

CHAPTER 1

The Challenge of Meeting Children's Needs in the Context of Difficult Family and Community Environments

Babies are born dependent on others to meet their physical, psychological/emotional, and cognitive/intellectual needs. A committed caregiver and/or an entire family typically devotes much time and energy to nurturing the baby and helping him or her grow and develop. Ideally, this caretaking process results in the formation of a two-way attachment relationship that serves as the template through which the growing infant experiences the world and learns to relate to others. In the best of all possible worlds, a family feels great happiness anticipating the birth of a child. When prepared emotionally, physically, and financially, most families can deal with the mixture of pleasure and stress associated with raising a child. However, unpredictable circumstances related to the home situation, the baby's health, the family's economic and psychological state, and the community and neighborhood in which the family lives can cause the birth experience and the child's early years to be shrouded with worry and concern. Unforeseen challenges may set in motion a chain of reactions when parents are not prepared to deal with the inevitable responsibilities associated with raising their new baby or when their personal situation changes, as following the death of a family member or a deployment into the military. When parents cannot care for their baby, relatives may do so, and when the extended family is unavailable, the child welfare system may step in. Society therefore maintains a vested interest in ensuring that families meet the needs of their children.

Social workers assist families and children, either through small-scale direct interventions or on a larger scale by helping communities establish and maintain essential services. This book presents different methods of helping children within their families, in schools, and in community settings. Whereas much of the focus here is on micro-level clinical practice with children and

their families, the ecological perspective that guides such interventions always evaluates and considers the surrounding physical, economic, and political environments that may facilitate or hinder helping efforts.

THE SOCIAL CONTEXT OF CHILDREN'S LIVES

Children's basic needs include nurturance, responsiveness, predictability, support, and guidance from caretakers (Garbarino, Stott, & Associates, 1989; Garbarino, 1992). Fulfilling these needs requires at least one caring adult who will take the responsibility of being an active presence in the child's life. Over time an attachment relationship develops between the dependent baby and the nurturing caretaker, and this relationship has a crucial role in determining how the child will respond to others in the future. When the child's early relationships are neglectful, abusive, or traumatic, this can result in enduring emotional, behavioral, cognitive, social, and emotional problems later in the child's life (Perry, 2006; Osofsky, 1997).

Statistics from 2016 indicate that approximately 9.2 million poor children in the United States were living in single-parent families, with the majority in single-mother families (Children's Defense Fund, 2016). It is very challenging to balance the economic necessities of earning a living with finding the time to take care of home responsibilities and, in addition, to nurture and develop and maintain a loving relationship with a baby and young child. Although some mothers manage this very well, others do not, and the children may suffer neglect or abuse.

According to the Children's Defense Fund (2016), in 2014 nearly 1 in 11 children lived in extreme poverty (defined as an annual income of less than half the poverty level), and children in single-parent families were more likely to be poor. Black children have the highest poverty rate. Single mothers experience the combined effects of social isolation, economic pressure, and the burden of having sole responsibility for raising a child (Gustafsson, Larson, Nelson, & Gustafsson, 2009; American Psychological Association, 2007). These factors can seriously affect the mothers' ability to form a positive attachment with their babies.

What is the impact on children of living in impoverished environments, which may be characterized by unemployment, pervasive substance abuse, inadequate health care, poor quality child care, and high levels of child abuse and neglect? Numerous studies have found that these socioeconomic disadvantages can contribute to higher incidences of impairment in children's social, behavioral, and academic functioning (Achenbach, Howell, Quay, & Conners, 1991; Achenbach, McConaughy, & Howell, 1987; American Psychological Association, 2007; Brooks-Gunn & Duncan, 1997; Institute of Medicine, 1989; Perry, 2006; Perry & Szalavitz, 2006; Schteingart, Molnar, Klein, Lowe, & Hartmann, 1995; Siegel, 2012). Poverty is a serious social and personal crisis, and interventions to help poor children and families require

broad-based efforts to find political and economic remedies, in addition to helping children with their emotional-behavioral difficulties.

