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BELIEFS AMONG LICENSED CLINICAL SOCIAL WORKERS ABOUT ASSESSING PARENTS ABUSED AS CHILDREN

Emma Celina Duarte
California State University - San Bernardino

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BELIEFS AMONG LICENSED CLINICAL SOCIAL WORKERS
ABOUT ASSESSING PARENTS ABUSED AS CHILDREN

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Emma Celina Duarte

June 2015

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Approved by:

Dr. Laurie Smith, Faculty Supervisor, Social Work
Dr. Rosemary McCaslin, M.S.W. Research Coordinator

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ABSTRACT

Child abuse is a pressing national issue that affects thousands of children every year in the United States. The lifelong implications of child abuse have been well documented in the literature, which identifies psychopathology, interpersonal violence and suicide risk, and substance abuse as a prominent triad of the negative sequelae of child abuse. Parents abused as children represent a subgroup that introduces additional domains of clinical interest and unique needs, including parenting stress and perceived parenting competence. These complex clusters of needs are clinically significant, and the beliefs licensed clinical social workers (LCSWs) hold about parents abused as children can significantly affect the assessment process. This study sought to assess LCSW beliefs about assessing parents abused as children through qualitative interviews with 10 LCSWs with clinical experience that could have included this population. This study found that LCSWs emphasize the three domains of psychopathology, interpersonal violence and suicide risk, and substance abuse in their assessment processes, thus reflecting LCSW beliefs about the saliency of these issues. The exploration of strengths and resources also emerged as a significant area of assessment and case conceptualization, which demonstrates congruence with core social work values. Culture, parental stress and client-perceived competence were not, however, emphasized in the participant responses. Overall, this study points to the strong congruence between the expressed LCSW beliefs about assessing this population and the domains emphasized in the literature, as well as core social work values.

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I would like to thank anyone and everyone who assisted me in finishing this project. To all of the LCSWs who took time from their busy careers and limited time with families to interview with me: thank you truly. Your insight, humor, and deep commitment to your clients and to social work made these interviews both informative and inspiring.

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DEDICATION

This project is dedicated to all parents, but especially those who have been abused as children. There is no job in the world like being a parent: it comes with few instructions, little training, and no re-dos. We do the best we can, and we love our kids fiercely as we screw up a little each day. For those who come into this experience with painful childhoods, the stress and the difficulty of parenting can be magnified. I want these parents to know that there are people out there who get it. There are people out there who can help. You are not alone.

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CHAPTER ONE

INTRODUCTION

This chapter will discuss the beliefs among LCSWs about assessing parents abused as children. It will explore context of the study, in particular, the prevalence and adverse implications of child abuse. Parents abused as children will be introduced as a discrete population, and the need for specific attenuation by clinicians to the unique characteristics of this population will be explored. Clinical areas of concern for parents abused as children will be introduced, including increased risk of psychopathology, substance abuse and interpersonal violence. The purpose of the present study and its significance to social work will also be discussed.

Problem Statement

Child abuse is a pressing national issue, with significant economic and social consequences. The Federal Child Abuse Prevention and Treatment Act (CAPTA), (42 U.S.C.A. §5106g), as amended and reauthorized by the CAPTA Reauthorization Act of 2010, defines child abuse and neglect as, at minimum: “Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm” (Child Welfare Information Gateway, 2013). This definition, however, fails to capture the visceral realities of child abuse as it happens to

children across the country. Child abuse does not discriminate: it occurs in every community, across socioeconomic, ethnic, cultural, religious and educational lines (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2015). In 2013, there were 679,000 victims of child abuse and neglect estimated nationally, resulting in a rate of 9.2 victims per 1,000 children in the population. Furthermore, in 2013, "a nationally estimated 1,520 children died of abuse and neglect at a rate of 2.04 children per 100,000 children in the national population," (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2015).

Child maltreatment has long-term negative sequelae in the domains of physical and psychological health that can persist well into adulthood. Adults abused during childhood are more likely to suffer from chronic physical illnesses, including heart disease, diabetes and obesity (Felitti, 2002).

Analyses of neurological structures have shown that the brains of child abuse survivors demonstrate reduced growth and improper formation in certain regions, and researchers speculate that these structural abnormalities may contribute to impaired cognitive, linguistic and academic abilities across the lifespan (Anda et al., 2006). In terms of psychological health, one study found that as many as 80% of young adults abused as children met criteria for at least one mental health disorder (Silverman, Reinherz, & Giaconia, 1996).

Strong correlations have also been found between a history of child abuse and later adverse behavioral phenomena. Adults abused as children are about 9 times more likely to engage in illegal activity, and reports suggest that 14% of all men in prison and 36% of women in prison in the United States were abused as children, which is about twice the frequency seen in the general population (Harlow, 1999). In addition to an increased prevalence of criminality, it has been found that child abuse survivors are more likely to engage in risky behaviors. Abused children are 25% more likely to experience teen pregnancy (Child Information Gateway, 2013). One study found that compared with adults with no history of child abuse or adverse childhood events (ACEs), people with five or more abusive childhood events “were 7- to 10-fold more likely to report illicit drug use problems, addiction to illicit drugs, and parenteral drug use,” and this study determined “the attributable risk fractions as a result of ACEs for each of these illicit drug use problems were 56%, 64%, and 67%, respectively” (Dube, et al., 2003). Substance abuse is a common coping mechanism for women sexually abused as children who have been unable to resolve this trauma, with the percentage of substance-abusing women who were abused as children estimated as ranging from 51% to 75% (Galaif, Stein, Newcomb, & Bernstein, 2001; Harmer, Sanderson, & Mertin, 1999; Langeland & Hartgers, 1998; Gersild, 2001). Studies have found substance abuse to be highly related to the perpetration of child maltreatment as well, particularly physical abuse and neglect. Maternal substance abuse

disorders are positively associated with increased incidence and severity of child abuse and neglect, and paternal substance abuse disorders are positively associated with harsh parenting practices and concomitant increased risk for abuse against children in the home (Kelly et al., 2015).

In addition to these adverse correlates of abuse, the perpetuation of violence is of significant concern among child abuse survivors. The intergenerational continuity of abuse has long been a subject of academic study from a variety of different theoretical orientations. About 30% of children abused and neglected will later become perpetrators themselves and abuse their own children (Child Information Gateway, 2013). Furthermore, survivors of child abuse are significantly more likely to be involved in intimate partner violence, and many times these two forms of abuse go hand in hand. The effects of continuing interpersonal violence may contribute or modulate parenting modalities and techniques, as well as impact parental stress.

As such, knowledge of a previous child abuse history is salient factor when working with individuals in a parenting role. Though significant research has been done with child abuse survivors, including exploring best- and evidence-based practices, scarcely any research has been done addressing the therapeutic relationship with clinicians providing therapy or the beliefs and attitudes clinicians may hold about assessing members of this population. Numerous studies have pointed out that the efficacy of therapy lies primarily in the therapeutic relationship rather than a given intervention modality (Martin,

Garske, & Davis, 2000). Furthermore, preexisting beliefs, attitudes and biases about a given population may significantly modulate or interfere with the process of building rapport (Thompson, Bender, Lantry, & Flynn, 2007). As such, it is important to assess and understand how clinicians approach this population insofar as it may affect the clients' experiences of therapy and possibly later outcomes.

Purpose of the Study

The purpose of the current study is to explore the beliefs among LCSWs about assessing parents abused as children. Furthermore, this study seeks to explore how clinicians utilize the knowledge of past child abuse in treatment planning and treatment goals, particularly with regard to parenting. The current study seeks to explore not only whether clinicians utilize this information in risk assessment for both the safety of the client and that of the children currently in the client's home, but also how this information may impact their approach to general family and individual therapy interventions.

Adult survivors of child abuse come in contact LCSWs in various contexts and for a variety of reasons. For some, it is through alleged or substantiated abuse of their own children or children for whom they are caregivers, and the initiation of services may be either voluntary or involuntary. For others, counseling services may sought to deal with the lingering ghosts of their childhood trauma. Still more may initiate counseling simply to help with

the daily stressors of family and modern life, only to disclose past child abuse during assessment or further into therapy.

While the initial mode of engagement is widely variable, it is the intention of this study to explore how mental health professionals approach parents abused as children and how the clinician's own backgrounds and theoretical perspectives may mediate this approach. As such, study participants were selected among mental health professionals from a variety of specializations, including public agencies, private practice, community-based services and forensics. Although clinical experiences and considerations identified by these informants may not be representative of all mental health professionals, it is hoped that by examining their clinical assessment process and beliefs some initial insights into the clinical approaches to parents abused as children will be understood.

Academic research has explored the generational transmission of abuse from a variety of perspectives and theoretical orientations. Unfortunately, dedicated research aimed at giving clinicians clear guidelines for working with child abuse survivors who now are parents has been sparse. Furthermore, an assessment of the dissemination, consumption and utilization of this research amongst clinicians working with this population has not been performed. It is the hope of the current study to explore how mental health professionals are approaching this population and the degree of congruence

between assessment insights and beliefs with social work values and domains identified in the literature as particularly relevant to this population.

The present study utilized a qualitative vignette design in order to gain as much insight into the participants' beliefs and approaches about assessment based on their interpretation of the hypothetical client presented. Through these vignettes, the researcher assessed themes that indicated clinical beliefs across several domains, as well as uncovered areas for further exploration and research.

Significance of the Project for Social Work

While child abuse rates are decreasing, approximately 30% of children who are abused as children will grow up to be abusers. Understanding the intergenerational transmission of violence is a step toward proactively preventing child abuse rather than reactively offering services once a child has already experienced maltreatment. Furthermore, for those 70% of child abuse survivors who do not abuse, those in a parenting role may have unique needs that may not be being addressed. Research that can guide practice and future research for this population is valuable and needed. This understanding, however, has little impact if it remains buried in academic journals: it is through clinical application that knowledge gained through research can have real world effects. Understanding transmission processes is only the first step, and the translation of these data into a clinical framework or approach is required to best help this population and those clinicians serving it. Findings from the

current study aim to provide insight into how clinicians currently assess this population. Furthermore, it aims to show areas of opportunity for clinicians in the battle against child abuse and meeting the needs of parents who are child abuse survivors.

