, Read, & Campbell, 2008).

Theory

Trauma theory holds that there are biopsychosocial consequences to any individual when he/she sustains a serious threat. The person responds to what has happened in order to preserve physical and emotional integrity. There is a possibility that the physical, psychological, and social consequences may in fact become harmful to the individual (Bills, 2003).

There have been many gains in our biological understanding of the impact of trauma on the mind and body (Teicher, 2002). Psychologists and psychiatrists have long observed that childhood abuse can lead to attachment disruption, self-defeating personality defenses, and arrested psychosocial development in adults. But more recent brain imaging studies reveal the possibility for permanent neuronal damage in the developing brain itself (Bremner, 1999).

Since a majority of the population will experience traumatic stress during their lifetime, the impact of stress can be devastating to the individual and society (Keesler, et al., 1995). The more we understand how a traumatic experience can manifest itself clinically, the better we can do with offering treatment approaches and prevention. A person who experiences a traumatic event can suffer from the following: a) cognitive dysfunction, i.e., memory and attention deficits; b) emotional problems, i.e., affective dysregulation, depression, severe anxiety; c) behavioral manifestations including self-mutilation, substance abuse, sex addiction, impulsivity and aggression; d) learning difficulties due to increased arousal and lack of attention or concentration, i.e., state-dependent learning; and e) memory dysfunction from dissociation and the biochemical changes with memory processing during extreme stress (Bills, 2003).

An understanding of key concepts from trauma theory is necessary to process an individual's response to trauma. SAGE is a cognitive-behavioral translation of understanding the Sanctuary Model. The Sanctuary Model is a trauma-based therapeutic milieu approach which has been applied in many different inpatient, residential, and school settings (Bloom, 1997; Bloom, 2000; Abramovitz & Bloom, 2003; Bills & Bloom, 1998; Bills & Bloom, 2000). SAGE stands for Safety, Affect Management, Grieving, and Emancipation. Much of the initial focus in treatment is on Safety and Affect Management. The definition of Safety encompasses four domains: physical, psychological, social, and moral (Bloom, 1997). Most of the problem behaviors and overwhelming emotions that present difficulties for clients, clinicians and behavioral health settings reflect problems with appropriate affect management. Grieving can be clinically recognized as a failure to move on, reenactment behavior, chronic depressive symptoms, sudden regression, and unresolved bereavement. Emancipation represents the objective--the hopeful vision of what the future can look like as a result of recovery and includes the willingness to engage in transformation that would lead beyond the "sick" role. This linear conceptualization of the essential tasks of recovery allows the clinician to be very comprehensive in the approach to the individual patient while keeping things simple. It is also possible to apply any of the many useful psychodynamic cognitive-behavioral, analytical, biological, social, nonverbal/creative therapies to the patient in a way that he/she benefits from the wisdom of many models. (Foderaro, 2001; Foderaro & Ryan, 2000).

Methodology

For this study, the researchers used a convenience sample of secondary data from the University of Southern Mississippi, School of Social Work. The University of Southern Mississippi, School of Social Work operates as a dual campus program. The primary campus in

located in Hattiesburg, MS and the Gulf Coast Campus is located directly on the Gulf of Mexico in Long Beach, MS. Hattiesburg is approximately 65 miles North of the Gulf of Mexico. The School of Social Work operates both a BSW and an MSW program at both campus sites. For most purposes, the School of Social Work operates as one functional unit. Student data is primarily kept at the Hattiesburg site of the university.

For this study, no personally identifying student data were used or analyzed. The researchers looked at both undergraduate and graduate student GPAs. The use of GPA on school performance, related to trauma, is supported with the previous research done by Driver and Beltran, 1998. The researchers used a simple excel spreadsheet formula to come up with a GPA mean for the semester of all students enrolled in a specific semester. The mean GPAs were then compared with two years prior to Hurricane Katrina and two years post-Hurricane Katrina.