However, all children raised in poverty do not develop psychological problems. The ratio of risk and resilience cannot be calculated with certainty, although practitioners should certainly try to reduce risk factors and do whatever possible to stack the deck in favor of the child and family. Sometimes an intervention to help the mother will have trickle-down positive effects on the child. The assessment of risk and resilience factors is discussed more fully as part of the tripartite assessment in Chapter 4.

The *ecological-transactional focus* of this book emphasizes the interacting multisystemic factors that contribute to children's mental, emotional, and behavioral difficulties, including both familial and environmental influences. Developmental factors also play a critical role in how children respond to favorable and stressful events in their lives. However, as previously mentioned, it is important to emphasize that any single element alone is seldom sufficient to lead to emotional problems. It is far more likely that *multiple factors*, both developmental and systemic, will interact to produce problematic behavior in a child (Cicchetti, 2008).

As depicted in Figure 1.1, the complex interplay between children and their social environments makes it essential to consider *simultaneously* a troubled child's biological, temperamental, and developmental status, the surrounding familial cultural context, and his or her physical and social environment. Although political advocacy may be essential for long-term improvement of the insidious effects of poverty, substance abuse/dependence, and violence, immediate supportive assistance must be offered to children and their families who are living in the midst of and trying to cope with these conditions. Children demonstrating troubled and troubling behaviors require prompt, direct services, even when these are provided in less than ideal social environments.

THE CASE OF JACOB, AGE 10, AND DAMIEN, AGE 14

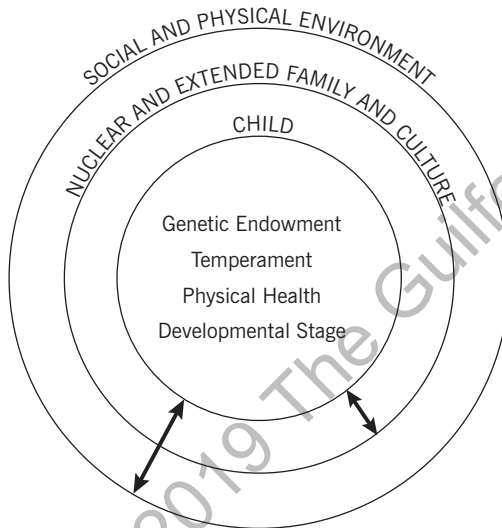
The following account is taken from a front-page article in *The New York Times* (Wilkerson, 1994). As when I prepared the second and third editions of this book, I wondered whether this case would seem out of date for this fourth edition over 20 years later. Sadly, it is not; the situation of urban children who live in high-crime, drug-infested neighborhoods is as bad as ever, and this case could just as easily appear in our local newspapers today.

Presenting Problem Situation

Damien, age 14, and Jacob, age 10, were arrested for armed robbery in the shooting death of a pregnant woman who refused to hand over money she had withdrawn from an automated teller machine. Jacob gave the go-ahead signal

FIGURE 1.1. Interactive influences of child, family, and environment.

Nuclear and Extended Family and Culture	Social and Physical Environment
Ethnicity	Peers
Values and Beliefs	School
Family Lifestyle	Housing
Structure and Boundaries	Neighborhood/Community
Socioeconomic Status	Recreational Resources
Role Expectations	Hazards
Religion	



for the robbery, and Damien, a drug dealer who was trying to obtain money to pay drug debts, carried out the shooting. Damien pleaded guilty to second-degree murder, and both boys received the maximum sentence for juveniles—remaining in state custody until the age of 21.

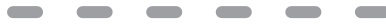
Family Information

Both boys were born to mothers on welfare, each of whom had first given birth at age 14. Damien's father had abandoned his family, and Jacob's father was shot to death in a bar fight when the boy was 4 or 5 years old. Both boys grew up in an atmosphere of physical abuse; Jacob's father used to beat his mother, and Damien said that he ran away from home because his mother beat him. Both boys lived in crack houses, and Jacob's mother had a history of alcohol and crack dependence.