CHAPTER TWO

LITERATURE REVIEW

Introduction

In this chapter, the theoretical framework guiding this study will be introduced and several dimensions of assessment salient to parents with child abuse histories will be explored. The theory of reasoned action will be presented as an orienting context for the examination of the LCSW assessment processes. Previous research on the intergenerational continuity of abuse will also be presented, as well as findings discussing psychopathology, interpersonal violence and suicide, substance abuse, parental stress, and parental competence as related to child abuse survivors.

Theory Guiding Conceptualization

Theory of Reasoned Action

Theoretical interest in attitudes and behaviors has long been part of the social science cannon. Allport (1935) and Thurstone (1931) are generally the considered pioneers of attitudinal research, and each defined attitudes as oriented to behavior. Early studies seeking to measure attitudes as predictors of behavior, however, were inconsistent. Following a thorough review of existing research, Wicker (1969) concluded that the correlations between attitude and behavior were weak. After this unfavorable study, attitudinal researchers sought a model that demonstrated statistically sound predictive abilities.

In 1974, researchers Ajzen and Fishbein postulated the theory of reasoned action to achieve this goal. The theory of reasoned action assumes that individuals use reasoning in which information is systematically utilized and processed prior to intentional behaviors (Ajzen & Fishbein, 1980; Fishbein, 1980). In contrast to psychoanalytic theory, Ajzen and Fishbein (1980) argued that behavior is not controlled by unconscious motives or desires, that behavior is random or without intent. On the contrary, Ajzen and Fishbein contend that people consider the meaning and implications of their behavior before determining if they will engage in the behavior. According to this theory,

the most immediate and important predictor of behaviour is the person's intention or the person's motivation to perform a behaviour and the amount of time and effort they are prepared to devote to ensure that an action is undertaken. Intention is determined by two constructs: attitude and subjective norm. Attitude is the person's overall evaluation of what it would be like to perform a behaviour, whereas subjective norm refers to the person's perceptions of social pressure to perform or not to perform the behaviour. (Mullan & Westwood, 2010).

Numerous research studies have supported the key predictions of the theory of reasoned action (Landridge et al., 2007). One meta-analysis found that intention explained 28% of the variance in behavior among 422 prospective studies involving 82,107 participants (Sheeran, 2002). In other

studies, it was found that 30-50% of the variance in intention can be attributed to attitude and subjective norms (Mullen & Westwood, 2010). These studies support the validity of this theoretical framework to assess attitudinal and behavioral processes.

This model is easily applied to the assessment process LCSW clinicians engage in when working with parents with child abuse histories. The process of assessment by LCSWs when working with this population can be predicted by exploring their attitudes about assessment and the subjective norms both related to clinical social work practice and those surrounding this population. LCSW beliefs about assessing parents with child abuse histories and the evaluation of their assessments combine to form the clinician's attitude about assessment. Social work educational standards, professional guidelines and the opinions of reverent others, as well as the clinicians motivation to comply with these standards, guidelines and opinions comprise the subjective norms associated with the issue. These components interact to form the clinician's intention regarding assessment and lead to the clinician's actual assessment behavior, such as the types of information the clinician gathers and attends to, the areas of focus, and how the clinician assesses domains such as risk, stress and competence.

While there is currently no literature supporting the application of the theory of reasoned action to LCSWs beliefs about assessing parents abused as children, it is evident that the theory can be used to help understand their

process of assessment. By evaluating LCSWs attitudes about assessment within the context of clinical social work practices and their perceptions of the unique characteristics of the population, we can explore how the population is approached and conceptualized by LCSW clinicians.

Assessment Dimensions

While the theory of reasoned action orients this study's exploration of LCSW beliefs about assessment, the following research will be presented as a brief survey of existing data in relevant dimensions of assessment of child abuse survivors. These items have been identified in the literature as significant for this population.

Psychopathology

Arguably, the most significant assessment dimension for an LCSW when working with a parent abused as a child is the client's presenting psychiatric issues. While some studies have reported that adults who experienced child abuse account for over half of utilizers of mental health services, researchers have argued recently that these figures may be unrealistically low due to underreporting (Harper et al., 2008). Furthermore, adults with histories of childhood abuse frequently evidence symptoms of post-traumatic stress disorder (PTSD) and other mental health disorders that result in a need for specialized treatment oriented to their trauma experience (Harper et al., 2008). Lang et al. (2004) found that women reporting a history of childhood physical abuse were twice as likely to have a history of major

depressive episodes in their lifetime and four times more likely to be currently in a major depressive episode. Bernet and Stein (1999) found that participants with child abuse histories who were also depressed reported an earlier onset of their first depressive episode, more frequent depressive episodes, and a greater likelihood of meeting criteria for other psychiatric disorders and substance dependence. Furthermore, studies have shown “significantly increased rates of depression, suicidality, and low self-esteem” in women with a history of childhood sexual abuse (Lang, 2004).

Unfortunately, It appears that many of these individuals have difficulty seeking and receiving effective treatment (Harper et al., 2008). It has been found that child abuse survivors seeking mental health services report long wait periods, prohibitive costs, lack of clinicians with specialized abuse training, judgment from the therapist, insufficient treatment lengths, less satisfaction with services, and due to these negative experiences, suspicion of mental health professionals is high amongst the population (Palmer, Brown, Rae-Grant, & Loughlin, 2001; Switzer et al., 1999; Monahan & Forgash, 2000). As a result, many parents abused as children will not reach out to a mental health professional until their level of impairment due to their symptomology has reached significant levels. Symptoms may be debilitating enough to lead survivors to maladaptive methods of self-regulation such as suicidal ideations or dysfunctional behavioral patterns to ease the pain (Kendler et al., 2000; Owens & Chard, 2003).

Interpersonal Violence and Suicide

Many researchers have suggested that the experiences of childhood violence may initiate a chain reaction of trauma throughout survivors' lives, beginning in childhood and continuing into adulthood (Banyard et al., 2001). For a child growing up in an abusive household, basic interpersonal skills may be stymied or distorted, and children exposed to violence in the home often view violence or intimidation as an effective method of problem solving (Margolin, 1998). Some of the long-term effects of violence exposure is the internalization of behaviors seen in parental role models and engaging in future interpersonal behavior that is similarly destructive (Cohen, Hien, & Batchelder, 2008).

According to Bowlby, attachment forms the basis of psychological development insofar as childhood attachment experiences form the children's internal working models of themselves and their caregivers (1969). As children grow, they form expectations of interpersonal interactions based on these models, which forms the basis for their interpersonal schematic of the world. They tend to select relationships, and recreate dynamics within those relationships, that match their internal working models, and therefore attachment dynamics can act as self-fulfilling prophecies throughout life (Thomas, 2005).

Findings from studies of attachment suggest that maltreated children are at higher risk for developing insecure attachments with caregivers, such as

those characterized by an incoherent strategy for regaining emotional security (Timmer et al., 2005). Abusive experiences during childhood are thought to disrupt the attachment process, resulting in interpersonal schemas that tend to be negative and pervasive across different relationship types (Lang, 2004). These schemas, such as abuse as a way of showing love or connecting with someone, may influence and motivate adult interpersonal behavior, thereby increasing the likelihood of subsequent victimization or perpetration of abuse (Cloitre, Cohen, & Scarvalone, 2002).

Revictimization, including intimate partner violence, and perpetration of abuse, such as abusing one's child, are well documented among survivors of childhood abuse, and each has consistently been found as a significant correlate of child abuse history (Rodriguez et al., 1998). Coid et al. (2001) found that women who experienced childhood abuse were two to three times more likely to experience domestic violence. Whitfield, Anda, Dube, and Felitti (2003) found that women who experience childhood sexual abuse were approximately three times more likely to currently be a domestic violence situation, and women who reported both childhood sexual abuse and witnessing their mother being battered were six times more likely to be a current victim on intimate partner violence. Furthermore, risks of victimization increased as different types of childhood maltreatment compounded (Lang, 2004). Although published rates of child abuse survivors later abusing their

own children or children within their home vary significantly, an estimate of 30%, plus or minus 5%, is frequently cited (Coohey, 2004).

General models for the intergenerational transmission of child maltreatment, however, do not control for the gender of the parent performing the abuse. According to Bandura, Ross, and Ross (1961), the manner in which a child abuse survivor will use or tolerate interpersonal violence as an adult may be related to the gender of the person who abused them. A gender specific model of the transmission of violence argues:

Girls who were physically abused by their mothers (female-to-female violence) but not their fathers would be more aggressive toward their own children. Girls who were physically abused by their fathers (male-to-female violence) but not their mothers would be less aggressive and more likely to tolerate hitting and being battered by their partners. And girls who were physically abused by both their parents would be more likely to abuse their children and be battered than girls who were not physically abused by their parents. (Coohey, 2004)

Modest empirical support has been found for this gender-specific model of intergenerational transmission of abuse (Laghinrichsen-Rohling, Neidig, & Thorn, 1995; O'Keefe, 1994; Simons, Whitbeck, Conger, & Wu, 1991).

High rates of co-occurring child abuse history and intimate partner violence are concerning, as it has been found that mothers abused as children and who had experienced partner violence had more negative maternal

attitudes and poorer parental functioning, resulting in higher rates of physical abuse and poorer outcomes for their children (Rumstein-McKean & Hunsley, 2001). Furthermore, battered women who are exposed to more stressors, such as psychopathology as noted above, may be more likely to abuse their children (Coohey, 2004). National survey data reports that of fathers who frequently abused their wives, 50% also had abused a child three or more times within the previous year, and mothers reporting husband-to-wife aggression had twice the rates of child abuse than those not reporting husband-to-wife aggression (Margolin et al., 2003). Interestingly, while Levendosky and Graham-Bermann (2001) report that a maternal history of child abuse and current intimate partner violence account for only 5% of the variance in current parenting behaviors, Margolin (2003) contends that maternal parenting behavior may be affected directly and indirectly by their experiences of violence through its impact on her overall psychological functioning.