Approximately 300 GPA scores per semester were analyzed. Of these 300 GPA scores, approximately one-sixth of the scores were graduate students the rest undergraduate students. The difference in GPA score numbers between undergraduate and graduate students, reflect the general breakdown of undergraduate and graduate student enrollment at the School of Social Work. The GPA scores do not correlate to individual students, as students were likely to take more than one course per semester. The researchers looked at individual course grades given. Each grade represented a specific GPA score, for example a grade of A = 4.0, a grade of B = 3.0 and so on. The University of Southern Mississippi, at the Graduate level, utilizes a plus/minus system for grading. For the graduate students the GPA scores were averaged to have comparable scores with the undergraduate students. So if a student had a grade of A-, this would correlate to a GPA score of 4.0; if a student had a grade of B+, the grade would be recorded as a B, or a GPA score of 3.0. This alteration in course grade, did introduce some issues with internal validity, however, it made for comparison between the two groups of students easier.

Researchers ran both a z-test score statistic to determine significance, and later a t-test score as the researcher reduced the sample size to a much smaller number. Results of these test scores are discussed below.

Findings

The researchers found that there was no statistically significant difference between graduate student summed GPA scores pre-Katrina or post-Katrina. When looking at the undergraduate students summed GPA scores, the researchers also found that there was no statistically significant difference in pre-Katrina or post-Katrina scores. However, it was interesting to note that the summed GPA scores of undergraduate students taken during the semester that Hurricane Katrina stuck, was numerically lower than all other semesters.

The researchers also controlled for students who were taking courses on the Gulf Coast campus comparing these summed GPA scores to the main campus about 60 miles inland. The researchers again found that there was no statistically significant difference between the two groups. Since there was no statistical difference, an in-depth review of statistical findings has been purposefully excluded from this paper.

Conclusion and Limitations

The primary limitation of this study is the use of the chosen data set. Summed GPAs and student GPAs do not give an in-depth look at explanatory factors which may impact student

academic attainment. GPA scores are not equivalent to level of knowledge gained or student mastery of subject matter. GPA test scores are merely a reflection of the grade earned in a course. The use of GPA scores for this study was merely a convenience item that was available and at hand for the researchers. Additional mental health and academic testing would have increased the strength and validity of this study, by providing more understanding of the impact of trauma on academic attainment.

The second major limitation of this study, is that it is not generalizable. The data set used was not randomly selected, this data set was looking at student GPAs from a social work program in South Mississippi. The findings are limited to only those students, enrolled in the time period under review, at this specific university.

So what was learned from this study? First, a lack of statistically significant data does not equate to a lack of a decent research question. The researchers took the lack of significant findings to be more a reflection of problematic data (summed GPAs) and lack of an in-depth database looking at student academic abilities and mental health assessments, or other measures. The researchers believe that a more refined tool addressing both these issues are needed for future academic comparisons between academic achievement and experience of a traumatic event.

The researchers were puzzled by the drop in undergraduate GPA scores for the undergraduate students the semester that Hurricane Katrina impacted the university. While the drop in GPA scores was not statistically significant, it did provide a visual difference when comparing summed GPA scores. This difference was nothing more than odd, but did spur much discussion on why there was the difference. The researchers hypothesized that perhaps undergraduate students do not have the same level of emotional coping and traumatic response skills to traumatic events as compared to the graduate students. This "difference" does beg for additional research and academic review.

To conclude, this study, while not showing statistical significance, did imply that students, at least those pursuing undergraduate studies, were negatively impacted by human caused traumatic events. This finding would be consistent with other findings in the academic literature.

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MSW DOES NOT Mean "Must Save the World!"

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Abstract

Self-care is an often neglected topic in the helping professions. Social workers, in particular, have a strong tradition of taking care of the needs and problems of others, but in the process, their own needs are often neglected. This paper examines self-care as the cornerstone of sound social work practice, and its basic premise is that we will only be able to work effectively with our clients to the extent that we are able to take care of ourselves. This paper explores the topic of self-care as it relates to the four dimensions of the human person: physical, intellectual, emotional, and spiritual. This essay also addresses boundary issues and job burnout as they relate to self-care.

Introduction

When I decided to pursue a career in social work over 20 years ago, I was clearly on a mission. The world was in trouble, and I had determined that it was up to me to help save it. I had first tried to save the world through the educational system. I emerged from four years of undergraduate work in English Education with the proverbial sheepskin in my hand, and I set out to work in a large urban city public school system; there, I thought, I would certainly make a difference! It wasn't too long before I realized that I was not ready for that system, and that the system was not ready for me and my bright ideas.

Discouraged and disillusioned, I left the educational system for an office job that involved no face-to-face contact with those whom I was helping. While this job offered me the opportunity to help clients at some level, it was not fulfilling. I missed working directly with people, and I knew that this would be a job and not a career.