Jacob was the youngest of eight children, in a family in which he saw relatives and friends use guns to settle disputes. He saw his sister shot in the face when he was 4 or 5. Another sister introduced him to marijuana when he was

9. His mother did not appear for Jacob's first court hearing on the armed robbery charge, and when she subsequently came to testify, she was intoxicated and could not remember Jacob's birthday.

Damien dropped out of school after the seventh grade and went to live with a teenage older brother who was a drug dealer and who initiated him into the drug trade. Damien had earlier been a ward of the court after his mother was accused of beating one of his brothers. He apparently had no contact with his father. Damien took the gun used in the robbery/murder from his brother's house; in preparation for the attack, in Jacob's presence, Damien sharpened the bullets.



Discussion

It is not difficult to identify the familial and social factors that coalesced in the behaviors resulting in this tragic murder. An overview of this case summary reveals the following negative influences and risk factors in the lives of these boys:

Family Disintegration

Female-headed single-parent households
Absent fathers (Jacob's was killed; Damien's abandoned the family)
Youthful runaway behavior (Damien)

Poverty

Both families were supported on welfare

Exposure to Violence and Abuse

Witness to spouse abuse (between parents—Jacob)
Witness to child abuse (parental abuse of sibling—Damien)
Personal experience of child abuse (Damien)
Witness to gunfights within family (Jacob)

Exposure to Substance Abuse

Residence in crack houses
Parental alcohol and crack dependence (Jacob)
Sibling drug dealing (Damien)
Drug abuse/dependence in the neighborhood
Encouragement to use drugs

Jacob's lawyer summarized his young client's situation by stating that "Jake is the product of his environment. He comes from a dysfunctional family. The

older neighborhood boys were his heroes. They sold drugs. They had guns. They were his role models. He wanted to be like them” (quoted in Wilkerson, 1994, p. A-14).

Charles Patrick Ewing, a lawyer and forensic psychologist, comments in his book *Kids Who Kill* (1990): “Juvenile killers are not born but made. . . . Virtually all juvenile killers have been significantly influenced in their homicidal behavior by one or more of a handful of known factors: child abuse, poverty, substance abuse, and access to guns” (p. 157). Certainly, these conditions do not *always* produce child killers; many youngsters manage to survive the ravages of noxious familial and social environments without succumbing to antisocial acts. Some even achieve great success, against all odds (Anthony & Cohler, 1987). Nonetheless, when the cards are stacked so heavily against healthy development, as they were for both Jacob and Damien, the outcome in terms of antisocial behavior is understandable. Furthermore, in addition to Ewing’s list of factors contributing to homicidal behavior, we should consider the possibility that Jacob may have been born with fetal alcohol syndrome and/or the effects of his mother’s crack addiction and that Damien may have suffered head injuries due to the serious and repeated beatings he received. Furthermore, mothers who are drug or alcohol dependent may be unable to respond appropriately to their babies’ emotional needs for bonding. Both boys’ seeming lack of empathy may be related to insecure or avoidant attachment due to the abuse and neglect they both suffered in the first 2 years of their lives (Karr-Morse & Wiley, 1997; Perry, 1997; Lieberman, 2004; Siegel, 2012). Heide (1999) points out that many abused youth have not experienced bonding with others and consequently they do not develop the values, empathy, and self-concept that fosters the self-control that might inhibit them from killing. The lack of an attachment figure in the first few years of life may cause an inability to establish stable relationships later in life (Siegel, 2012).

We know nothing about either boy’s academic record, such as possible learning or hyperactivity problems, or about any individual areas of strengths or achievement. However, both boys learned to survive in the face of situations that were, at times, life threatening, and they learned to adapt in circumstances that required great perseverance and strength. If only this resilience could have been focused on more positive interests and goals! This case illustrates how the cumulative influence of individual, familial, and social factors can culminate in juvenile criminal behaviors. Even when social and familial factors appear to predominate as causal, however, remediation necessitates intensive work with such youths on an *individual* basis. It is likely that after years of abuse and neglect, youngsters such as Damien and Jacob internalized and then replicated the dysfunctional behavior they witnessed and experienced during their formative years. Rehabilitation would require much more than environmental change to significantly alter such youngsters’ sense of personal identity, their sense of self-respect and competence, and their views about future goals for their lives. Few if any prisons have programs that can provide the kind of in-depth treatment these boys would need. In fact, it is

more likely that they would learn more antisocial behaviors from emulating other prisoners. Chapter 14 discusses in detail the treatment approaches for children who witness family and community violence.