In addition to domestic violence and the perpetuation of the cycle of child abuse, childhood abuse experiences are significantly associated with later suicidal thoughts, attempts, and completions. Childhood maltreatment has been found to be a significant risk factor for suicidal ideation and behaviors across the lifespan (Pompili et al., 2011, Rhodes et al., 2012, Bryan et al., 2013; Fergusson et al., 2013). Many studies, however, interpret suicidality as both a symptom and a result of psychopathology, and emphasize

the strong association between childhood maltreatment and negative mental health outcomes, under which suicidality is subsumed (Spartaro et al., 2004). One study found that suicidal ideation rates showed no significant difference between child abuse survivors and non-abused participants, when the presence of an affective disorder was controlled for (Silverman, Reinherz, & Giaconia, 1996). Another study argued that suicidality could not be excised from affective psychopathology, and as such, the two domains could not be analyzed independently (Owens & Chard, 2003). Many of these articles argue that rather than considering suicidality a domain necessitating independent study, it is more accurately understood as a symptom of psychopathology.

There is, however, a recent collection of studies supporting an independent association between child abuse experiences and increased suicidality, particularly as related to the level of lethality associated with suicidal ideation and behavior. Several studies have demonstrated a strong association between childhood maltreatment and later impulsive/aggressive behaviors, which they found strongly correlated with increased lethality amongst suicidal participants (Dunn et al., 2013, Mann et al., 2005, Thornberry et al., 2010). These associations remained strong even when controlling for psychopathology (Mann et al., 2005). Impulsivity and aggressiveness may predispose individuals to suicidal behavior regardless of the presence or degree of psychopathology, as they are associated with structural and functional dysfunctions in key brain regions implicated in the regulation of

mood, impulse, and behavior (Zouk et al., 2006). Moreover, Andover et al. (2007) found that individuals endorsing frequent suicidal ideation who also reported histories of childhood physical and sexual abuse evidenced more frequent and severe attempts than those without abuse histories. Even researchers supporting independent associations of suicidality and child abuse caution, however, that complex and multifaceted interactions among crucial risk factors may be evoked to explain the association between childhood abuse, impulsive and aggressive behaviors, and suicidality, and recognize that support for an independent association of suicide risk and child abuse experiences has been mixed (Andover et al., 2007).

Substance Abuse

Substance abuse is inexorably tied to child abuse: decades of research across cultural, socio-economic, and geographic groups shows that parental substance abuse is significantly related to increased rates of child abuse (Howard, 2000). A survey of dozens of State child welfare agencies in the United States found that parental substance abuse was a factor in at least 50% of substantiated cases of child abuse and neglect, and 80% of administrators polled cited substance abuse and poverty as the two primary factors contributing to abuse and neglect (U.S. Department of Health and Human Services, 1999). Furthermore, it has been found that substance abuse by parents is predictive of both abusive interactions with children and of domestic violence and other forms of interpersonal violence (Howard, 2000).

There are multiple theories as to the mechanisms of these strong correlations. Some studies point to the frequency with which substance abusing parents divert resources from the home into the acquisition of substances, a process which may put children at risk for neglect, and other forms abuse due to the frustrations of financial hardship. Furthermore, while intoxicated, parents may lack the coping skills to parent effectively, and may respond to negative interactions with their children with violence, emotionally abusive tactics, sexualized punishments, and physical abandonment for varying periods of time (Nair et al., 2003).

Even more vivid, however, is the association between childhood abuse experiences and later substances abuse by the maltreated child in adolescence and adulthood. The results of numerous studies (Bohn, 2003; Bulik, Prescott, & Kendler, 2001; Kendler et al., 2000; Liebschutz et al., 2002; Newmann & Sallmann, 2004; Schuck & Widom, 2001; Stewart & Israeli, 2002; Widom, Weiler, & Cottler, 1999) support the link between abuse histories and subsequent substance abuse in women and men. A meta-analysis of studies investigating rates of adult substance use problems with concomitant child abuse history, specifically child sexual assault and child physical assault, found significantly increased rates across gender and abuse type (Simpson & Miller, 2001). A meta-analysis found that the average rate of substance abuse problems among adult and adolescent females abused as children was 40.5% and 38.3% respectively, which was nearly three times the benchmark rate of

14% for each group found among the general population in the National Household Survey (Simpson & Miller, 2001). A very similar pattern was found for studies involving adult males reporting childhood sexual abuse, where average rate of substance abuse problems across these studies (65%) was 2.6 times greater than the general population rate of 25%. Among adult females with substance use problems, it was found that the average rate of childhood physical assault to be 38.7% as compared to a general population rate of 21%, and among adolescent females, the rate was found to be over twice the general population rate, 46.2% vs. 21% respectively. The average rate of childhood physical assault among adolescent males in substance abuse treatment, however, was found to be significantly higher, 44.7% as compared to the benchmark rate of 31%. Interestingly, this analysis did not find a significant increase in the rates of child physical assault as compared to the benchmark rates (31.2% vs 31%) amongst substance abusing adult males (Simpson & Miller, 2001).

These studies are careful not to describe or imply a causative relationship, as the research is all based in correlational relationships among the data. Several studies also address whether a third factor may cause both the childhood abuse and substance use rather than the childhood abuse itself playing a causal role in the development of substance abuse disorders. Family history of substance abuse is the most frequently cited potential factor for later substance abuse, regardless of childhood abuse experience (Yama, Fogas,

Teegarden, & Hastings, 1993). Parental substance abuse is also associated with increased risk for insufficient supervision and limited parental monitoring of children's activity (Chassin, Curran, Hussong, & Colder, 1996), which can put children at risk for both intra- and extra-familial sexual abuse (Simpson & Miller, 2001). In addition, parental substance abuse likely acts as causal factor for the development of substance abuse later in life due to genetic and modeling components involved in being raised by substance abusing parents (Lex, 1991).

While the literature does not cite a causative relationship between child abuse and later substance abuse, research with both clinical and community samples often describe attribution by the participants of at least part of their substance abuse to their childhood abuse experiences. One study revealed that 25% of incest victims in alcohol treatment programs attributed both the advent and the severity of their drinking problems to their incest experiences (Janikowski & Glover, 1994). Another study found that individuals with alcohol and other substance abuse disorders and histories of sexual or physical abuse frequently believed that their trauma was a considerable factor in causing their substance use and that it was a moderate factor in precipitating their most recent relapses, regardless of the time passed since the trauma (Brown et al., 1993).

Furthermore, as substance abuse and child abuse are related so closely, the risks of continuing cycles of substance abuse and child abuse

appear to be cumulative (Nair et al., 2003). The literature argues that child abuse and substance abuse are not only mutually reinforcing, in that they commonly co-occur, but also that a history of one significantly increases the risk for another across the lifespan (Howard, 2000). Again, while causation is not argued, and other factors such as genetics and environmental patterns are introduced as influencing factors, these concomitant issues must be attended to when working with parents abused as children.

Parenting Stress

Parental stress is an area of significant concern when exploring the needs of parents abused as children. Past findings suggest that childhood abuse, and the impairments with which it is associated, may make the tasks associated with child-rearing more difficult, as abusive experiences may increase stress related to parenting, reduce motivation to engage in parenting activities, and weaken important social supports (Ruscio, 2001). Studies have shown that mothers with childhood abuse histories tend to be more dissociative, report increased anxiety and hypervigilance, and endorse more feelings of powerlessness, fear, shame and distress compared to other women (Gibson & Leitenberg, 2001; Merrill, Thomsen, Sinclair, Gold, & Milner, 2001; Meston, Rellini, & Heiman, 2006). Furthermore, difficulties such as negative views of themselves as mothers or fathers, greater use of permissive behaviors, less emotional control in stressful parenting situations and increased physical discipline toward their children have been reported among

child abuse survivors (Cole et al., 1992; DiLillo & Damashek, 2003). Several studies have suggested that parents abused as children may find the emotional demands of parenthood to be particularly overwhelming. In one study, incest survivors reported less emotional control in both neutral and stressful interactions with their children as compared to daughters of both substance abusing parents and a no-risk control group (Cole, Woolger, Power, & Smith, 1992). Burkett (1991) found that sexually abused mothers were more self-focused (as opposed to child-focused) in their interactions with children, and that they relied more heavily upon their own children for emotional support than mothers without child abuse histories.

In particular, women who were sexually abused as children often exhibit anxiety and stress related to intimate aspects of parenting. Anxiety regarding intimate parenting refers to discomfort with, uneasiness about, or avoidance of parenting tasks involving intimate child care and affection such as bathing, dressing, diapering, hugging, and kissing” (Bowman, 2009). Douglas (2000) found that adult mothers sexually abused as children report higher levels of intimate parenting anxiety, persistent fear of sexually abusing their children, and in some cases, fear that their children will sexually abuse them. Anxiety about intimate parenting, as well as anxiety focused on abusing or being abused their children, may lead some mothers to become emotionally distanced from their children, thus increasing the risk of neglect and abuse (Douglas, 2000). This abuse may come at the hands of the abused mother, or,

due to the emotional distance and decreased vigilance, at the hands of others without the mother's knowledge.

Finally, it has been found that there are low levels of social support among adult survivors of childhood sexual and physical abuse and among victims of domestic violence (Campbell & Lewandowski, 1997). This suggests another manner through which victimization history negatively affects adult functioning: the cyclical mechanism of stress associated with a lack of social support and concomitant lack of support to deal with stress (Runtz & Schallow, 1997).

Parental Competence

Parental competence refers to “a parent's contentment, liking, satisfaction, and/or perceived effectiveness as a parent,” (Strickland & Stamp, 2013). Beliefs about one's own parenting abilities can significantly shape the types of interactions a parent has with his or her child, which can in turn significantly modulate the quality of the overall relationship. Low parental competence is correlated with both negative perceptions of one's children and negative and disproportionately severe reactions to child misbehavior (Strickland & Stamp, 2013). High parental competence, however, has been associated with more engaged, warm, consistent, and satisfactory parent-child relationships (Strickland & Stamp, 2013).

