Intergenerational Addiction and Child Abuse: Treatment and Policy Approaches

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Abstract

This single case study reviews the therapeutic needs of a DCFS mother who was raised in an abusive, alcoholic home environment and was in need of addiction treatment to reunify with her own children. Issues of abuse and neglect, addiction, roles and patterns of adult children from alcoholic homes, and addiction treatment are examined. The Stone Center's relational model of women's development is utilized to understand the gender-related therapeutic needs of mothers who have lost their children to DCFS and are also addicted to alcohol and drugs. Implications for practice are discussed, including specific needs of women in addiction treatment, coordination of services between child welfare and treatment facilities, and child welfare policy with reference to the mandates of the Adoption and Safe Families Act (ASFA) and its impact on reunification for families with addiction.

Introduction

Parents seeking reunification with children they have been found to have abused and neglected often struggle with profound suffering resulting from having been abused as children, from substance abuse, and, often, from gender-related trauma due to various forms of discrimination against women. This paper draws from an extensive case example and a review of the literature to shed light on how clients with these challenging problems can be understood and helped to reclaim their own happiness and the pleasure of parenting their children.

The paper begins with a review of the relevant literature related to addiction treatment, the systemic family effects on children raised in a home where a parent is addicted, the differences between male and female development that affect addiction treatment implications and strategies, the Stone Center's self-in-relation theory, and trauma as it relates to recovery from addiction. The case study provides a window into the internal world of a child welfare mother, raised in an alcoholic home environment, who is now seeking reunification with her own children. The theoretical model that informs this case study is women's development-in-relation theories from the Stone Center. Implications for social work practice, coordination between child welfare and substance abuse treatment, and child welfare policy are discussed.

Women who were raised in alcoholic, abusive home environments and become mothers in the child welfare system face complex problems. Parents who were victims of child abuse may repeat the dysfunctional cycle and abuse their own children. Child abuse, if left untreated, has developmental, behavioral, and emotional consequences that continue into adulthood and result in harmful intergenerational patterns. A woman's childhood experience of neglect contributes to an increased likelihood of neglectful parenting of her own children (Dunn, Tarter, Mezzich, Vanyukov, Kirisci, and Kirillova, 2002). Magura and Laudet (1996) report that these parents lack mature characteristics that include the ability to trust, the ability to make healthy partner choices, and the ability to manage stress and nurture others. Adults who were abused as children are at greater risk for substance abuse disorders (Miller, Downs, and Testa, 1993). Also, children raised by alcoholic parents are considered at risk for the disease, at an approximately fourfold greater risk than other children (Kinney, 2003). Maternal substance abuse is one of the most common reasons children enter the Department of Children and Family Services (DCFS) system

(Azzi-Lessing and Olsen, 1996). Eighty percent of abuse cases are associated with the use of alcohol and other drugs (McCordy and Daro, 1994). The relationship between substance abuse and child neglect is rendered more complex by the high comorbidity with psychiatric disorders (Dunn et al., 2002).

The child welfare system and the substance abuse treatment system have been criticized for not providing a coordinated, family-centered effort to help families recover and achieve reunification. These agencies are seen as neglecting the family system and instead providing separate and conflicting services (Azzi-Lessing and Olson, 1996; Carten, 1996; Smith, 2002). Substance abuse treatment providers and domestic violence programs may also provide separate and conflicting services. Domestic violence programs use an empowerment model while avoiding the stigmatizing labels of enabling, codependency, and disease that are used in substance abuse treatment programs. Substance abuse providers might view many domestic violence staffers as uninformed and naïve regarding the manipulating behaviors of substance abusers. Disagreements between experts also inhibit the coordination of treatment and respective understanding of the connections between domestic violence and substance abuse (Fazzone, Holton, and Reed, 1997). This further complicates coordination with the child welfare system.

Special issues for women in recovery from addictions are another concern. Gender differences are an important factor in substance abuse programs and recovery for women. Substance abuse treatment centers have historically been dominated by treatment models based on the needs of men (Finkelstein, 1994), although it has been shown that the intervention models effective in treating men do not meet the needs of women (Azzi-Lessing and Olsen, 1996; Reed, 1987). A comprehensive and well-coordinated service delivery system that addresses the specific needs of women is needed. Azzi-Lessing and Olsen (1996) identified the following needs for a system to effectively deliver services to women in the child welfare

system: a family-centered approach, housing assistance, child care, transportation, and job skills. Further investigations, examining not only the concrete needs of women but also the developmental process of women, have questioned traditional addiction treatment models of confrontation.

Relational therapy models at the Stone Center have provided insight into the developmental process of women in relationships that affect their needs in recovery from addictions (Covington, 1997, 2002). Women define themselves in terms of their relationships. Women's self-development includes a more diffuse individuation process than the traditional linear step progression. Disconnections in relationships result in problems. Addictions programs have been quick to label this diffuse individuation process as codependent. Enhanced connection rather than increased self-object differentiation and separateness is the goal in women's development. An example is Covington's (2000) comprehensive program, "Beyond Trauma: A Healing Journey for Women," that addresses the connection between trauma and substance abuse in women's lives.