EMOTIONAL AND BEHAVIORAL PROBLEMS

As stated by Hinshaw (2008), “emotional and behavioral problems in children and adolescents are distressingly prevalent and often lead to serious impairments in such crucial life domains as academic achievement, interpersonal competencies, and independent living skills” (p. 4). According to the U.S. Department of Health and Human Services (1999), about one in five children and adolescents in the United States suffer from some type of mental health problem during the course of a year. The overall prevalence rates of childhood problems are estimated to be between 14 and 22% for all children, and “a significant proportion of children do not grow out of their childhood difficulties” (Mash & Dozois, 1996, p. 9).

Typical Problem Syndromes in Children

Professionals who work with children document that psychopathology in children is a relatively common occurrence, with overall estimates of developmental, emotional, and behavioral disorders ranging from 14 to 23% of all children, with more severe forms of mental disturbance occurring in an estimated 8–10% of all children (Brandenburg, Friedman, & Silver, 1990; Boyle et al., 1987; Mash & Dozois, 1996, 2003; Mash & Barkley, 2007, 2014).

Because of the growing focus on an individual's *strengths*, rather than on deficits, many social workers and social work educators have turned away from the “medical model” in which individuals are categorized with various disorders using classifications of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013). However, the fact is that anyone whose work involves children will inevitably encounter some who are showing great difficulty in adjusting and who will benefit from interventions based on a thorough assessment of their problematic behavior. The process of making such biopsychosocial assessments is discussed in Chapter 4. Knowledge about the specific categories of problematic behavior of children is essential for practitioners in their efforts to formulate an assessment and plan the kind of treatment that will be most helpful.

Achenbach and Howell's (1993) formulation of children's typical problems was derived from parent, teacher, and self-report forms of the Child Behavior Checklist (CBCL) administered to a 1989 sample. This grouping of problems was summarized by the *New York Times* (Goleman, 1993) and later adapted by Mash and Dozois (1996, 2003). These problems also appear in DSM-5 under slightly different categories. Over 20 years later, this listing of

children's problems continues to serve as a guide for many practitioners who give parents, teachers, and school-age children the checklists to fill out as part of the assessment process. This topic is discussed more fully in Chapter 4, but some of the categories of behavior that are screened on this form include the following: withdrawn and/or depressed behavior, attention difficulties, aggressive behavior, and anxiety.

All of these behaviors worsened over the 13-year period from 1976 to 1989 among the groups of children who were studied by Achenbach, who suggested that multiple factors probably contributed to the widespread increase in children's problems. Among these, he cited children's exposure to violence; reduced time with parents and reduced parental monitoring of children; more families with both parents working; more single-parent families; and fewer community mentors to help children learn adaptive social and emotional skills. These possible contributing factors continue to be very relevant in the first decades of the 21st century, so it is logical to expect that there has been a continuing increase in children's problems.

Children's Emotional Problems and Resilience

In contrast to the poor advice given by some pediatricians, most children do *not* outgrow their difficulties (Mash & Barkley, 2007), and they can benefit from some form of treatment. It is essential for practitioners who are treating children to be knowledgeable about different types of problematic behaviors seen in children and their recommended treatments, especially evidence-based treatments, when these have been reported in the professional literature. However, practitioners must be able to identify not only the child's problematic behaviors but also his or her areas of strength and positive adaptation. We know that different children respond differently, even in the same family. For example, all children in a multiproblem family could be considered at risk of developing problems. This is not a simple equation, however, as a significant proportion of children who are at risk do not develop problems later (Mash & Barkley, 2007). The term "resilience" has been used to describe children who not only survive adversity but also somehow become stronger in the face of it (Davies, 2011). A comprehensive understanding of any child requires that practitioners assess both the child's maladaptive and adaptive responses. The foundation of this assessment rests on knowledge of normal child development and of the many ways children can respond to stressful situations.