Investigations of the parenting characteristics of child abuse survivors suggest that many have negative and abnormally skewed perceptions of their

parenting behaviors and effectiveness, and may lack important parenting skills as compared to non-abused parents (DiLillo, Tremblay, & Peterson, 2000). In addition, these adult survivors are often unaware of normative child development and may have unrealistic expectations of their children, which stands as a risk factor for physical abuse and neglect (Cross, 2001). One significant concern is the ability of parents abused as children to regulate the anger and frustration in response to childcare, ranging from severe misbehavior to even basic or routine caretaking. Appropriate expressions of anger appear to be particularly difficult for those with a history of childhood sexual abuse (Briere, 1992). High or inappropriate levels of parental anger have also been linked to physical abuse of children, and as child misbehavior is likely to incite poorly regulated parental anger and aggression (DiLillo, Tremblay, Peterson, 2000).

The confluence of child abuse history and mental health issues leads to further issues with parenting competence. It has been found that maternal depression is positively associated with hostile and rejecting home environments, that these mothers have poorer communication and have more negative interactions with their children (Belsky & Vondra, 1989). One study found that depressed mothers evidence more negative interactions with their children, including irritation or frustration with their children, yelling and spanking behavior (Lyons-Ruth, Wolfe, Lyubchik, & Steingard, 2002).

Unfortunately, each of these domains of assessment is associated with poorer outcomes for children. A recent meta-analysis of the impact of children's exposure to domestic violence found that these children evidence more depressive symptoms, anxiety, and worry, as well as seem to be more prone to aggressive behaviors (Evans, Davies & DiLillo, 2008). These children evidenced "more internalizing, externalizing and trauma symptoms" than those not exposed to violence (Evans, Davies & DiLillo, 2008). These high levels of internalizing and externalizing behaviors appear to be mirrored in children of abused parents, even when severe domestic violence is not present (Holden & Ritchie, 1991). Due to these generational correlates of child abuse experiences, understanding and attending to the unique needs of parents abused as children is of considerable importance.

Summary

This chapter explored the body of literature pertinent to the current study. The theory of reasoned action was described and the potential applications of the theory to LCSW beliefs about assessing parents abused as children were explored. Broad assessment domains identified as particularly relevant to this population were explored, including psychopathology, interpersonal violence and suicide, substance use, parental stress and parental competence. While the adverse implications of child abuse are well-studied, best practices for clinical assessment or treatment of parents abused as children have not been studied. As such, this study seeks to

explore clinical best practices as they relate to parents abused as children, with this survey of available literature informing and guiding the study methodology and the analysis of the data gathered.

CHAPTER THREE

METHODS

Introduction

This chapter will outline the development of the present study design, the purpose of the research project and the rationale for the study design and areas of focus. The development of the interview instrument will be discussed, and the content of each vignette and the interview questions will be presented. Sampling procedure will be examined, as well as the manner in which data were collected and analyzed.

Sampling

The present study consisted of a sample of 10 licensed clinical social workers with experience assessing and providing therapy services to adult populations that could have potentially included parents abused as children. The participants were recruited by snowball sampling, thus allowing the researcher to involve only the desired population (i.e., licensed social workers) who possessed unique knowledge about the study's focus, who were willing to participate, and who represented a range of perspectives (Grinnell & Unrau, 2011). By using a snowball sampling method, the researcher was able to interview social workers from a variety of agencies and settings, including public mental health, private practice, community-based providers, and participants with extensive forensic experience. Participant eligibility was

dependent on two criteria: 1) participants had to be licensed clinical social workers and 2) currently or previously had worked in an environment that could possibly have included assessment and clinical interaction with parents abused as children. These parameters ensured a sample that was best suited to explore the beliefs of LCSWs about assessing parents abused as children. As the participants were interviewed under their licenses rather than as associated with their agencies, an agency access letter was not needed for the present study.

Study Design

The purpose of the present study was to explore beliefs among licensed clinical social workers about assessing parents abused as children. By examining the process LCSW participants utilized in assessing a case vignette, this study aimed to gain a better understanding of the beliefs LCSWs hold regarding this population and the impact this may have on the process of assessment and treatment considerations. A qualitative research approach was utilized, and was well suited for the present study's purpose. The researcher developed an interview instrument which utilized hypothetical case vignettes to explore participants' interpretative process of assessment, prompt discussion of subjective beliefs and perceptions, allow for elaboration, and to suggest themes for further inquiry and research.

Vignettes were utilized as a way to delve into the participants' assessment process and to highlight the assessment dimensions emphasized

in the literature. Vignette methodology afforded the opportunity to have participants respond to a standardized collection of information rather than other methods that may have drawn on participant's experiences, which may have been idiosyncratic or not specifically related to this population. Three separate vignettes were generated, and each client presented with a different symptomatic cluster, a different focus on interpersonal risks, the presence or absence of direct or implied substance abuse issues, as well as different types of abuse experienced by the client. The rationale for three vignettes was that a single vignette could not adequately capture the broad domains addressed in the literature while still being believable as an actual client. While each vignette emphasized different domains focused on in the literature, the vignettes were kept intentionally open to interpretation so as to allow participants to choose the areas or domains they wanted to focus on.

Each vignette was written as a presentation of a client seeking individual therapy with the participant, and the information provided was from the participant's first session with the client. The first vignette presented a 28-year-old Hispanic male currently living with his girlfriend and his two sons, ages 7 and 4. This client endorsed several symptoms consistent with Major Depressive Disorder, a history of neglect by his mother and emotional abuse at the hands of his mother's boyfriends, a long history of drinking alcohol but recent sobriety, and the intimation that the client may be physically abusing his sons, though the client insisted that he is a good father. The second vignette

presented a 37-year-old African American female currently living with her husband and four children, ages 5 to 15. This client endorsed and presented with several symptoms consistent with anxiety or PTSD, described a history of physical abuse by her father, and there were several indications that she was the victim of domestic violence in her current relationship. The third vignette presented a 23-year-old Caucasian female living with her boyfriend and 3-year-old daughter, and who was five months pregnant with her second child. This client described several symptoms consistent with Bipolar Disorder, a history of sexual abuse by her uncle beginning at young age, a history of methamphetamine use but currently testing clean, and apparent suicidal thoughts (see Appendix B for each vignette in full). In addition to these domains, each vignette alluded to high stress levels related to parenting, and varying degrees of client-perceived competence related to parenting.

Open-ended questions were used to evaluate the participant's assessment of the client presented in the vignette, and this approach allowed participants to expand and elaborate on the interview questions and to emphasize the areas of the vignette they wanted to focus on. The first question asked what strengths the participant saw in the presented client. The second question asked about the participant's overall assessment of the client. In the event the participant did not identify a diagnosis, a follow up question asked about the participant's diagnostic impression of the client. The third question asked about what additional information the participant would seek out from

the client. The final open-ended question asked about possible treatment goals the participant would have for working with the client.

Scaling questions were also used to explore how the participants assessed risk and the presence of parental stress and competence in the vignette, and the response options were presented as a Likert scale ranging from 1 to 5. The first question asked about risk of child abuse, with 1 representing No risk, 2 representing Low risk, 3 representing Medium risk, 4 representing High risk requiring a mandated report, and 5 representing Severe risk requiring an immediate call to police. The second question asked about suicide risk, with 1-4 representing None, Low, Medium and High respectively, and 5 representing Severe requiring hospitalization. The third question asked about domestic violence risk, with 1-5 representing None, Low, Medium, High and Severe respectively. The last two scaling questions asked participants to assess the presence of parental stress and client-perceived competence, with 1-4 representing None Indicated, Low, Medium, and High respectively, and 5 representing Severe for stress related to parenting, and Unrealistically Exaggerated for client perceived competence related to parenting. Scaling questions were utilized to ascertain specific impressions of risk, which may not have been addressed directly in the open-ended responses. Furthermore, as related to child abuse and suicide risk, the scaling questions sought to assess if participant's concerns about risk were significant enough to warrant further action, including hospitalization, mandated reporting, or a call to police. Finally,

while each vignette focused on a separate area of risk, each participant was asked about risk in all three domains, as the literature highlights the common coincidence of interpersonal violence and suicide risk among child abuse survivors.

The research question in the present study asked what are the beliefs of LCSWs about assessing parents with child abuse histories. This researcher hypothesized that participants would emphasize psychopathology in their assessment and would identify symptomology associated with and name a specific diagnosis. Furthermore, this researcher hypothesized that participants would specifically attend to Post Traumatic Stress Disorder symptoms, even if these were not specifically highlighted in the participants' given vignette. Secondly, this researcher anticipated that the participants would emphasize completing a thorough risk assessment and seek out information relating to the type of risk most prominent in the vignette. Finally, this researcher hypothesized that the respondents would not identify or seek to investigate parental stress or perceived parental competence as dimensions of assessment.

Data Collection and Procedures

Data was collected through face-to-face interviews conducted by the researcher. Although face-to-face interviews have the possible limitation of being more time-consuming and costly as compared to many quantitative methods, this method was necessary for this study as a means to gain rapport

and buy-in with participants. Furthermore, face-to-face interviews allowed the researcher to explore the participant's process of assessment, and allowed for the discussion of themes or dimensions of assessment beyond those emphasized in the literature. Moreover, this method allowed for the clarification of participants' responses, and where appropriate, follow-up questions to gather richer responses.

The researcher initially met with three known LCSWs to request an opportunity to interview them as well as to obtain contact information for additional participants through snowball sampling. The researcher explained the purpose the study, the procedures of the data collection, and described the importance of the participant's clinical expertise in assessment to the study. The researcher then contacted the potential participants provided by confirmed participants to request their participation. Upon agreeing to participate, the researcher worked with the participants to schedule interview times and locations. Interviews were conducted at a location of the participant's choice, including the participant's office and local coffee shops. Prior to conducting the interview, each participant was provided an informed consent form, which the researcher reviewed verbally. This form included detailed information on the purpose and procedures of the study. Concurrent with the verbal explanation, participants were given an informed consent form to read, and acknowledged their receipt by signing the form with an X, including consent for audio recording. Complete anonymity of the participant

was emphasized throughout the interview and data analysis process.

Participants were informed they were in no way obligated to participate in this study and were able to withdraw from the study at any time without consequences. After reading and acknowledging the receipt of the informed consent, the participants were asked to complete a brief demographics questionnaire, however, this form did not include any personally identifiable information.