The federal government enacted the Adoption and Safe Families Act (ASFA) in 1997 to establish a timely process for the provision of safe and permanent homes for children in foster care (Pub. L. No. 105-89). ASFA places tighter restrictions on the time allotted for family reunification and allows for termination of parental rights if a child is in foster care for longer than 15 months. The 1997 legislation changed the emphasis from family preservation to child health and safety. Ensuring the child's development in a stable environment takes precedence over reunifying the family.

Laudable as these goals may be, the ASFA negatively affects reunification possibilities when addiction treatment is necessary. Recovery from addiction may not be possible within the time limits allotted by ASFA (Carten, 1996; Smith, 2002). Substance abuse is a chronic disorder; several relapses

may occur before one maintains sobriety. Mothers who were abused or neglected as children are more prone to relapse than individuals without a history of abuse. A history of childhood trauma can lengthen the time needed for substance abuse treatment (Steinglass, 1987).

Two major reports released in 1999 highlight the need to address this intergenerational cycle of substance abuse and child abuse if effective progress is to be made on either problem. These studies are *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection* by the U.S. Department of Health and Human Services (DHHS) and *No Safe Haven: Children of Substance Abusing Parents* by the National Center on Addictions and Substance Abuse (CASA) at Columbia University (Howard, 2002).

Review of the Literature

The literature as summarized below draws attention to the self-help movement (Alcoholics Anonymous, 1976), the disease concept of addictions (Jellinek, 1952, 1960; Vaillant, 1996), assessment models (American Psychiatric Association, 2000; American Society of Addiction Medicine [ASAM], 1993), placement criteria (ASAM, 1993), family dynamics (Markowitz, 1993), trauma (Herman, 1992), and women's psychological development (Covington, 1997, 2002; Gilligan, 1982; Jordan, Kaplan, Miller, Stiver, and Surrey, 1991; Miller, 1976, 1988).

Addiction

The man takes a drink, the drink takes a drink, and then the drink takes the man.

　　　　　—A Chinese saying (Kinney, 2003)

Bill Wilson and Dr. Bob Smith founded the fellowship of Alcoholics Anonymous in Akron, Ohio, in 1935. The 12-step program of Alcoholics Anonymous draws its wisdom from Carl Jung's ideas of a "spiritual experience," the Oxford Group (a nondenominational, theologically conservative, evangelical Christian group), and the ideas put forth by William James (1999) in *The Varieties of Religious Experience*.

Bill Wilson's (1999) own experience of "one alcoholic talking to another" in a moment of hopelessness and total deflation (hitting bottom) and a moment of conversion and needing others (recognition of a higher power) established the fellowship in which millions of alcoholics have achieved sobriety (Alcoholics Anonymous, 1976; Kurtz, 1979). In the 1930s, Dr. William D. Silkworth, an early friend of the program, defined *alcoholism* as "an obsession of the mind that condemns one to drink and an allergy of the body that condemns one to die" (Kurtz, 1979, p. 22). The AA program suggests a lifestyle change through the practice of the 12 steps for those individuals who will admit powerlessness over alcohol and make a decision to turn their wills and lives over to the care of a higher power. Alcoholics Anonymous stresses the importance of abstinence "one day at a time," and the use of a sponsor as a mentor to assist in "working the program." Alcoholics Anonymous provides support from other recovering alcoholics, the embodiment of hope, concrete suggestions, simple slogans to guide the reordering of one's life, and a safe haven. It is often referred to as a "simple program for complicated people." Alcoholics Anonymous has been described as "the single most effective treatment for alcoholism" (Kinney, 2003, p. 308).

Spiegel (1993, p. 158) addressed the therapeutic value of the anonymous programs: "The 12 steps constitute an opportunity for internal, structural, therapeutic change . . . . The anonymous programs provide a holding environment," and the recovery process provides a way to "negotiate the separation-individuation process." Spiegel drew a parallel between the bonding that occurs when one's defenses crumble in the 12-step programs and the "good enough" mother who leads one to a greater level of "object constancy." He further stated:

The recovering person is able to move back and forth between the "good

enough" mother (AA) and the outside world. Thus the program with its varied tools and components offers a kind of an institutional consistency, and the experience of individuation becomes a corrective emotional experience. As the Anonymous program—the people, the principles, the slogans, the literature— is internalized, recovering persons can truly take it with them wherever they go (p. 159).

Alcoholism and substance abuse result from a combination of factors, including biochemical, genetic, familial, environmental, and cultural dynamics. Studies point to the presence of biochemical and genetic factors in the intergenerational transmission of alcoholism (Goodwin, 1984; Porjesz and Begleiter, 1985; Straussner, 1989). Other studies correlate addictions with familial factors such as early separation from parents, childhood abuse, and families with high incidences of multigenerational abuse of alcohol or other drugs (Black and Mayer, 1980; Carroll, 1985; Kaufman, 1985; Steinglass, Weiner, and Mendelson, 1971). Environmental and cultural factors have also been related to addictions (Carroll, 1985; Kaufman, 1985).