The organization for which I was working sponsored a job fair, and there were many local businesses represented. I made my usual rounds, making small talk and collecting ink pens and other freebies. As I was returning to my cubicle, I stumbled upon the booth of a recruiter from a major university with an excellent School of Social Work. After a brief conversation, I was filling out forms. There was no doubt in my mind that I would become a social worker, an MSW. I had finally found my calling. Although I have gone on to earn a Master's Degree in Psychology and a Ph.D. in Developmental Psychology, social work remains my first love. Social work gave me a solid theoretical and clinical grounding, and my learning and experience as a social worker are neatly integrated and interwoven into my current clinical practice.

"MSW Does Not Mean 'Must Save the World'" is based on my experience as both a clinician and a clinical supervisor. I entered the field of social work with just as much enthusiasm and idealism as I had when I entered the teaching profession, and with the same goal of saving the world. I have made many mistakes along the way, and I have experienced a

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tremendous amount of growth as a result of these mistakes; for that I am grateful. Although my enthusiasm for helping others has not waned, I have learned that MSW does not mean "Must Save the World."

Ultimately, this paper is about self-care, the foundation of sound social work practice. Taking care of ourselves is not always easy, and it can be viewed by others (and even by ourselves) as selfishness; however, self-care is critically important, especially when we recognize that we will only be able to work effectively with our clients to the extent that we are able to take care of ourselves.

Self-Care: The Cornerstone of Sound Social Work Practice

It would not be an overstatement to say that social workers and those in other helping professions are used to taking care of other people's needs and problems. In fact, The preamble to the social work code of ethics begins with the following: "The primary mission of the social work profession is to enhance human wellbeing and help meet the basic human needs of all people . . ." (p. 1).

While it may be tempting to get our marching orders from this opening statement, we must march on to read what follows it:

> . . . with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. . . Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems (p. 1)

As is the case with many helping professionals, self-care was not easy for me. I believed that meeting my own needs was selfish, and the mere thought of placing my needs before the needs of others left me with an enormous amount of guilt and anxiety. I only allowed myself to consider my own needs and desires after those of others were met or fulfilled, and as one might guess, that rarely happened. It wasn't until I entered into therapy and spiritual direction that I was able to work on my loving myself and considering myself and my needs, wants, and desires as important that I finally "got permission" to care for myself.

What is Self-Care?

Simply stated, self-care is what we do to take care of ourselves, and it has to do with those things that we do to contribute to our overall well-being. It involves our behavior **and** our thoughts. At the behavioral level, we practice self-care when we engage in activities that are in our best interest and that promote our highest good. Self-care at this level can include eating healthy foods, getting enough rest, and nurturing ourselves.

At the cognitive level, self-care can include refraining from negative self-talk, identifying and eliminative negative thought patterns, bringing our gifts and talents into our conscious awareness, and believing that that we are worthy of good care. Self-care also includes setting and enforcing appropriate boundaries in our relationships, both personal and professional, as well as identifying our needs and asking for help from others when necessary. This last point acknowledges our interconnection with others, and it recognizes that we need not feel that we

have to do it alone. Sometimes our needs extend beyond ourselves, and part of taking care of ourselves is enlisting the support of others when necessary.

The PIES Model of Self-Care

This model is based on the four dimensions of the human person: Physical, Intellectual, Emotional, and Spiritual. Abraham Maslow's (1971) Hierarchy of Needs has contributed much to our understanding of basic as well as higher level needs of individuals**.** Matthew Kelly (2005) spells out many needs in each of these four areas, and this section draws much on his holistic analysis. While Maslow's (1971) seminal work focuses on the hierarchical structure or nature of needs, pointing out that unless we address our more basic, survival needs, our ability to thrive in all of aspects of our lives will be severely limited, the emphasis here is more on the dynamic interplay and interrelationship among the four types of needs presented. Here, I invite the reader to imagine a circle (a pie) divided into four sections (slices), with each section representing one of the four dimensions of the human person. In order for us to maintain health and wholeness, we must pay attention to each slice of the pie, with the goal of creating an overall sense of balance.