Once these items were completed, the participants were given a packet that included the interview guide and a single, randomly selected vignette. The participants were asked to read the vignette and assess the client presented, and then the researcher asked each participant the four open ended questions and five scaling questions described above. All but one participant's responses were audio recorded; one participant declined audio recording and the researcher took extensive notes based on this participant's responses in lieu of audio recording. Interviews lasted approximately 15-30 minutes to complete, and upon completion, the researcher invited participants to ask any questions they may have had regarding the project or the interview. A debriefing statement was provided following each interview, including the name and contact information of the researcher's faculty research advisor. Furthermore, participants were informed that the research findings will be available online, which could be accessed through the California State

University San Bernardino library, by Summer 2015. A \$5.00 Starbucks gift card was also provided as a token of appreciation for his or her participation.

Protection of Human Subjects

Prior to conducting interviews, this researcher completed Human Subjects Ethics Training in the Protection of Human Participants. Participant anonymity was protected as no personally identifiable information was collected during interviews and participants were asked not to disclose any personally identifiable information during the interview. Participants completed an informed consent prior to providing any information and were given a debriefing statement upon completing the interview. All audio data was stored in a locked box until transcription was completed, and then promptly destroyed to further protect confidentiality. The School of Social Work Sub-Committee of the Institutional Review Board of California State University, San Bernardino, approved the protocol described above.

Data Analysis

The data analysis process began by transcribing each interview, and the researcher identified thematic qualitative clusters among the responses. These clusters were then analyzed to examine LCSW beliefs about parents abused as children and their process of assessment. These thematic cluster categories included the assessment dimensions discussed in the Literature Review and other dimensions that emerged in the course of the research.

Quantitative data was imputed into Statistical Packages for the Social Science software, which is designed specifically for research studies such as this.

These Likert-scale responses were categorized and coded for quantification purposes, and were analyzed based on frequency and intensity of responses.

The resultant data provided the mean, median, and modal frequencies of participant responses.

Summary

This chapter covered the methodology that was utilized in executing the present study to assess LCSW beliefs about assessing parents abused as children. The study design, sampling techniques, and the data collection procedures and process were explained, and the instrument employed for the interviews was described. Procedures to protect human subjects were reviewed and the data analysis process was described.

CHAPTER FOUR

RESULTS

Introduction

This chapter presents the findings of the current study in the form of short narratives. Participant responses to the vignettes are organized along the predominant themes that both emerged from the data, as well as those highlighted in the literature. These themes are: psychopathology, interpersonal violence and suicide risk, substance abuse, parental stress and competence, client strengths and resources, and culture. Quantitative data regarding risk will be presented near the end of this discussion. Also included in this chapter is a description of participant demographics.

Demographics

The sample comprised of 10 Licensed Clinical Social Workers who have experience working with adult populations in a therapeutic context. Of the 10 participants, 7 were female and 3 were male. The age range of the sample was 31 to 61 years, with a mean age of 39.6 years of age. The participants' years of clinical experience ranged from 5 to 25 years, with a mean of 11.9 years, and experience specifically with adult populations ranged from 4 to 20 years, with a mean of 10.4 years. Half of participants, 5, identified as Caucasian, while 3 identified as Hispanic, and 2 identified as Asian or Pacific Islander. Participants also indicated the setting where they gained the

majority of their clinical experience, with 4 participants having worked primarily in public outpatient clinics, 2 participants having worked primarily in forensic settings, 2 participants having worked primarily in private practice, and 2 participants having worked primarily in community and school based settings.

Findings

Psychopathology

Many participants initially focused their responses to the question of overall assessment on identifying specific DSM IV-TR and DSM V diagnoses. Each participant offered a preliminary diagnosis for the client identified in the vignette, and 70% of participants cited specific diagnostic criteria when making the given diagnosis. Participants also offered differential diagnostic considerations. One participant emphasized the “need to rule out any kind of medical conditions [or] substance abuse, which could be impacting her mood,” (Participant K2D, survey interview, March 2015), where another would have wanted to “rule out any psychosis,” due to some evidence of disordered thinking or delusions in the client (Participant 1D4, survey interview, March 2015).

In addition to the standard diagnostic process, several participants explored issues unique to parents abused as children. One participant explored issues unique to maternal mental health,

It doesn't talk about any postpartum depression with her first daughter, does it? Okay, so I would look in to see if she had any specific

postpartum issues. I'd also refer her to a psychiatrist, because you can take anti-depressants and mood stabilizers when you are pregnant.

(Participant S4V, survey interview, February 2015)

Another participant emphasized the importance of exploring her trauma from the perspective of attachment, stating "I think getting more information about some of her trauma-based reactions, her sort of level of attachment and ability to attach, because that's going to impact both her and her children,"

(Participant L6H, survey interview, March 2015).

In addition to diagnosis, each clinician offered potential directions for treatment and intervention. The most common initial treatment goal, shared by 80% of participants, was some version of ensuring the safety of the client and his or her family. One participant stated, "Treatment goal number one goal is obviously maintaining her safety," (Participant W3K, survey interview, March 2015), while another stated, "Immediately would be to ensure safety, both her and her children. I think addressing the trauma if the safety areas are addressed, but only if everyone is safe," (Participant L6H, survey interview, March 2015).

Once safety is established, however, participants described a variety of treatment goals and areas of focus. One participant emphasized increasing self-efficacy, coping skills, and resource mobilization,

Start [with] gaining some sense of control, and then start building in some tools for her to have in terms of coping, stress management,

trauma resiliency type of treatment, and then mobilizing resources...

Then you're going to be increasing what's missing, which is her coping, her ability to express her emotions in a safe place, some trauma treatment, family of origin issues, in addition to building the relationship and support she has with the boyfriend... then mobilizing resources so that she has the outlet and so when she's not coping or while she's going through the treatment, she has support beyond just him.

(Participant K2D, survey interview, March 2015)

Other participants emphasized family therapy interventions more significantly than individual interventions, with 40% of participants identifying family therapy modalities as a possible intervention with the client. These participants, however, were also cognizant of the complex issues associated with conducting family therapy where there is risk of interpersonal violence, and 75% of those endorsing family therapy as an intervention would only consider it if it provided an emotionally (and potentially physically) safe space for the family to interact and process their experiences.

One topic where there was significant disagreement amongst participants was the efficacy and necessity of rapidly exploring the client's childhood abuse directly and early in the therapeutic relationship. One participant saw focusing on the client's trauma as necessary to ensure the safety of the client's children, "I would focus on the trauma, so that he doesn't have to repeat that cycle of abuse with his kids. We would work on seeing that

how he is relating to the children is perpetuating behaviors, abusive behaviors,” (Participant A9K, survey interview, March 2015). Other participants, however, felt that building rapport was more important than a rapid exploration of the client’s trauma, “Initially, I wouldn’t elicit too much abuse information because I just don’t expect him to give that to me. We don’t even have a relationship built,” (Participant 2L7, survey interview, February 2015).

While each participant emphasized different elements of psychopathology, attending to the symptoms and consequences of the client’s mental health disturbances was the most dominant and thoroughly explored theme within the data. The next most dominant theme was that of identifying and exploring issues of risk in terms of interpersonal violence and suicide risk.

Interpersonal Violence and Suicide Risk

Interpersonal violence risks were identified by 100% of participants. Furthermore, 100% of participants indicated some orientation to child abuse risk, even before being asked specifically to assess this domain. One participant plainly stated,

First of all, you want to assess to see if the kids are being abused. You want to try to get and elicit more information about what he does when he’s upset, any abuse that’s going on. You want to get that out of the way. Even if he doesn’t share, you have to make a report anyway.

(Participant 2L7, survey interview, February 2015)

Another participant wanted to further explore the effects of the client's symptoms on her interactions with her children,

I'd also want to find out if there's neglect potentially, since she seems so anxious and hyper-vigilant herself. I wonder if maybe she's potentially neglecting her children because she's so, disabled by the anxiety? Which is possible. Women who experienced a lot of trauma experience that numbing, as a result of that numbing may be very disengaged from her children, so I'd want to rule out potential neglect or assess that further. (Participant 1D4, survey interview, March 2015)

A third participant introduced the concept of homicidality to her areas of risk when discussing potential child abuse in the home, stating,

I want to know if she's ever thought about hurting her kids, because of the issues that she's had with her experience of abuse. I'm wondering if that ever crosses her mind. I mean, in terms of physical abuse, but also the homicidal ideation piece too. (Participant K6M, survey interview, March 2015)

Participants also discussed the issue of domestic violence. One participant indicated,

Although she doesn't admit to DV, there's very clear indications that she might be experiencing some DV with the way she was dressed... she also mentions being fearful of disappointing him, so it has a lot of

the fear of women who are potentially in that cycle of abuse, victims of that cycle of abuse. (Participant 1D4, survey interview, March 2015)

Each of the three participants provided with Vignette 2 (see Appendix B) discussed the issue of domestic violence in their assessment, as that vignette specifically gave indications of intimate partner violence. Four of the remaining participants also attended to the risk of domestic violence, despite no direct indication of domestic violence in the other two vignettes.

Participants also discussed and explored the issue of suicide risk. All 10 clients indicated that they would explore suicidality in the course of their assessment. In particular, one participant stated,

I would want to clarify her lethality, if she's actually dangerous to self when she talks about frequently thinking about dying. I want clarification on that, as far as does she have a plan? Does she have access to the means to follow through? (Participant S4V, survey interview, February 2015)

Overall, the most consistent feature of each interview was participants' desire for more information. Each participant repeatedly identified areas that they wanted more information or to explore further as related to areas of safety and risk. As one client stated,

I'd also want to check if there is domestic violence, where are the kids when this happens? Is there abuse for the children? Is she experiencing suicidal ideation or homicidal ideation toward her husband

if there is abuse? I'd just want to check in on all the risk factors.

(Participant R6W, survey interview, March 2015)

Substance Abuse

A third domain that was discussed in the data was the issue of substance abuse. While only two of the three vignettes specifically referenced substance abuse, 80% of participants stated that they would be interested in getting more information regarding substance use. Additional screening for substance abuse was a common theme, particularly for those vignettes where substance abuse history was indicated,

You want to do more of a thorough like AOD [Alcohol and Other Drugs] screening, because he said he's not drinking, it doesn't mean he's not using other things or that he really did stop drinking, so you want to do a more thorough assessment. (Participant 2L7, survey interview, February 2015)

For those participants responding to the vignette without an indication of substance use, half still indicated that they would seek out more information about possible substance use. In particular, one participant stated,

She says she's never done drugs, but what does that mean? Does she consider alcohol a drug? What about prescription pills? Does she need sleeping pills to turn off her anxiety? Just because she hasn't done street drugs doesn't mean she isn't using substances to cope.