Implications for Social Workers

The fact that millions of children are suffering from serious mental health problems means that social workers, teachers, and others will encounter these children in schools, in child welfare institutions, in jails, in foster homes, and on the streets (LeCroy & Ashford, 1992). Their presence is by no means restricted to mental health clinics, as only about half the children who need

mental health services receive them. Important decisions about what services to offer and which family members to include and in what settings depend on a careful biopsychosocial assessment that takes account of cultural and other factors. These issues are discussed in Chapters 4 and 5. It is essential that those working with children have basic knowledge about child development (Davies, 2011), cultural variations in child rearing (Webb, 2001; Fong, 2001, 2004), and the various possible deviations from children's usual developmental course to evaluate a presenting problem in a manner that fully considers the inner world of the child, in addition to all relevant external factors. An understanding of the concepts of risk and resilience (Fraser, 1997; Davies, 2011) can help practitioners avoid a narrow and linear view of causality.

AN ECOLOGICAL PERSPECTIVE ON ETIOLOGY

The Need to Consider Multiple Factors

Nothing in life is simple, as we quickly realize when we are attempting to ascribe causality to human behavior. "The task of unraveling causes and determinants of childhood mental disorders is formidable because of the complexity of interactions between biological, psychological, social, and environmental factors" (Institute of Medicine, 1989, paraphrased in Johnson & Friesen, 1993, p. 27). This view of the etiologies of mental and emotional disorders in children and adolescents has been summarized as follows:

Support for multifactorial or systems understanding of the etiology of mental disorders has been accruing rapidly during the past two decades. Systems views are replacing univariate and stage theory models in all mental health disciplines, including social work, psychiatry, special education, clinical psychology, and others. (Johnson & Friesen, 1993, p. 27)

Of course, social work has a long history of employing extensive psychosocial assessment, as pointed out by Lieberman (1987); the addition of "bio-" to "psychosocial" represents increased awareness of the importance of innate factors (whether genetic or acquired) that can influence how an individual copes with a problem. Growing understanding about the impact on the brain of adverse experiences in early childhood (Siegel, 2012; Applegate & Shapiro, 2005) further supports the influence of biological factors on the developing child.

The idea that a child him- or herself may be an active agent influencing the systems of family, school, and government was first proposed by Bronfenbrenner (1979). It has subsequently been elaborated by many, including Stern (1985) and Siegel (2012) with regard to the infant–mother interaction and in the publications of the Erikson Institute (Garbarino et al., 1989), which stress the mutual influences between children and their physical, social, and cultural contexts. The implications of this dynamic view lead to a more complex

understanding of social interactions, which are no longer viewed as unidirectional.

For example, when a highly active, intensely reactive, distractible child is adopted by a low-key, calm mother, she may believe that the child is “hyper” because of her own inability to soothe and quiet the baby. However, temperamental differences between parents and children, whether the children are biological or adopted, attest to the notion of “match” or “goodness of fit” between parent and child as the appropriate unit of attention, rather than the maladaptation of the individual parent or child (Thomas, Chess, & Birch, 1968; Shapiro, Shapiro, & Paret, 2001a). Simplistic, single-cause explanations no longer suffice in a multisystems perspective that considers “the continual, mutually influencing forces of biology, culture, behaviors of significant others, organizational processes, economics, and politics” (Johnson, 1993b, p. 86). If this wider view seems cumbersome and broad, it certainly avoids the previous overemphasis on parental pathology as *the* cause of children’s problems. Germain and Gitterman (1987) state that “neither the people served, nor their environments, can be fully understood except in relationship to each other” (p. 493).