Both Maslow (1971) and Kelley (2005) make a distinction between those needs that enable us to survive (Physical) and those that enable us to thrive (Intellectual, Emotional, Spiritual). The so-called primary, physical, survival needs include shelter, food, water, and sleep. The so-called secondary needs (Kelley, 2005) are those that help us to thrive. These include love, friendship, acceptance, spiritual practices, and reading intellectually stimulating material. Physical needs can also fall into the category of thriving. For example, when we give our bodies proper rest and regular exercise, we are helping our bodies to thrive. At the physical level, we also help our bodies to thrive by eating a balanced diet, using food as fuel or energy as opposed to using food as comfort or entertainment in an attempt to feed our emotions.

The four dimensions of the human person are interrelated, and each one has an impact on all of the others. For example, our physical condition can affect our emotional status, both positively and negatively. Similarly, our emotional status can positively and negatively affect our physical well-being.

The Four Dimensions

Physical

As mentioned earlier, our physical needs have to do with those things that we need to survive. They include food, clothing, and shelter. Those physical needs to help us to thrive include regular exercise, such as walking, biking, cleaning, swimming, running, working out at the gym, a well-balanced diet, and adequate sleep and rest. Attention to the physical slice of the pie contributes enormously to our overall health and well-being, while neglect of these needs can thwart our growth in the other areas. In my work with clients, I integrate the fields of mental health and the arts to promote healing. I perform and teach African dance and drum, and these are some of the modalities that I use when working with clients, with powerful results. Examples of "Eat the PIES" are explained below.

Exercise: "Eating the PIES"

Participants engage in movement therapy through participation in the "Freedom Dance," using the song and rhythm of the African dance, "*Funga*." Participants will learn the song (Intellectual) and dance movements (Physical/Intellectual); then they will dance to the *Funga* rhythm (Physical/Emotional). This activity begins with a meditative, centering activity (Emotional/Spiritual) to create an atmosphere of openness, safety, and support. This activity closes with a solo circle where participants are encouraged to express their own creativity and individuality through their own dance movements (Physical/Emotional).

Intellectual

As pointed out earlier, our intellectual needs are not essential to our survival, but we need to satisfy these needs if we are seeking to thrive. This area of need has to do with stimulating our intellect and expanding our intellectual capacity. Activities in this area can include reading good books, doing crossword puzzles, engaging in intellectual debate, formal education, attending workshops, learning a new skill, and learning a different language. Kelley (2005) argues that to stretch our intellectual capacity, it is not enough to read a magazine or other material that provides entertainment. He insists that we must read material such as sacred texts and wisdom writings, those of psychology, philosophy, and spirituality. These challenge us beyond our intellectual comfort zones and put us face to face with questions about life's meaning, our existence, our purpose, and with the mysteries of life (Kelley, 2005). Just as we nourish our physical bodies by regular exercise and proper diet, we need to nourish our minds a proper diet that is stimulating and challenging.

Emotional

As with our intellectual need, satisfying our emotional needs is not essential to our survival, but it is essential if we are to thrive. We satisfy our emotional needs by spending time with people we love, being emotionally fed by these relationships, and sharing in the development of others' lives. This sense of reciprocity helps us to know that we are all connected and a part of the same human family. Our families, friends, and colleagues help us to feel loved and accepted, and these emotional connections help us to thrive (Kelley, 2005). Kelley (2005) considers intimacy to be the greatest need of the human person, and it is measured by self-revelation. When we are intimate with each other, we are not afraid to show our true selves, our beauty as well as our vulnerabilities and weaknesses. Unless we are willing to reveal ourselves to others and to create a safe place where people feel that they can reveal their true selves to us, our relationships remain at the level of superficiality.

It is important to note that if our emotional needs are not met in healthy ways, they will seek their own satisfaction in inappropriate and unhealthy ways (Kelley, 2005). For example, when we are preoccupied with our own needs, worries, and tensions, it is not only difficult to work effectively with our clients; we also run the risk of attempting to satisfy our needs (for friendship, popularity, understanding) through our relationships with our clients (Nouwen, 1979).

One clear example of this is inappropriate self-disclosure, wherein we share information about ourselves to satisfy our own emotional needs instead of offering information about ourselves that might serve to benefit the clients. Another example is attempting to satisfy our

need to be needed by doing things for our clients that they can do for themselves. It is also important to point out that many helping professionals enter their professions with deep emotional wounds and traumas, and they may, consciously or unconsciously, seek to work out their issues in the process of helping their clients. In such cases, individual therapy, pastoral counseling, spiritual direction, or other forms of more formal support is needed.