E. M. Jellinek (1952, 1960), the father of alcohol studies, is responsible for the paradigm shift from the belief that alcoholism is a sign of moral inferiority to the perception of alcoholism as an illness or disease. He identified a definite pattern of symptoms and a progression of the disease. The four phases of alcohol addiction include:

1. prealcoholic phase (socially motivated, but includes psychological relief);

2. prodromal phase (increase in tolerance, blackouts, gulping, sneaking drinks);

3. crucial phase (loss of control of the amount consumed after taking the first drink, rationalizations, attempts to control use by deliberate periods of abstinence, geographical changes, and centering life around alcohol); and

4. chronic phase (decrease in tolerance, tremors, indefinable fears, failure of rationalization, inability to see a way out of addiction, and physical deterioration).

Jellinek also defined species of alcoholism: Alpha Alcoholism (psychological dependence); Beta Alcoholism (physical problems such as cirrhosis and gastritis); Gamma Alcoholism (physiological changes in the body, withdrawal, loss of control); Delta Alcoholism (psychological and physical dependence but no loss of control); Epsilon Alcoholism (binge or periodic drinking); familial alcoholism (history of family alcoholism); and secondary/reactive alcoholism (superimposed on a psychiatric illness).

Vaillant's (1996) classic longitudinal study of adult development also examines the natural history of alcoholism. The goal, as originally designed, was to study adult development in two groups of men over 50 years, beginning in adolescence. The two groups were comprised of Harvard undergraduates and men from high-crime, inner-city neighborhoods. During the course of the study, members from both groups developed addictions. This seminal study, originally published in 1983, has significant findings for the addictions field, most notably a lack of support for the theory of an "alcoholic personality" that predates the addiction. The major predictors of alcoholism include a family history of alcoholism, being raised in a culture whose norms proscribe childhood alcohol use, heavy adult alcohol use, and acceptance of intoxication. Treatment was not usually initiated until the individual had experienced eight or more lifetime problems. The outcomes were recovery or death. Successful recovery was associated with the experience that the pain of drinking is greater than the pain of recovery, an active support system, the sense of hope and belief that recovery is possible, and the development of new interests.

Substance abuse rarely is confined to one drug alone. Probably the most commonly

abused drug, next to alcohol, is marijuana, and so the nature and effects of marijuana abuse are briefly described below. Despite the popular belief that marijuana is a "safe" drug, there are many symptoms that indicate otherwise. Marijuana, generally smoked, produces euphoria, relaxation, slowing of reaction time, and a reduction in visual acuity and the perception of time; reduces muscle coordination; and disrupts learning and concentration. Marijuana slows the ability to learn new tasks and disrupts short-term memory. Cognitive impairments have been found to linger in chronic marijuana users (Block and Ghoneim, 1993; Pope, Gruber, and Yurgelum-Todd, 1995; Pope and Yurgelum-Todd, 1996). Delta-9-tetrahydrocannabinol (THC), the principal psychoactive substance in marijuana, remains in the body's cells and can be found in the urine or blood up to six weeks after the last use. Occasional use of marijuana does not produce tolerance. Chronic marijuana users may develop tolerance to the effects of the drug, and may also experience reverse tolerance or become more sensitive to the effects of the drug over time. Withdrawal signs do not occur with occasional use. Heavy and chronic use (one to three joints per day) does produce symptoms of withdrawal (NIDA, 1996). When combined with alcohol, marijuana can increase the chance of an accidental overdose or death. Marijuana also can produce a psychotic reaction in individuals who are at risk for developing psychosis (Craig, 2004).

Assessment Models

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition, revised) (DSM-IV TR, 2000) criteria for alcohol dependence include three of the following symptoms over a 12-month period: increased tolerance; signs of withdrawal; drinking larger amounts or over a longer period; unsuccessful efforts to control drinking; considerable time spent in activities related to drinking; important social, occupational, or recreational activities given up; and the continuation of drinking despite problems. The DSM-IV TR

distinguishes alcohol abuse from addiction by defining one or more of the following symptoms in a 12-month period: recurrent drinking that results in a failure to fulfill major role obligations, drinking while in physically hazardous activities, recurrent legal problems, and continued drinking despite social or interpersonal problems caused by the use.

Kinney (2003) quotes the American Society of Addiction Medicine (ASAM) definition of *alcoholism* as:

> A primary, chronic disease with genetic, psychological and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking (2003, p. 63).