(Participant 1D4, survey interview, March 2015)

Even though the two clients with substance abuse histories endorsed sobriety, 40% of participants suggested that substance abuse treatment be explored as an adjunct for therapy services. One participant stated,

I know that she's been tested for drugs, so if there's a substance abuse issue I feel like that needs to be treated, number one. In addition to the risk evaluation, I really feel that the substance abuse issue is pretty high up there. (Participant K6M, survey interview, March 2015)

Over half of participants, 60%, however, described the client's sobriety as a strength. While two participants interpreted the client's sobriety as showing motivation for change, two more described sobriety as indicative of the client's personal strength and resiliency, given their substance use was likely a powerful coping skill. As one participant described,

He stopped drinking, and the issues the alcohol was covering up are coming forth. The drinking probably kept those issues at bay, so look how strong he is that he is dealing with them, coming for help, without the alcohol that made them bearable. (Participant A9K, survey interview, March 2015)

Overall the majority of participants discussed substance abuse, even when substance use issues were not specifically identified in the vignette.

Strengths and Resources

Strengths and resources was the final domain heavily explored within the data of the present study. While specifically prompted by the first question,

100% of the participants were able identify at least one strength of the client, and 80% of the participants included discussions of strengths beyond their responses to the first question. The most common strength identified was that of insight and/or help-seeking behavior evidenced by the client. As one participant stated,

To me the ultimate strength is the fact that she knows that she is not okay, that she has these mood swings and they they're not okay. She doesn't seem to be justifying them or minimizing them. She knows that they are problems. (Participant K6M, survey interview, March 2015).

Furthermore, 40% of participants identified the client' motivation and follow-through of seeking and coming to a therapy session as a strength.

Resiliency was another strength that was identified or alluded to by 60% of participants. One participant pointed to the client's lack of suicidal behavior or completion as a strength, even in the face of persistent ideation,

She's a strong person because despite of everything that she's going through, she's still here. She obviously things about suicide, but it doesn't say anything about pervious attempts. She has managed not to hurt herself. (Participant W3K, survey interview, March 2015)

Another described the client as a survivor,

She's a survivor, and I think anything you do needs to be placed in that she's a survivor. But unfortunately now what's helped her survived is no longer working, so how can she then work towards something that is

more functional for her, but not put it in a negative light. That's the key, I think, because she has already had enough. (Participant K2D, survey interview, March 2015)

Overall, the participants readily identified strengths, but also sought to explore recourses to help the client cope. Though not specifically prompted by the interview questions, many participants also explored resources external to the client, such as social supports. The importance of identifying and building social supports for the client was an area of remarkable agreement amongst participants. All 10 participants cited social supports as a significant area of assessment and/or treatment. One participant stated, "I would really need to assess also her support system, other than her boyfriend, her current boyfriend, I'm not really getting any sense that she has a solid support system. I feel that would be something we will need to establish in our sessions," (Participant K6M, survey interview, March 2015). Another cited the importance of "building a stronger relationship with her husband and her children, as well as finding some healthy supports outside the home. Does she have relationships with any of her siblings? Does she participate in any religious or support groups?" (Participant R6W, survey interview, March 2015). A third participant emphasized the value of building support systems for the client's ability to parent effectively, stating,

Looking at what support system she has to begin to deal with the emotional impact of being pregnant, having a child, not feeling that

she's capable of being a parent, wanting to, I think at some level, but not knowing how to. (Participant K2D, survey interview, March 2015)

Additionally, while participants emphasized the present of existing strengths and resources, many (70%) also expressed the desire to have a significant goal of treatment be to explore, bolster, and develop additional strengths and resources.

Parental Stress, Parental Competence and Culture

While identified as significant domains within the literature, participants in this study did not extensively discuss stress and client-perceived competence related to parenting. Several participants alluded to significant experiences of stress in general, but no participants discussed stress specifically related to parenting. Furthermore, only two participants commented on client-perceived competence prior to being prompted by the scaling questions, referencing the client's desire to be a good parent "but not knowing how to" when discussing the need for increased social supports, (Participant K2D, survey interview, March 2015), and another stating "I think her biggest strength is recognizing that she's not meeting or she doesn't necessarily know how to meet the needs of her family," (Participant W3K, survey interview, March 2015).

In addition to the lack of attention paid specifically to parental stress and competence, the relative lack of attention paid to culture by participants in this study was also interesting. Each vignette identified a racial or ethnic

background for the client, but also hinted at cultural elements that could have been identified as relevant. Despite this, only 20% of participants' referenced culture, and both of these references were brief and fairly superficial. In fact, one reference seemed to reflect negative stereotyped beliefs about discipline within a given racial group, where the participant sought to explore how "her African-American background and upbringing may have influenced and perhaps been ok with some of the physical abuse by her father," (Participant 1D4, survey interview, March 2015). The second reference was more inclusive, seeking more information about how the client's racial background influenced her life experiences. Otherwise, however, culture was absent from participants' assessments of the three vignettes.

Quantitative Data

In addition to the qualitative data presented above, this study included quantitative data that sought to explore risk, parental stress and parental competence (Table 1). The high degree of attenuation to child abuse risk described by participants above was reflected in the scaling question responses as well. Across the three vignettes, the mean score the participants gave for risk of child abuse was 3.7, indicating the mean risk assessment fell between medium and high, requiring a mandated report. Both the median and mode scores were 4, however, indicating that participants largely considered the risk of child abuse to be both high and requiring a mandated report. In addition to the desire to further explore the suicidality of the client, participants

gave a mean score of 3.4 for suicide risk, with a median of 3.5 and a mode of 4, indicating participants' assessment of suicide risk fell between medium and high, requiring hospitalization. Furthermore, across the three vignettes, the mean score the participants gave for risk of domestic violence was 3.3, with a median of 3 and a mode of 3, indicating the participants' risk assessment fell between medium and severe but was largely identified as medium.

The quantitative data also explored the participants' assessment of the presence of parental stress and client-perceived competence related to parenting. During the narrative portion of the interview these issues were only briefly and superficially discussed, but when specifically asked about these domains participants identified in the clients' high levels of stress related to parenting with a mean score of 4.4, a median score of 4 and a modal score. The data indicate that participants' assessments of stress were largely high, but some participants identified it as severe, skewing the mean higher. In terms of client-perceived parental competence, participants indicated a mean score of 2.2, a median score of 2 and a modal score of 2. These data represent participants' assessments of competence as low.

Table 1. Assessment of Risk, Parental Stress and Parental Competence

		Child Abuse Risk	Suicide Risk	Domestic Violence Risk	Parental Stress	Parental Competence
N	Valid	10	10	10	10	10
	Missing	0	0	0	0	0
Mean		3.700	3.400	3.300	4.400	2.200
Median		4.000	3.500	3.000	4.000	2.000
Mode		4.0	4.0	3.0	4.0	2.0
Std. Deviation		.6749	.6992	.9487	.5164	.4216
Variance		.456	.489	.900	.267	.178

Summary

This chapter presented the data collected from the ten LCSW participant interviews. Demographic data was presented, including the participants' age, racial/ethnic background, and relative experience in the field. Upon assessing the vignette provided, participants provided information regarding their beliefs about the client's strengths, overall assessment and diagnostic impression, further information needed from the client, early treatment goals, an assessment of risk of interpersonal violence and suicide, and the presence of parental stress and client-perceived parental competence. This information emphasized four domains: psychopathology, interpersonal violence and suicide risk, substance abuse, and strengths and resources. These domains were described and illuminated through brief narratives from the participant interviews. Briefly discussed were the domains of parental

stress, client-perceived parental competence, and culture. Finally, quantitative data on participants' assessments of risk and presence of parental stress and client-perceived parental competence were presented.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter carefully and critically interprets the data obtained through this study. The narratives obtained through the interviews are revisited for symmetry with findings from the literature, as well as congruence with social work values. Furthermore, this chapter addresses unexpected domains that emerged in the data but that have not yet been discussed in the literature as related to parents abused as children. This chapter also explores the implications of the results, identifies limitations of the study, and suggests ideas and thoughts for future research.

Discussion of Findings

The research question in the present study asked what are the beliefs of LCSWs about assessing parents with child abuse histories. This researcher hypothesized that participants would emphasize psychopathology in their assessment and would identify symptomology associated with and name a specific diagnosis, which was supported fully by the data. While this researcher hypothesized that participants would specifically attend to Post Traumatic Stress Disorder symptoms, even if these were not highlighted in the participants' given vignette, this was only moderately reflected in participant responses. This researcher anticipated that the participants would emphasize

a thorough risk assessment and seek out information relating to the type of risk most prominent in the vignette, which was strongly supported by the data. Finally, this researcher hypothesized that the respondents would not identify or seek to investigate parental stress or perceived parental competence as dimensions of assessment. While there was little discussion of these two domains in the narrative response, these were attended to in the quantitative scaling questions, with participants identifying high parental stress and low client-perceived competence across the vignettes.

The most significant finding in the current study is the noteworthy congruence between the domains identified in previous studies regarding the most salient issues affecting parents abused as children and those domains heavily attended to by the participants in this study. Furthermore, participants demonstrated the core social work values of dignity and worth of the person, importance of human relationships, and competence. While these values were not specifically cited, the participants' reflected a strong orientation to these values as guiding and informing their clinical beliefs about assessing this population.

Congruence with Social Work Values

As the sample in this study was limited to LCSWs, this researcher was interested in the degree to which participants' responses reflected core social work values. While not specifically asked about by any question in the interview, participants' responses demonstrated an orientation and valuation of

the core social work values of dignity and worth of the person, importance of human relationships, and competence. Each of these values was reflected in the participants' responses, areas of focus, and initial treatment goals.