In his 1979 book, *The Wounded Healer*, noted spiritual writer, Henri Nouwen addresses the importance of healing our wounds before attempting to help others to heal:

> Since it is his task to make visible the first vestiges of liberation for others, he must bind his own wounds carefully in anticipation of the moment when he will be needed. He is called to be the wounded healer, the one who must look after his own wounds but at the same time be prepared to heal the wounds of others (p. 82).

Spiritual

Although there is no real agreed-upon definition of spirituality, it can be broadly defined as a deep sense of wholeness, connectedness, and openness to the infinite (Shafranske & Gorsuch, 1984). Kelley (2005) points out that although our spiritual needs may change depending on our particular developmental stage and according to our life circumstances, the three spiritual needs that are relevant to us regardless of where we are on our spiritual journey are silence, solitude, and simplicity.

Silence and Solitude

Silence and solitude often go hand in hand. In "The Classroom of Silence," as it is often called, we come into awareness of our deepest needs and our deepest desires. We become aware of those things that are really important to us, those things that get crowded out by the busyness of our ordinary daily lives. In the spiritual life, silence and solitude are likened to "coming home to ourselves," and being at home with ourselves demands these two disciplines (Wicks, 2003). It is important to note that silence and solitude are difficult for most, and it can be very frightening to sit quietly alone with oneself. I have described elsewhere the difficulties that I encountered during my initial attempts at silence and solitude (Adamson Holley, 2007). The key, I have found, is to be patient and to stick with the process, no matter how frightening or *seemingly* fruitless and meaningless.

I begin each day with silence, solitude, meditation, spiritual reading, and prayer, and without it, my day just doesn't seem to go right. I enter what I have designated as my sacred space, which contains incense, candles, many pillows, sacred images, and devotional material. My quiet, meditative time, a time of intentional grounding and centering, is the most important part of my day, and it is one of the few things in my life that I consider as non-negotiable. I also use this time to reflect on each client that I will work with that day, and I offer a prayer for the client and for our work together.

Simplicity

In our modern, technological culture, simplicity can often seem elusive. We are continually encouraged, if not expected, to leads lives of complexity. We are bombarded with messages that urge us to spend more, to do more, and to be more. We are taught that more is definitely better. A life of simplicity, on the other hand, teaches us that less is more. It encourages us to be grateful for who we are and for what we have, without the internal or external pressure, or compulsion to have more, to do more, or to be more. A life of simplicity can lead to inner peace, and it can have a liberating effect on us.

My travels in Southern and West Africa allowed me to experience this type of simplicity, and life in Africa brought me face-to-face with the reality of my very complicated life; it was here that I first discovered that less is more. In Africa, people had far fewer "luxuries" and very simple schedules; yet people there seemed unencumbered and genuinely happy. Far removed from the pressures and demands of life in the city, I, too, felt a sense of joy and freedom. It was my experiences in Africa that initially motivated me to remove the clutter in my life.

Small Group Exercise: "Baking PIES"

In a small group, participants will use a handout and color pencils to graphically represent the percentage of time that s/he currently devotes to each of the four dimensions. Participants will list the specific activities or practices that correspond to each of the four dimensions. After "baking the PIES," participants will share with group members their responses to the following:

- Which dimension(s) receives the most attention? Explain.
- Which dimension(s) receives the least amount of attention? Explain.
- What specific things might you do **this week** to create more balance?

Participants are then invited to share their responses with the larger group.

Self-Care Ideas

Here are some of the ways that I take care of myself. The reader may have things that he/she does that are not included here. Only you know what will work for you.

- Take a long, hot bubble bath.
- Listen to music.
- Take a meditative walk.
- Work out at the gym.
- Sit under a big tree in the woods.
- Read books that I enjoy.
- Write in a journal.
- Volunteer.
- Play African drums.
- Dance.
- Have a session with my therapist/spiritual director.
- Talk to my sister.

- Engage in daily spiritual practices, i.e., reading sacred texts, meditation.
- Spend time alone in the mountains.
- Clean my house.
- Do deep breathing and relaxation exercises.