ASAM (1993) has also defined placement criteria to guide decisions about the appropriate treatment setting. Six dimensions are evaluated to determine the level of care required. These dimensions include an individual's potential for withdrawal, biomedical conditions and complications, emotional-behavioral conditions, acceptance of the need for treatment, relapse potential, and recovery environment with supportive resources. The evaluation of these dimensions guides the recommendations for appropriate treatment settings, which include: Level 0.5, early intervention; Level I, outpatient services; Level II, intensive outpatient services and partial hospitalization; Level III, inpatient residential services; and Level IV, medically managed intensive inpatient services.

How successful is treatment? A study conducted by Miller, Walters, and Bennett (2000) indicated that one year after treatment, one-third of clients remained asymptomatic, one in four remained continuously abstinent, and one in ten used alcohol moderately without problems. Shen, McLellan, and

Merrill (2000) studied the relationship between the patients' motivation for substance abuse treatment and their post-treatment outcomes. Their study found that client motivation made a substantial difference in the treatment outcomes, thus suggesting that treatment is more effective for clients who are motivated to receive it. This means that a central therapeutic issue is how to help clients discover and deepen their motivation to care for themselves without relying on alcohol.

Family Relationship Patterns for Children Raised by Alcoholics

We admitted we were powerless over our parents and that our lives had become unmanageable.

—Step one from the Anonymous Program of Adult Children of Alcoholics

Children who grow up with parents who are empathically impaired and are addicted suffer narcissistic injury. The lack of empathy and resulting narcissistic injury damages family interactions over time. Wegscheider (1981) identified adaptive roles of the child of an alcoholic as including hero, scapegoat, lost child, and mascot. Black (1981) identified adaptive rules that help the child survive: don't talk, don't trust, don't feel. Black suggested that adult children continue these coping strategies into adulthood and often use a variety of mechanisms for psychic withdrawal and self-protection.

Attachment is the essence of the secure parent-child relationship (Ainsworth, 1973; Bowlby, 1969; Main, 1995; Stern, 1985). Winnicott (1971) discussed the importance of the "holding environment" and the "good enough" mother. The effects of excessive alcohol or drug use by a parent distort these normal, powerful parent-child attachment relationships. The drug becomes an all-consuming preoccupation. "In addition to the parents' behavior being directly distorted by the effect of drugs, the parents may value their drugs more than their child" (Markowitz, 1993, p. 215). Children do not have the knowledge to understand the intermittent effects of alcohol or drugs on the behavior of their parents. Markowitz (1993) described the consequences of impaired parental empathic behavior:

- the well-being of the child becomes secondary;

- the parent becomes physically and emotionally unavailable to the child;

- displacement of the parents' feelings onto the child, possibly resulting in unfair punishment;

- blackouts create confusion, fear, and anger and result in the child feeling "not seen";

- impaired social judgment may result in abusive behavior and the child experiencing a sense of helplessness, shame, and humiliation; and

- the keeping of family secrets results in a mockery of the child's reality testing.

Children of alcoholics develop the coping technique of becoming overly attuned to their parents' needs. Caretaking skills help them mirror the nurturing they crave for themselves. Children become "confidante, comforter, adviser, and supporter of the parents; these children develop a special sensitivity to unconscious signals manifesting the needs of others" (Markowitz, 1993, p. 219). These adaptive strengths of sensitivity, responsibility, desire to please, and the need to rescue others may come at the high price of neglect of their own wishes, feelings, and needs, as well as feelings of emptiness and aloneness. Children of alcoholics often have a need to maintain control due to the experience of a chaotic and unpredictable environment. Exerting control often enables the child to play a role in holding the family together. However,

[T]hey often cling to the illusion of being in a position to control their substance-abusing parent's behavior. They

ascribe the cause of their intermittent abandonment to their own "badness" so that they can continue to view the parent as good and thereby continue to hope for the caring and connectedness they seek. This perpetuates the illusion and sustains the hope that they can influence the parent's moods and behavior by adjusting their own behavior (Markowitz, 1993, p. 221).

Shame keeps the individual from seeking help, erodes self-worth, and produces destructive secrets. "To feel shame is to feel nakedly exposed to the world, unprotected from critical eyes" (Potter-Efron, 1988, p. 10). Healing can take place when the client can own the ambivalence and accept that the wished-for loving parent never existed and cannot be created.

Women who have been hurt by alcoholism in their families face unique challenges. Covington (1997)'s emphasis on mutual connections describes the recovery process of women who are addicted to alcohol or drugs. She suggests that the literature on codependency pathologizes women's potential strength in relationships and invalidates their motive for connection. "The codependent label reflects an intrapsychic paradigm, that the disease is in the individual, not the relationship" (p. 11). She proposed that recovery from codependency not only requires a strengthening of self, a solidifying of boundaries, and focusing on one's own needs, but also requires placing value on the importance of healthy mutual connections as the healing energy and goal of recovery.

Women, Development, and Addiction

We admitted we were powerless over alcohol— that our lives had become unmanageable.