The Importance of Cultural Factors

It is also essential that social workers understand their own cultural biases and learn about the culturally based beliefs of their clients regarding role expectations, typical ways of expressing feelings, and patterns of social exchange (Webb, 2001; Fong, 2001, 2004). For example, a male child who has been taught both implicitly and explicitly that being “macho” means “stand up for yourself and don’t let anyone get away with insulting you or your family” cannot be criticized for initiating a fistfight with a bully who called him a “wimp” and his sister a “tramp.” To label this child “aggressive” misses the child’s compelling motivation to defend his family’s honor in a culturally sanctioned manner. This situation challenges the school social worker, who may be brought in to devise a creative response that respects the child’s cultural identity even as it discourages fighting on the school premises. Different cultures have different beliefs about child behaviors that are acceptable and those that are not. Furthermore, attitudes about accepting help in the form of social or mental health services vary greatly among cultures, and practitioners must be sensitive to the implications of discussing a child’s “problem behaviors” with a parent who may feel that the child’s behavior reflects directly on the quality of her or his parenting and even on the family’s honor (Webb, 2001).

Children and adolescents in immigrant families are often in conflict between two competing sets of values and norms, which may require them to follow one set of behaviors in the family setting and another in the school and community (Huang, 1989; Wu, 2001; Fong, 2001). This situation will require concerted attention from school social workers and others who deal with increasing numbers of immigrant children.

CURRENT ISSUES IN SOCIAL WORK WITH CHILDREN

Historical Overview

A consideration of current social work practice with children has more meaning when it is viewed in a historical perspective. The practice of social work with children has taken many forms—from its beginnings in court-affiliated clinics for juvenile delinquents in 1909, in which social workers studied cases and treated families, to agency and private practice in the 21st century, in which social workers may work with families, with children in groups, or with individual children (using play therapy and other methods appropriate for young clients). Parent counseling has always been an essential component of working with children, even when children reside with extended family members or live in foster homes. Intervention with a child's biological parent(s) remains central to the work with the child, because of social work's enduring belief about the importance of family identity to the child's sense of personal identity and because of the profession's commitment to the concept of family preservation (discussed in Chapter 2).

During the early decades of this century, social workers intervened with families according to their understanding of the problem, which took the form of a "diagnosis" of social factors contributing to the problem situation (Richmond, 1917). During the next phase of more specialized and regulated practice, many social workers worked under the guidance and direction of psychiatrists in child guidance clinics; the psychiatrists "treated" the children while the social workers "guided" the parents, thus introducing the concept of "parent guidance." In situations in which a family failed or was in danger of failing to meet the child's basic needs, the child welfare system assumed the role of parent surrogate, "doing for the deprived, disadvantaged, dependent child what the effective family does for the advantaged child" (Kadushin, 1987, p. 267). During the 1950s and 1960s, child welfare enjoyed special recognition and status as a specialty area within social work. Later this elite status diminished somewhat, as other professionals became involved in child placement decisions, abuse investigations, and adoption procedures (Kadushin, 1987).

After the promulgation of family therapy in the 1970s and later, social workers tended to view a child's problems as symptomatic of a troubled marriage; therefore, intervention tended to focus on the marital dyad or on the family unit, rather than on individual members of the family. As a result, the child's presenting problem might be downplayed or ignored by family therapists, who considered it just the tip of the iceberg. An important goal in family therapy has been to remove the child from the role of the "identified patient" (Satir, 1983). However well intentioned this goal, more recently there is growing recognition that symptomatic children may have internalized problems and therefore require individual help, regardless of whatever assistance is offered to the parents or to the family unit. Social workers increasingly utilize specialized methods such as play therapy (including the use of art, sand play, music, and storytelling) in their work with young children. It is notable that

the American Board of Examiners in Clinical Social Work (ABE) has a specialty and a credential in practice with children and their families as a subspecialty of advanced clinical social work. This specialization clearly recognizes the body of specialized knowledge in this field, as well as the necessity for ongoing supervision and continuing education.

Cutting-Edge Issues in Practice with Children

Practice in the second decade of the 21st century must take full account of the social environment, which has a major impact on families and children. In addition, practitioners must continue to pay attention to children's biological and emotional responses to their life circumstances. Methods of intervention must be grounded in a thorough understanding of *all* relevant contributing factors and adapted to both the individual child's developmental needs and to the possible contributing and/or ameliorating factors in the child's surrounding family and social environment.