In addition to these activities, I take what I have termed my "Designated Dorothy Day," wherein I take every Friday off from work to do whatever I want to do. I begin by changing my voicemail message to indicate that I will be away **and unavailable** on that particular day. Then I turn my phones off, and sit in my sacred space for my morning devotional, meditative time. From there, I flow through my day doing those things that bring me joy.

Self-Love

Self-love is a topic that deserves special attention. If we truly love ourselves, we will devote time to caring for our needs. For many of us, however, the ability to love ourselves is severely limited by past abuses, past trauma, and negative messages that we received about ourselves, often beginning in childhood. In such cases, the help of a skillful, nonjudgmental helping professional may be needed to help us in the healing of these emotional wounds. In his book, "Healing the Shame that Binds You, Bradshaw (2005) offers important insight into the long-term effects of past abuses and traumas, and he guides the reader toward the path of total self-love and acceptance, the foundation of happiness and of our ability to love others.

Bradshaw (2005) emphasizes that loving ourselves involves a willingness to give ourselves time and attention, and he offers the following as points of reflection:

> How much time do you spend with yourself? Do you take time for proper rest and relaxation, or do you drive yourself unmercifully? If you're a human doing, you drive yourself. You need more and more achievement in order to feel okay about yourself. If you're willing to love and accept yourself unconditionally, you will allow yourself time just to be. You will set aside times when there's nothing you have to do and nowhere you have to go. You will allow yourself solitude, a nourishing time of aloneness. You will take time for hygiene and exercise. You will take time for fun and entertainment. You will take vacations. You will take time to work at your sex life. You will be willing to give yourself pleasure and enjoyment (p. 226).

When we love someone, we want to spend time with that person, and our relationship with the person is considered to be very important. Most of us are not aware that we actually have a relationship with ourselves; loving ourselves and spending time with ourselves is also important. In one of my devotional books there is an entry entitled, "Spending Time with Me," and it helps me to be mindful of the importance of my relationship with myself:

> Today I will remember to stay home and give myself the quiet, comfort and safety of my own company. When I forget how much I need to be with myself, I lose contact with my best friend – me. Any relationship needs time in order to keep it a going concern, and my relationship with myself is no different. . . (Dayton, 1992, p. 362).

As alluded to earlier, self-love and self-acceptance were not easy for me, and it took the process of therapy and spiritual direction for me to be able to love myself and to feel worthy of self-care. I was blessed to have a therapist/spiritual director who had traveled a similar path and who was able to draw on that experience as she guided me on my healing journey. Appendix A is a poem entitled, "I Love Me," and it reflects the sense of self-love and self-acceptance I experienced as a result of my work in therapy.

Boundary Issues

In order for us to take care of ourselves, we must have clear boundaries. Katherine (2000) defines a boundary as "a limit that promotes integrity" (p. 13). We have thousands of boundaries that serve to protect every treasured aspect of our lives, our relationships, our time, our home, our money, our priorities, and our health. Essentially, a boundary is a limit. By the limits we set, we protect the integrity of our day, our energy and spirit, the health of our relationships, and the pursuits of our heart (Katherine, 2000). When we violate our own boundaries or allow others to violate them, our lives are less integrated, and we can lose our sense of self.

Not having clear boundaries often flows out of our need to be liked, to not make waves, or to please others. I remember that in my first social work position, my boundaries were not very clear. I did a lot for my clients that they could and should have clearly done for themselves; I kept late hours, and I was very accessible. Moreover, I refused to hold my clients accountable for their actions. In hindsight, I can see that my lack of boundaries was my attempt to be liked by my clients. Fortunately, no obvious harm was done by my actions, but my clients did not experience the full benefit of treatment, and it is unlikely that much real change or growth took place.

Lack of clear boundaries robs our clients of important learning and growth opportunities, and it is a serious impediment to self-care. Having clear boundaries acknowledges that our clients are very capable. It acknowledges that clients are responsible for their own lives, and that we stunt their growth or can even harm them if we try to take care of everything for them. Using a person's own strengths and resources is what good therapy is all about. The power is in the one we're trying to help. Moreover, by having clear boundaries, we offer a powerful model for our clients whose boundaries are often blurred.

It is important to point out that, when we begin to establish clear boundaries, others may resent us for it. We may encounter their negative reactions as we engage in these different interactional patterns, as others may want us to operate in those familiar ways. Be careful not to revert to former ways of being or to feel guilty about having set clear boundaries. Once people get over the initial shock, and we persist in our boundaries, most people will learn to honor and respect them. Others may leave, and that's okay too.