> —Alcoholics Anonymous, 1976, p. 59

The first step of Alcoholics Anonymous is paradoxical. Only by admitting powerlessness over an addiction can one become free to find where one truly has power. The paradox of step one can be especially difficult for women. "Admitting powerlessness . . . [may be a] familiar one-down position." Recovery is about empowerment and finding one's true inner power. It is important for women "to acknowledge the power of their addiction while discovering their personal power through recovery" (Covington, 1997, p. 13).

Recent understandings of women's psychological development emphasize the centrality of relationships in women's lives (Gilligan, 1982; Jordan, Kaplan, Miller, Stiver, and Surrey, 1991; Miller, 1976, 1988). The Stone Center at Wellesley College has developed a theoretical perspective based on relational models of healing and empowerment for women. Traditional theories, usually representative of men's experience, have described development in a linear step progression from dependence to separation and individuation, with the goal of a differentiated, autonomous self. The relational model of development of women views development as growth with and toward connection. Healthy connection is the means and the goal of psychological development. Jean Baker Miller (1976) suggested that women's sense of connection to others is based on empathy and mutuality in relationships. Healthy connections are mutual, creative, energy-releasing, and empowering. Mutual empowerment is a process of relational interaction in which each person grows through "power with" others rather than "power over" others. Psychological problems are traced to disconnections or violations within relationships. Non-mutual relations and disconnections create a "depressive spiral" that results in disempowerment, confusion, and diminished self-worth (Miller, 1988).

Women frequently use substances to maintain connections and to feel connected. Covington (1997, p. 3) stated: "Women's motives for connection can lead them toward substances and substance abuse in a culture where they have been given the primary responsibility for relationship, yet where important relationships, institutions,

and political systems are frequently far from mutually empathic and mutually empowering." Covington describes five patterns of relational disconnection that foster substance abuse: non-mutual relationships; isolation and shaming; limiting relational images; abuse, violation and systemic violence; and distortion of sexuality. Miller (1988) described a state of "condemned isolation." The experience of condemned isolation is one in which the woman feels isolated in her important relationships, feels that she is at fault, and feels that there is no possibility of changing the situation. The shamed individual feels "nakedly exposed" and "deeply fears abandonment by those he loves and rejection from the community as a whole" (Potter-Efron, 1988, p. 10). Covington (1997, p. 6) noted that this state of "shame and condemned isolation is highly correlated with drug use, as drugs become a way of coping with feelings that are seemingly beyond the scope of what is human and what could possibly be brought into connection with any good outcome." Other authors have correlated the removal of children by DCFS with the mother's increased drug use (Smith, 2002); shame also increases drug use (Potter-Efron, 1988). The mother whose children are under care because a charge of abuse or neglect has been founded may experience the child protective service process as a shameful "rejection from the community" and may believe that there is no possibility of changing the situation. Sadly, the women who most need connection instead can suffer from "condemned isolation." To counteract this isolation, the mother needs to be supported in the recovery process, and Covington proposed that recovery for addicted women should focus on repairing the failures of mutuality in relationships.

Trauma

Traumatic events destroy the victim's fundamental assumptions about the safety of the world, the positive value of the self, and the meaningful order of creation.

—Herman, 1992, p. 51

Trauma and addictions are interlinked. A history of abuse increases the likelihood that a woman will abuse alcohol or other drugs (Covington and Kohen, 1984), because many women who are trauma survivors use alcohol or drugs to medicate the pain of the trauma (Covington, 2002). Addiction treatment has not traditionally addressed issues of trauma in early recovery. Covington stated: "By integrating trauma treatment with addiction treatment, there is less risk of trauma-based relapse" (2002, p. 11). Covington's comprehensive program (2000, 2002) utilizes Judith Herman's framework for integrating the dual recovery of trauma and addiction. Herman's framework (1992) is a three-stage model for trauma recovery: safety, remembrance and mourning, and reconnection.

The Psychological Safety Net

Principle number one: The healing environment must be characterized by emotional warmth and responsiveness. The therapist must display an appreciation of the patient's basic worth and an acceptance of the patient's individuality.

—Wood, 1987, p. 109

Mothers charged with abuse and/or neglect can experience the court process as profoundly shaming and merciless in its confrontation. While alcohol drug counselors are trained to confront the alcoholic's denial, this confrontation may be damaging rather than healing for an individual who is already filled with shame. Pape (1993) reports that the confrontation model is not appropriate for women, and can reinforce a woman's sense of powerlessness and further lower her self-esteem. Markowitz stated: "By allowing clients to share shameful feelings about the self in a therapeutic environment that is accepting and understanding, the clinician can bring clients to experience themselves as worthwhile, valuable human beings" (1993, p. 226). Other researchers suggest that traditional confrontational methods are more effective with male alcohol drug-affected clients than with women (Yaffe, Jenson, and Howard, 1995).

Without effective intervention, shame can drive clients towards more drinking in an effort to relieve the pain (Potter-Efron, 1988). "Damage from shame begins to heal when the shame is exposed to others in a safe environment. It is essential that a client's revelations of shame never be themselves shamed" (Potter-Efron, 1988, p. 14). Safeguarding the client from shame implements what Wood (1987) defined as a "psychological safety net" that is required for recovery for the adult child from an alcoholic home: To assure the client that he or she will not be subjected to the trauma that was common place in the past.