The following list of cutting-edge issues, though by no means exhaustive, represents matters of concern to my students, my colleagues, and myself in our ongoing efforts to provide the most relevant and helpful service to children and families in the second decade of the 21st century. The chapters that follow in this book address these issues through case examples and literature reviews, as well as through my own experience and knowledge based on more than 30 years as a social work practitioner and educator.

1. *The impact on children of deteriorating social conditions, such as violence, poverty, and all forms of substance abuse/dependence.* Where and how can we intervene to protect children and enhance the quality of their lives? As reflected in the case of Jacob and Damien, many children in urban areas report that outbreaks of violence involving guns and knives have occurred in their schools. Furthermore, the trip from home to school may be marked by episodes of gang warfare in which innocent bystanders are injured or killed. When children's basic safety is in jeopardy, how can they concentrate and learn in school and complete their basic developmental tasks as well? This situation requires attention on a macro level to involve the community and the schools on behalf of the children. These issues are addressed in Chapters 9, 13, and 14. Mass shootings occurring in schools have led many schools to routinely engage students in practice drills involving hiding under desks and locking and/or barricading classroom doors. Although these practices have the goal of preparing for a possible future crisis, they also convey to many young students the fact that safety is not a guarantee in the school, and this can increase the anxiety levels among students with fragile temperaments. Chapter 9 addresses specific school-based interventions intended to help all students, as well as those who are expressing problematic behaviors.

2. *Selecting intervention alternatives at multiple levels*—with the child, the parent(s), the extended family, the school, the community, and government

(political advocacy). How can individual social workers be expected to intervene in *all* areas simultaneously, as might best serve the needs of a particular situation? In view of extensive individual, family, and social needs, should the profession focus on developing subspecialty areas of expertise? For example, should specially trained practitioners carry out lobbying/advocacy efforts, while family practitioners work with family units and child specialists work with individual children? What would be some advantages and disadvantages of this approach? Although we might like to do it *all*, the maxim “jack of all trades, master of none” bears careful thought as demands for more specialized practice increase. This topic is explored in Chapter 2.

3. *Understanding the long-term effects on children who are exposed to different forms of family dysfunction, such as domestic violence, abuse and neglect, substance abuse, and parental absence and/or abandonment.* When parents are unable to carry out their caretaking responsibilities, there will be an inevitable negative effect on the attachment relationship with their children. Furthermore, developing knowledge about the brain indicates that there are serious effects on the child's brain from early neglect and lack of positive interactions with a caretaking adult (Perry, 1997, 1999, 2006). Social workers must utilize a distinct appreciation of the different forms of attachment relationships and how these can influence a child's later relationships with others. Chapter 6 addresses different interventions with the family for the benefit of the child.

4. *Providing culturally sensitive practice.* How can social workers develop sufficient knowledge about numerous ethnic groups to practice effectively? The immigrant population is increasing rapidly, and based on predicted birth and immigration rates, “minorities” will become the majority by the middle of the 21st century (Shinagawa & Jang, 1998). Practitioners who are Caucasians of Anglo-European heritage (Gibelman & Schervish, 1997), must learn how to engage and interact with parents who have diverse beliefs about parent-child roles and about how to obtain help for their children (Nader, 2008). Practitioners need to develop “cultural curiosity” about parent-child behaviors in other cultures and be willing to learn from their clients (Webb, 2001). An understanding of one's own beliefs forms an essential foundation of practice with diverse clients. This topic resonates in each chapter, and Chapter 16 focuses exclusively on the challenges of immigrant and refugee families and children.