Avoiding Burnout

Burnout is a serious problem, and it can happen to anyone in any profession; however, social workers are considered to be at very high risk for burnout since our work involves attending to the needs of others, and since we are often overworked, underpaid, and under appreciated. The dimensions of burnout are emotional and physical exhaustion, cynicism, and ineffectiveness (Maslach and Leiter, 1997).

Because burnout is related to stress, many of the methods detailed in the PIES section of this paper can help prevent burnout. For example, it is important to build or maintain a foundation of

good physical health; therefore, emotional connection, getting enough rest, and making exercise a part of your daily life are essential to reducing stress.

So far, the discussion about burnout has focused on what individuals can do to prevent it, and this can lead to the assumption that burnout is caused, at least to some extent, by the individual. Extensive research conducted by Maslach and Leiter (1997) challenges the conventional wisdom that burnout is a problem of the individual, a result of flaws in their character, behavior, and productivity. Instead of focusing on changing people, as this perspective would necessitate, Maslach and Leiter (1997) argue that changes should take place in the environments in which people work, in the structure and functioning of the workplace.

Maslach and Leiter (1997) argue that variables such as work overload, lack of control over one's work, lack of reward for contributions, lack of connection with others in the workplace, lack of fairness, and value conflicts contribute more to burnout than any individual variables. The current author believes that both individual and organizational variables should be considered when addressing the problem of burnout.

Final Thoughts

During my workshops, I often offer the following thoughts as a point of encouragement to those of us who tend to become discouraged when clients do not progress as we believe they should:

1. Be Realistic. Being realistic has to do with understanding our limitations. We must understand what we can and cannot do.
2. You will not reach all of your clients. We have to recognize that behavioral change and emotional growth are complex processes involving clinician, client, and environmental variables. Our clients come to us with histories and their own unique set of circumstances. Some of the issues that they face have had a developmental process of years. It is unrealistic for us to expect our clients to be able to change overnight.
3. Develop a process orientation. It is important that we focus on the process of our work with clients, not exclusively on the outcome. This is not to say that we should not concern ourselves with outcomes; however, we must avoid falling into the trap of judging ourselves based on how well a client progresses. We must recognize and appreciate that the effects of our work are often not manifested until years after we have worked with a client.
4. Honor and respect the client's right to self-definition and self-determination. This has to do with allowing clients to make their own choices and decisions without imposing our judgments, ideals, and values onto our clients.
5. Develop a partnership with your clients. It is not uncommon for clients to come to us with the expectation that we will solve their problems. If we are not careful, we can easily fall into the trap of doing the work for our clients. An effective social worker recognizes that she/he cannot heal or cure a client.

Attachment

"I Love Me"

How do I love me? Let me count the ways.
I love me when I'm wise enough to give God all the praise.

I love me when I take the time to do the things I like;
Like when on a bright and sunny day, I go out and ride my bike.

I love me when I eat the food that helps my body to thrive;
I love me when I awake in the morning, grateful that I'm alive.

I love me when I'm tired and allow myself to rest;
I love me when I've missed the mark because I know I've done my best.

I love me when I honor how I really think and feel;
I love me when I recognize that love's the only thing that's real.

I love me when I allow myself to experience all my pain;
Not to run and hide and repress that stuff that in time will come up again.

I love me when I forgive myself for making foolish mistakes;
I love me when I get back on track no matter how long it takes.

I love me when you criticize me and my confidence doesn't shrink;
I love me when I love myself no matter what you think.

I love me when you hate me even though I've done no wrong;
Your thoughts of me are inconsequential because I've learned to suffer long.

I love me when you remind me of all the evil things I've done;
Because the blood of Christ reminds me of the victories I've won.

I love me when you tell me we can no longer be together;
The depth of the love I have for myself is much stronger than your stormy weather.

I love me when I treat **you** well despite your treatment of me;
When I love me in this type of way, my heart and soul are truly free.

I love me, I love me, I love me; please don't think I'm being conceited;
I'm just learning to give myself the love and attention I've always needed.

It's taken a long time for me to love myself the way my God and Maker does;
And there is nothing in this whole wide world can ever separate me from that love.

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