Single Case Study

The following case study of a young mother in conflict with the child welfare system focuses on challenges for social workers in all practice settings, as the profession seeks to improve the quality of life for vulnerable children and their families. First, a note about methodology. Stake (2000) and Yin (1989) recognized case studies as a common way to conduct qualitative inquiries. Case studies may point to a general understanding of the broader nature, causes, and treatments of the dynamic studied (Goodwin, 2002; Beutler, Williams, Wakefield, and Entwistle, 1995). A case study may serve to challenge a theory's assumptions or a public policy (Kratochwill, 1992). The following in-depth, intrinsic case study of the dynamics of a composite disguised DCFS family's intergenerational addiction will provide instrumental insight into the needs of women in recovery and in the child welfare system. While the uniqueness of the dynamics of this particular case are recognized, it also provides insights for the child welfare services as a whole.

Case Example

Deep uncertainty about one's right to exist and one's right to a separate identity leads to a terror in being in close contact with others

—J. McDougull

Introduction

The setting for this case was a private, not-for-profit, accredited, faith-based agency serving several counties, and consisted of a variety of social service programs. A DCFS case manager referred this client to the outpatient counseling and addictions program for an addictions assessment and facilitation of treatment services.

Presenting issues

Bobbi-Jo missed four appointments before keeping an appointment. She was reluctant to share information and needed encouragement in her first sessions. Bobbi-Jo's first appointment was six months after the Department of Children and Family Services removed her children. Her eyes filled with tears and her voice cracked as she began to tell her story. She described the abuse she had experienced and witnessed in her family of origin; she experienced shame and self-blame and hid the abuse to protect her parents. Bobbi-Jo relayed frustration and anger at DCFS for not protecting her and her siblings from the violence in her early childhood. She then proceeded to express outrage at this same agency for taking her children for a lesser offense, even as she spoke of her failure to create a safe environment for her own children. Bobbi-Jo indicated that since the removal of her children, she had increased her alcohol and pot use to deaden the emotional pain of loss, self-reproach, and shame. She began sobbing as she stated, "It hurts so much to not be with my children."

Background history

Bobbi-Jo was a 20-year-old, single, Caucasian mother of two girls, aged three years and six months. The father of the oldest child, a gang member, received a 20-year prison sentence prior to the child's birth. The father of the baby was 19, unemployed, and dependent on cocaine. Bobbi-Jo reported physical abuse from both men. At the time of her involvement with the agency, she was living with a 38-year-old man who provided a courteous respect with which she was not familiar.

Bobbi-Jo was the oldest of four sisters. At the age of six, she took on the caregiving role toward her younger siblings. She and her sisters were introduced to marijuana by their parents when Bobbi-Jo was 10 years old. She described the family experience of smoking together as someone might describe a traditional family recreational activity that provided bonding and togetherness. Bobbi-Jo distinguished between the family's recreational pot smoking and the fear, powerlessness, and terror experienced when both parents became intoxicated with alcohol. She developed survivorship skills to protect herself and her siblings from the anticipated trauma: Bobbi-Jo would prepare a bedtime snack and read her siblings a story, and they would huddle in a closet in sleeping bags, pretending they were camping in the woods. In the morning Bobbi-Jo would straighten up the disarray.

Bobbi-Jo experienced helplessness, guilt, and terror as she witnessed her parents' violence toward each other. In her teen years, she began to intervene to protect her mother and siblings. She remembered her mother needing medical care on one occasion, and Bobbi-Jo blamed herself for not being able to stop the abuse. Her mother took Bobbie-Jo and her sisters to an abuse shelter for two months. Her father was ordered by the court to attend domestic violence classes. No part of the treatment included discussion of the alcohol or marijuana use. When the family reunited, the physical abuse ceased, but emotional abuse continued. Bobbi-Jo remembered her mother repeatedly telling her that she was a "mistake" and her father telling her that she was a "worthless whore." Bobbi-Jo believed that no matter what she did, she would never be good enough.

The echo of these words resulted in humiliation, self-reproach, and two suicide attempts during junior high and high school. No intervention was provided following the suicide attempts, as her parents were intoxicated and oblivious to her distress (hence Bobbi-Jo's feelings of betrayal by child welfare and mental health systems). Two years later, her sister attempted suicide by cutting her wrist. Bobbi-Jo nurtured her back to health. Feeling a responsibility and an obligation to care for her younger sister, she accompanied her to a school social worker. A plea for family intervention resulted in a DCFS report that was unfounded.

A cross-generational alliance and reversal of roles developed between Bobbi-Jo and her mother. Bobbi-Jo became her mother's confidante. She listened to marital problems, sexual concerns, worries and fears; she provided emotional support. Bobbi-Jo transported her mother to doctor's appointments, errands, to purchase alcohol, and to court dates for her DUI and assault charges.