The National Association of Social Workers (NASW) Code of Ethics offers "a set of values, principles, and standards to guide decision making and conduct when ethical issues arise," (1999). Even in the absence of an ethical conundrum, these values influence social work practice. Asamoah et al. (1997) note: "Values are often proclaimed as a major distinguishing characteristic of the social work profession, perhaps more important than its knowledge base or methodologies." Furthermore, social work education seeks to instill these values in emerging social workers. These values are so fundamental to professional social work practice that are required to be embedded within the curriculum of any accredited master-level and baccalaureate-level social work educational program (Abbott, 2009).

The NASW Code of Ethics extolls the importance of social workers respecting the inherent dignity and worth of the person, which was a dominant underlying premise of much of the participant's responses. The Code of Ethics interprets this value as:

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change

and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. (NASW, 1999)

Participants reflected these values in their responses consistently, emphasizing self-determination where safety was assured, and their assessments demonstrated respect for and understanding of the difficult life experiences of the client. Furthermore, participants were remarkably non-judgmental in their discussions of possible abuse against children in the home, which this researcher anticipated would create negative sentiments towards the clients. While participants were mindful of respecting the clients' inherent worth and were consistently non-judgmental, one area emphasized by the Code of Ethics was largely absent from participant responses, that of culture. Only one participant sought more information about how culture affected the client's experiences, and culture was entirely ignored by 80% of participants.

Participants in this study also recognized the central importance of human relationships. In fact, their orientation to the importance of social supports and relationships was far more vivid than that which is described in the literature. Whereas social supports are given a passing consideration in the literature surveyed, 100% of participants identified the importance and need for the development of strong, supportive relationships. Per the Code of Ethics,

Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities. (NASW, 1999)

These values were each illuminated by the participants emphasis on building social supports, engaging family members in treatment, and strengthening relationships between the client and those close to them. By acknowledging the importance of social support and emphasizing their development as primary treatment goals, this value was strongly reflected in the data of the present study.

The final social work value that was specifically demonstrated in the data was that of competence. The Code of Ethics describes the value of competence as,

Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession. (NASW, 1999)

Participants demonstrated significant knowledge of the DSM IV-TR and DSM V (depending on the edition being used by their agency), and were attentive to differential diagnoses and other areas of clinical assessment. Participants

attended to both symptomology and interpersonal elements of the client's experience. Participants also were well aware of their legal responsibilities regarding mandated reporting and involuntary hospitalization, and were careful to seek out more information to confirm the appropriateness of these steps.

This value was most vividly demonstrated, however, in the remarkable congruence between the participants' areas of focus and the domains identified in the literature, including psychopathology, interpersonal violence and suicide risk, substance abuse. There was moderate congruence with participant discussions of parental stress and competence. In additions, two domains emerged that have been underexplored in previous research, that of culture and strengths/resources.

Psychopathology

The findings of this study support the hypothesis that participants would attend specifically to psychopathology in their assessments of the given vignette. Each participant offered a diagnosis based on the information provided, though many added that they would seek further information about onset, frequency, and severity of symptoms, as well as explore differential diagnoses. Furthermore, participants demonstrated significant familiarity with DSM IV-TR and DSM V criteria, and the diagnostic process advocated therein. Participants identified many of the symptoms contained within each vignette, and were able to conceptualize these symptom clusters within the framework of a specific diagnosis.

In this researchers opinion, however, participants did not overpathologize the clients in their assessments. While the diagnoses were certainly present, they did not define the participant's overall assessment of each client, nor did the specific diagnoses guide treatment goals. Instead, participants adopted a very strengths-based, recovery model oriented approach to the client presented. Rather than emphasizing deficits and pathology, participants focused the bulk of their assessments on areas of opportunity for the client. Many discussed strengths extensively, as discussed below. Even when addressing maladaptive behaviors, the majority of participants, 60%, viewed these as client developed means of coping with adverse experiences. By viewing these behaviors, such as substance abuse and staying in a potentially abusive relationship or even abusive actions toward the children, as mechanisms of coping the participants were able to acknowledge the difficulty of the clients' experiences and their process of coping as something that can be respected but also reshaped into more adaptive behaviors.

The approach participants took to discussing the client's own childhood abuse was, however, interesting conceptually. Though there was disagreement about the speed at which to explore the childhood abuse, or even the necessity of exploring it at all, nearly all the participant referenced the word "trauma" rather than "child abuse." The dominance of interpreting the client's adverse childhood experiences as trauma rather than specifically as

child abuse was unexpected but significant. By framing their understanding of the client's abusive experiences under the larger and more generalized umbrella of trauma rather than a very particular manner of victimization, some of the unique elements associated with childhood abuse may not be given appropriate clinical attention. Furthermore, as the phrase trauma is so inclusive of such a continuum of experiences, it's possible that the severity of child abuse is diluted through the associations with less impactful traumatic experiences. Though the participants' assessments attended to domains associated with survivors of child abuse, these may have been informed more by general trauma theories rather than knowledge more focused on child abuse experiences specifically.

This theme of coping skills was also an interesting and unexpected element that emerged in the data. Many of the participants framed their assessments of both positive and negative behaviors by the clients from the perspective of client coping skills. Coping skills are the strategic behaviors individuals use to deal with stress, and a combination of problem-focused and emotion-focused coping are used to cope stress (Smith, 2009). How one copes with stress varies from individual to individual, and can vary significantly across the lifespan. Significant research has been done on exploring maladaptive behavior from the perspective of coping skills among adults abused as children. In particular, substance abuse is often cited as a maladaptive coping skill used to deal with traumatic events (Bulik et al., 2001).

Many individuals who are abused as children report the use of substances as a coping strategy, with use often beginning during late childhood or early adolescence (Jarvis & Copeland, 1998).

This literature, however, has not been expanded specifically to adults abuse as children that are also in a parenting role. Additionally, utilizing the framework of coping skills to understand adaptive and maladaptive behaviors in response to childhood abuse experiences as a guide for treatment has not been vividly explored in the literature. These data, however, suggest that clinicians do utilize coping skills as a guiding framework for treatment goal selection. This conceptualization is very grounded in the recovery model insofar as it acknowledges the client's inherent ability to find methods of self-regulation or self-soothing (whether positive or negative), as well as the client's ability to develop adaptive coping skills that are driven by their own self-determination.

Interpersonal Violence and Suicide Risk

In addition to psychopathology, participants in this study heavily attended to interpersonal violence and suicide risk. Every participant addressed the issue of risk for child abuse and suicide risk, and 70% of the participants attended to issues of potential domestic violence risk for the participant. The need for further assessment beyond the information provided dominated the responses, and each participant expressed the desire to gather more in depth information from the client about specific domains associated

with each type of risk. Regarding suicide risk, participants expressed the need for information about the client's intent, plan and access to means to complete a suicide attempt. Regarding child abuse, participants sought to understand how the parents interacted with their children, and if these interactions included any type of abuse, but participants specifically attended to issues of neglect and physical abuse. In particular, one vignette a statement by a client Participants also emphasized that building rapport was key to being able to adequately explore these sensitive and emotionally charged issues. Participants also expressed a desire to explore further areas of interpersonal risk, such as homicidal risk but acknowledged that homicidal ideation is both more rare and less likely to be disclosed on an initial assessment.

An interesting finding was the ambivalence of participants to commit to further action regarding risk with the available information. A number of participants indicated that while they felt that the risk for child abuse or suicide was high, they could not confidently support making a mandated report or placing someone on a 5150 hold with the information provided in the vignettes. Furthermore, many participants wavered between a 3 (representing Medium risk) and a 4 (representing High risk, necessitating a mandated report) when asked to assess child abuse risk, with 30% of participants only choosing a 3 after stating that they viewed the risk as high, but that a mandated report was premature. Participants did, however, indicate that upon obtaining more information that clearly pointed to current child abuse in the

home or suicidality that met involuntary hospitalization criteria, they would move forward with further action.

Furthermore, with regard to reporting, not a single participant indicated if they would have sought more information about the reporting status of the abuse the clients experienced. In other words, no participant elicited information about whether the original abuse perpetrated against the clients themselves was reported. While clearly a historical report and no longer mandated, it is interesting that this piece was not addressed. Overall, however, the participants significantly explored interpersonal violence and suicide risk, and ensuring safety for the client and the children in the client's care, was a primary and most frequently cited goal of treatment.

Substance Abuse

Substance was the final domain significantly emphasized in the literature that was also extensively discussed by the participants. Eighty percent of the participants recognized and discussed issues of substance abuse in their assessments, but the depth in which the participants delved into substance abuse issues in their assessments varied significantly. Some made very brief statements that simply identified substance abuse as an assessment domain, but others provided sophisticated insights into the interactions between trauma, psychopathology and substance abuse. These insights alluded to the interrelatedness of these three issues, and how each can contribute to and exacerbate the other two. Literature assessing these three

domains a indicate the presence of one increases the risk of the remaining two, and that these domains compound and complicate the presentations of the others (Nair et al., 2003; Simpson & Miller, 2001). Participant discussions of these issues coincided with these perspectives from the literature.

In addition to recognizing the complex interactions between trauma, psychopathology and substance abuse, 40% of participants also recognized the importance of supplementing therapy services with dedicated substance abuse treatment. Here, participants alluded to the importance of collaboration between therapy and substance abuse treatment providers to offer comprehensive treatment options for clients with complex and compounding issues, though this was not stated or addressed directly.

Strengths and Resources

The strengths perspective, so valued in social work, was most clearly illuminated in the participants' direct and specific discussions of client strengths. While the interview guide did ask about client strengths, participants actually framed much of their assessments from the perspective of strengths and recovery rather than deficits. Insight into the client's symptoms and their need for help, as well as help seeking behavior, were the two most commonly strengths cited by participants. While this is a relatively superficial strength, clinicians discussed additional strengths as well that demonstrated both more sophisticated understanding and genuine acceptance of the client. These strengths were largely framed from the perspective of resiliency, but while

several participants used this word, it was largely used as a synonym for surviving the abuse. While resilience is often defined as rebounding following adverse events or experiences, resilience literature generally emphasizes that the concept encompasses not merely surviving, but it includes both thriving and having benefited from the stressor experience. The participants did not, however, expand their discussions of resilience to these more advanced resiliency components. Despite this, an orientation to resiliency is both fundamental to social work values, and to clinical practice. As Fraser, Richman and Galinsky (1999) argue,

The term “resilience” is reserved for unpredicted or markedly successful adaptations to negative life events, trauma, stress, and other forms of risk. If we can understand what helps some people to function well in the context of high adversity, we may be able to incorporate this knowledge into new practice strategies.