5. *Working with severely traumatized children with posttraumatic stress disorder (PTSD) and other responses to trauma.* Children are increasingly suffering the effects of exposure to traumatic events, such as community and family violence, terrorism, natural disasters, and war. This exposure can occur through television viewing, in addition to firsthand experience. Some children respond with symptoms of PTSD, and others express their anxiety through other symptoms, such as depression, generalized anxiety, conduct disorders,

and somatization disorders (Jenkins & Bell, 1997; Nader, 2008). The symptoms of PTSD represent dysfunctional, defensive coping responses to environmental assaults on an individual's level of anxiety tolerance. Trauma has a neurological effect on the brain, and social workers must appreciate this and learn how to provide crisis intervention and other treatments for traumatized children, such as trauma-focused cognitive-behavioral therapy (Cohen, Mannarino, & Deblinger, 2012) and play therapy (Gil, 2017). Chapters 9 and 15 discuss the interpersonal violence involved in bullying and suggests some appropriate school responses. Chapter 14 discusses many of the typical responses to family and community violence and reviews some of the recommended treatments to help children with PTSD (Foa, Keane, Friedman, & Cohen, 2009).

6. *Paying attention to the nature of early attachment relationships and to the studies that demonstrate the critical importance of brain development in early childhood* (Siegel, 2012; Osofsky, 1993, 1997). This work helps us understand why treatment attempts in later childhood and adolescence may require numerous repetitions in order to change behavior. This topic is covered in various chapters, and especially in Chapters 2, 10, and 14.

7. *Utilizing evidence-based research to guide choices about intervention methods in work with children and adolescents*. This requires the practitioner to be aware of research studies that demonstrate effective interventions with children so that clinical practice can be improved through consistent use of methods and practice procedures that have been shown to be effective. The limitations of these approaches with children must also be considered. Because the evidence-based focus has both ardent supporters and those who question its universal effectiveness, clinical practitioners should guide their practice according to their best judgment of what will be effective, and they also should keep track of the results of various treatments to better inform their future work. There is a burgeoning literature on the topic of evidence-based practice, and social workers must stay aware of the latest developments (Baggerly, Ray, & Bratton, 2010; Briggs & Rzepnicki, 2004; Kazdin & Weisz, 2003; Weisz & Kazdin, 2010, 2017; Reddy, Files-Hall, & Schaefer, 2005). Various chapters in the book present and discuss evidence-based practices when these are pertinent.

8. *Acknowledging the changing views about gender identity and how this may affect children's beliefs and their own experiences*. A child's discomfort with his or her gender becomes a family, as well as an individual, issue and is discussed in Chapter 6. Social norms vary on this topic, and stigma and discrimination may be added to the stresses of gender dysphoria. It is important for social workers to be aware of these issues and to be prepared to assist families and children who are struggling with them, as well as to work with professionals in schools and community facilities who are dealing with these children.

9. *Utilizing various self-care strategies to avoid vicarious traumatization and burnout.* The topic of self-care is discussed in Chapter 14, but it should be embedded into the practice of all social workers in various locales, especially those who work with young children. We must learn to take care of ourselves, so that we will not suffer burnout and so that we can continue to take pride in our work.

10. *Appreciating the calming and helpful effects from the practice of mindfulness.* These techniques can be adapted to help children learn to focus (as demonstrated in Chapter 7) and can be employed on a regular basis to help the practitioner become centered and focused on the unique specifics of the job at hand.

CONCLUDING COMMENTS

Social work with children is a demanding, all-inclusive field of practice. No longer can a practitioner focus primarily on a child's inner world, nor will it suffice to intervene exclusively with the child's family or social environment. A multilevel approach is essential to understanding, just as it is essential in planning and carrying out helping interventions.

Social workers must learn to scan a child's world and see the broad picture before determining where and how to initiate the helping process. The skills of listening, observing, and empathizing will assist practitioners, who must be able to see through a child's eyes in order to comprehend the child's situation with both head and heart.

DISCUSSION QUESTIONS

1. How can a social worker avoid becoming discouraged when faced with a child who has been victimized by physical and emotional abuse and neglect in a home in which both parents use multiple substances?
2. What services would be appropriate to offer within a school setting to recent immigrant children and their families for the purpose of assisting with their adjustment and integration into the community? What form of initial contact would make the children and families most comfortable?
3. Review and discuss the selected cutting-edge issues presented in this chapter, indicating how social work education can respond to these needs. Which issues do you think will prove the most difficult to resolve? Why?