Treatment interventions

Bobbi-Jo was seen for three months before she was willing to accept a referral to an inpatient treatment program. An empathic, accepting, nurturing approach, balanced by education and gentle confrontation counteracted excessive feelings of shame and self-reproach. Bobbi-Jo completed inpatient treatment and aftercare. She attended 90 meetings of Alcoholics Anonymous in 90 days. She developed a relationship with a sponsor and began working the 12 steps. She appeared to identify with her peers and to feel comfortable in the mutual support system. She completed parenting classes. Her drug screens returned negative. She was on the way to having her children returned.

Relapse

A series of stressful circumstances resulted in a relapse. Bobbi-Jo became pregnant for the third time. After a conversation with the case manager, she became frightened that DCFS would take this child at birth. Rather than motivating her toward a stronger recovery program, the fear of loss of another child outraged her and tapped into her old feelings of powerlessness, helplessness, and shame. Bobbi-Jo's recovery also brought tremendous guilt, as she attempted to detach from the family's ongoing crises and to quit her caregiving roles. Each time she said no to a family request, she felt guilt for not helping.

Then, a family argument occurred after Bobbi-Jo refused to go to the family home when called by her sister. Her mother and a sister were seriously hurt and hospitalized. Bobbi-Jo blamed herself. Her relapse resulted in further shame, self-blame, and continued drinking to relieve the emotional pain. The Department of Children and Family Services began the process of terminating her parental rights following her relapse.

Discussion of the case

The web of attachments had fallen apart for Bobbi-Jo. Psychologically, she had been abandoned by the important people in her life, while at the same time she was trying desperately to maintain connections. The important relationships in Bobbi-Jo's life were her children, her sisters, and her parents, for all of whom she played a caregiving role. She engaged in alcohol and drug use beginning at a young age because she felt it enhanced her connection with her parents and her peer relationships. Relationships, abuse, sexuality, and alcohol and drugs became interconnected. Bobbi-Jo associated alcohol and drug use with connection to the male partners in her life. These one-sided, nonmutual relationships led to confusion, distorted relational patterns, and psychological isolation. She spent her life protecting and taking care of these important relationships in the only way she knew how. The state's criticism of her parenting—which she viewed as nurturing in comparison to the parenting that had been provided to her—felt paradoxical to her. Bobbi-Jo was a victim in her family of origin as she nurtured others in the hope of finding love and approval for herself. The covert message was not to abandon her family members who needed her. Thus, she found herself hopelessly mired in difficulties for which she felt responsible. She repeated these patterns with the fathers of her children. Bobbi-Jo's caregiving role was the only satisfaction she could experience, and even that brought shame. Bobbi-Jo was deprived of mutual connections in childhood and she now felt conflict between a need for affiliation with her family and a push toward self-enhancement or autonomous behavior.

Changes that Bobbi-Jo needed to make to meet the DCFS requirement included:

- developing a clean and sober lifestyle,

- escaping from the necessity to live from crisis to crisis,

- establishing boundaries and affirming the healthy aspects of herself,

- identifying and dealing with feelings while facing the trauma from the past,

- developing solid reality testing, and

- building mutually satisfying relationships.

Accomplishing the changes necessary for the return of her children was not possible in the time frame established by DCFS. Bobbi-Jo needed extensive time to allow for self-development in an experience with others that balanced oneness and separateness, merging and differentiation; and growth in connection and relatedness. This could be provided in the AA program, women's group therapy, a halfway house, and with an individual therapist focusing on a reciprocal and relational process.

The program that Bobbi-Jo had hoped would protect her and her siblings, DCFS, was the very program to which she lost her own children. The loss of her children was, again, another failure of relational context. She had felt isolated by her own experience of non-mutual relationships, and now the authority of DCFS validated and underscored her failures. The criticism of her parenting was a shaming experience that repeated the experience of shame in her family of origin. The image of a healthy relationship haunted her as she tried to reconcile the loss of her children with the lack of societal protection in her own childhood. For Bobbi-Jo, DCFS became another systemic non-mutual relationship, with "power over" her future rather than mutual power with her recovery. Her intense shame promoted

isolation, hopelessness, and a return to the use of drugs to solve the flooding of emotional pain.

Social Work and Child Welfare Policy

This case study yields insights into social work's role in the prevention and treatment of the complex issues of child neglect and abuse as they relate to addiction. The five themes identified are:

1. Social work's role in identifying children at risk.

2. Assessing the client, establishing a relationship, and protecting the client from overwhelming shame and hopelessness while facilitating the acceptance of treatment.

3. Honoring the development of women within the context of connection and disconnection.

4. Recruiting, educating, and maintaining qualified child welfare staff.

5. Reevaluating the time frames in the Adoption and Safe Family Act.

The front lines

Social workers are on the front lines in schools, hospital emergency settings, mental health centers, family service agencies, abuse shelters, and psychiatric hospitals. The challenge is to identify the signs of abuse, neglect, and addictions and to protect the young from generational patterns of an abusive lifestyle. A social worker needs to be able to identify the danger signs of domestic violence, alcoholism, drug use, and mental illness and know when to intervene.

Treatment within a psychological safety net

An important task for DCFS case workers and social workers working with families in DCFS is to determine appropriate forms of treatment for clients with addiction problems. Treatment options available include medical and social detoxification, intensive outpatient programs, partial hospitalization, inpatient rehabilitation, and halfway houses. Outpatient individual, group, family treatment, and psychoeducational programs, as well as AA support groups, are part of the longer recovery process. Initial treatment includes assessment, establishing a working relationship, and achieving abstinence. Low self-esteem and excessive shame may pose an obstacle to accepting treatment for the adult child from an alcoholic home. The very need for treatment may confirm the client's deeply held conviction of being flawed. Self-disclosure may be impeded by the fear and expectation of rejection and judgment. Utilizing a nurturing holding environment, the therapist must mobilize the client's strengths through education, allow enough pain for the client to realize the need for change, convey a belief in the client's courage and ability to recover, tap motivation within the client, and protect the client from overwhelming shame and hopelessness that could lead to relapse. With the child welfare client, this nurturing approach and relationship-building must be balanced by factual information, given in an empathic manner, about the ASFA time lines and expectations.

Other important aspects of addiction treatment are educating clients to the psycho-physiological impact of addiction and any possible withdrawal effects on their physical, emotional, and psychological functioning. Parents charged with abuse and/or neglect often do not have medical insurance and must rely on publicly-funded treatment centers. Informing and coaching clients about the process of admission, the wait list, and the importance of continued contact with the facility while on the wait list is essential. Once a client has achieved abstinence through a structured program, issues such as guilt, shame, anger, rage, trauma, dysfunctional family relationship patterns, relinquishment of enmeshment with others, and development of a well-integrated sense of self will have to be addressed. Recovery from addiction is a process that often includes

relapse as part of the movement forward. An environment that provides the experience of mutually empowering relationships is essential. Reshaping the treatment process into one that is reciprocal and relational will enhance the self-development of women.

Recruiting, educating, and maintaining qualified child welfare staff

Working with the DCFS parent requires the case manager/social worker/therapist to be a good diagnostician, therapist, educator, and advocate, and to be knowledgeable regarding addiction treatment and the process of recovery. Most of all it requires an understanding of relational theory and the development of women within the context of connections and disconnections. The connections and disconnections between the client and the DCFS system have an impact on the recovery from addictions. What is required is the development of a relationship of mutuality that promotes the mother's sense of connection that fosters development. These experiences facilitate mutual, nonauthoritarian relationships that exemplify "power with" rather than "power over." The experience of "power with" a client is the antithesis of the current legal system, which emphasizes punishment and consequences.

General Accounting Office (GAO) research indicates that 90% of the states have difficulty recruiting and retaining child welfare workers. The factors in retention of child welfare workers include high caseloads, heavy administrative burdens, the risk of violence, limited supervision, and lack of training (U.S. GAO, 2002, 2003). However, NASW's Child Welfare Specialty Practice Section survey (www.socialworkers.org/practice/children/survey/default.asp) indicated a more positive experience for trained social workers. Well-trained professional social workers were able to find more satisfaction in child welfare work than the general workforce, which has reported being burned out (NASW, 2004). The seven findings from the NASW survey show that trained social workers differ from the general child welfare workforce in longer tenure, higher salaries, fewer administrative burdens, smaller caseloads, more comfort in making home visits, higher satisfaction with supervision, and adequate training opportunities. The report concluded that professionally trained social workers in child welfare are prepared to meet the challenges of the work, have a strong commitment to their jobs and the families they serve, and find their work satisfying and rewarding.

Child Welfare Policy: Some Questions

Is it possible that our system—one of blame and punishment—leads to further victimization of substance-abusing women, while diverting attention from societal factors that promote substance abuse (Carten, 1996; Walker, 1991)? Is it possible that a mother generally cannot complete addiction treatment and make the required lifestyle changes in the 15 months allotted by ASFA (Smith, 2002)? Is it possible that with improved coordination and communication between child welfare staff and addiction treatment staff, the rate of recovery for mothers in the DCFS system could increase (Azzi-Lessing and Olsen, 1996; Carten, 1996; Smith, 2002)? Is it possible that a treatment model that is sensitive to women's development in relationship could increase the reunification of mothers and their children (Covington, 1997, 2000, 2002, 2003)? The case study examined in this paper strongly suggests that the answer to all these questions is yes. Further study should investigate how to implement better treatment methods for better outcomes, for "The only known way to remediate the cycle of abuse and neglect in parents who have been traumatized is through a sustained process of intensive therapeutic care that heals the trauma and its aftermath" (Epple, 2004, p. 76).

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