As such, the concept of resilience is a very important perspective from which to frame interventions in clinical social work.

In terms of resources external to the client, social support was most consistently discussed. Social support identification and development were consistently identified by participants as key components of the assessment as well as treatment goal selection. Social support, which refers to an individual’s sense that they are cared about and held in positive regard by those in their support networks, has been identified as a key protective factor

in the development of adjustment difficulties following exposure to child abuse (Lamis et al., 2014). Furthermore, social support has been identified as a protective factor against the development of psychopathology and adjustment difficulties in survivors of different types of child abuse, including childhood sexual abuse and physical abuse (Esposito & Clum, 2002; Twaite & Rodriguez-Srednicki, 2004; Ullman & Filipas, 2005). Participants reflected a strong orientation to the need to identify potential sources of social that already existed within the clients life, including romantic partners (except in the vignette that intimated domestic violence), siblings and friends. Some participants also addressed potential social support in the form of religious membership, but were careful to advocate this only if the client were already religiously connected, or open to increased religiosity or spirituality in their lives. Where there appeared to be little social support, the participants felt a significant treatment goal should be the development and enhancement of social support sources, including support groups and increased social interaction outside the home.

Parental Stress and Parental Competence

This researcher was surprised to see the relative lack of specific attention paid by participants regarding parenting stress and competence. While the quantitative data shows that participants picked up on elements of high stress and low client-perceived competence, these elements were not discussed in any meaningful or dedicated way in the narrative portion of the

interview. In fact, this researcher was initially concerned that the prominence of the word “parents” in this study’s title, which is included in the informed consent form, would have primed participants to overemphasize elements of parenting and the client’s experience of parenting beyond what they would typically explore in their assessment process. The concern was unfounded.

The experience of stress related to parent is strongly correlated with physical and emotional abuse (Nair et al., 2003). Client perceived competence as a parent is also moderately to strongly correlated with the client’s experience of being a parent, and low feelings of competence are often coupled with feelings of guilt, shame and lowered self-efficacy in other domains of functioning (Bogenschneider, Small, & Tsay, 1997). As such, these are elements that should be attended to clinically as they can affect issues of risk, specifically child abuse and potentially suicide risk, as well as overall quality of life for clients, which is directly related to treatment outcomes. Continued education and development of skills in these two domains stand as areas of opportunity for clinical social work, as does the issues of culture, as discussed below.

Culture

Cultural competency has recently become a dominant theme and area of focus across branches of social work. Cultural competence is defined as social workers’ possession of “a knowledge base of their clients’ cultures” and ability to provide “services that are sensitive to clients’ cultures” (NASW,

2000). Council on Social Work Education (CSWE) (2008) *Educational Policy and Accreditation Standards* stipulates that school accreditation be dependent on the program educating students at the bachelor's and master's levels on 10 core competencies, two of which emphasize the influence of culture on identity and human development. As such, graduating social work students are expected to not only have exposure to various cultural elements of human experience, but also to use this exposure to demonstrate culturally competent practice.

Unfortunately, indications of cultural competence were largely absent from participant responses. While two participants mentioned culture in their assessments, 80% did not, and one of the two comments bordered on pejorative. While some research has indicated that child abuse in the African-American community occurs at higher rates than amongst other ethnic groups, this difference disappears when socioeconomic status is controlled for, as child abuse and neglect does plague those in poverty more than other socioeconomic levels (Drake et al., 2009). There does appear to be some support for fewer and less significant social support for survivors of child abuse amongst the African-American community as compared to Caucasian survivors, this data certainly does not support the supposition that there is something inherent to African-American culture that prompts or approved of child abuse. This researcher cautions, however, that this perspective was isolated to a single participant, and only alluded to a perspective that

implicated African-American culture in condoning abuse, but did not state this perspective directly. On the other hand, the second reference demonstrated both the CSWE core competencies of engaging “diversity and difference in practice” by seeking opening dialog about the experiences of the client presented in vignette 2 as an African-American in America, and how these cultural experiences shape her current life experiences (2008).

Overall the data of this study supports that LCSWs not only reflect social work values within their beliefs about assessment, but also congruence with domains emphasized in the literature. Additionally participants in this study emphasized strengths and resources in the clients described in the vignette. While discussions of culture were notably minimal amongst participant responses, the domains of psychopathology, interpersonal and suicide risk, and substance abuse were explored significantly and by every participant. Finally, while parental stress and parental competence were only briefly mentioned in the participants’ narrative responses, the mean scores associated with this domain show that clinicians are able offer intuitions consistent with literature discussing these two domains. Overall, this study stands as a fascinating insight into the ways in which LCSWs conceptualize and process assessments with clients, how they attend to salient information, and how they approach clients in general, but also the unique population of parents abused as children.

Limitations

One limitation of this study is the small sample size of 10 participants, and the snowball sampling method for recruitment, as these findings cannot confidently be considered representative of the LCSW population. A second limitation is that asking clinicians about their professional practices was potentially laden with psychological significance, and could have been construed as a probe into their level of competence or professionalism. Responses therefore may be shaped by normative expectations, such as the pressure to represent one's process of assessment as more "by the book" than how the clinician may conceptualize a case in practice. In fact, a number of participants remarked on the similarity of the current study's methodology with the case vignettes provided during the LCSW licensing exam, which may have shifted responses away from the clinician's actual process towards the kinds of responses needed to secure licensure. Additionally, there may be a significant difference between the expressed ideas of the LCSWs interviewed and how their behavior may actually manifest in session. Though the present study focuses on beliefs about assessment rather than assessment behaviors, this potential gap does remain unaddressed.

Finally, one significant limitation is the assumption that the congruence between participants' areas of focus and the dominant themes found in the literature is connected. No question in the interview guide specifically asked whether the participant has explored the literature, with what frequency, or

how deeply they have delved into it. As such, it is possible that the clinicians came to the same conclusions as the previous studies independently through their experience and clinical insight. The benefits of this study, however, supersede the limitations insofar as it advances the understanding of LCSW beliefs about assessing this high-need population.

Recommendations for Future Research in Social Work

Assessment beliefs and processes form the foundation for clinical mental health services. As the initial step in the therapeutic relationship, it sets the tone for therapeutic interactions. Furthermore, as assessment beliefs and practices drive diagnoses and treatment planning, they can be highly influential on the client's experience of therapy services as well as client outcomes. As such, assessment processes are an important yet highly underexplored area of research in social work. While research is virtually nonexistent on assessment with this population, there is also a dearth of social work research on assessment beliefs and processes in general. This stands as a significant opportunity for future study.

Furthermore, while the data presented in this study indicate that LCSWs are oriented to the existing body of research regarding this population, the research is not oriented to clinicians. Previous research has been almost exclusively focused on characteristics of the client population rather than focused on best-practices for working with parents abused as children, or even child abuse survivors in general. Those studies that do explore clinical best

practices generally focus on specific treatment modalities, such as Cognitive Behavioral Therapy or Motivational Interviewing, rather than addressing how clinicians assess clients and determine appropriate interventions. Exploring assessment beliefs and practices, and how these influence treatment selection could provide greater insight into how individuals in this population interact with and are served by mental health services.

Finally, it is of crucial importance for future study into best-practices to recognize that LCSWs bring unique and valuable knowledge to the field, and this expertise should be presented and respected in research. Oftentimes research and clinical practice are bifurcated, and as researchers are generally in possession of advanced degrees beyond that of many LCSWs in practice, researcher insights can be given greater weight. This hierarchical approach to social work knowledge, however, fails to capture the unique perspectives and insights of clinicians. In the future, clinical expertise, particularly with unique populations that are underexplored in traditional research, should be honored and actively sought out to support, inform, and guide research into best-practices.

Conclusions

Parents abused as children represent a unique population with unique clinical needs, and these clinical needs begin with an assessment completed by a competent clinician. This assessment has the power to drive diagnostic differentials, treatment goals, and ultimately the tone of the therapeutic

relationship. As such, investigating the beliefs of LCSWs about assessing this population is an important and valuable endeavor. Parenting is difficult. Surviving and coping with an abusive childhood is difficult. This combination creates specialized needs for abuse survivors in a parenting role, and LCSWs need to be competent enough to meet these needs. While participants in this study demonstrated significant competence and skill related to the assessment process, further research needs to be done to explore best-practices for this specific and high need population. LCSWs owe it to these parents abused as children to develop interventions and approaches that specifically and comprehensively address the myriad of needs as well as strengths associated with this population. They deserve therapeutic services that are both tailored to their needs and are effective in improving their outcomes and quality of life, because, as one participant so eloquently put it, they have “already had enough,” (Participant K2D, survey interview, March 2015).

APPENDIX A
INTERVIEW PACKET

INTERVIEW PACKET

Participant ID#: _____

Beliefs among LCSWs about Assessing Parents Abused as Children

Demographic Information

Age: _____

Gender:

Male Female Other

Race/Ethnicity:

White

Black or African American

Hispanic

Asian

Pacific Islander

Native American

Other (please specify): _____

Years of clinical experience: _____

Years of experience working with adult populations: _____

Interview Instructions

Following are three vignettes of clients seeking individual therapy, and the information provided is from their initial meeting with you. Please assess the client presented in each vignette, and when you have finished, the interviewer will ask you several questions regarding the case.

Interview Questions

1. What strengths do you see in this client?
2. What is your overall assessment?
 - a. Do you have a diagnostic impression?
3. Would you take any additional steps beyond information gathering before you end the assessment?
4. What treatment goals would have for working with this client?

5. How would you assess risk in the following domains?

a. Child abuse in current home

None	Low	Medium	High	Severe, requiring a mandated report
1	2	3	4	5

b. Suicide risk

None	Low	Medium	High	Severe, requiring hospitalization
1	2	3	4	5

c. Domestic violence in current home

None	Low	Medium	High	Severe
1	2	3	4	5

6. How would you assess the presence of the following domains?

a. Parental stress

None	Low	Medium	High	Severe
1	2	3	4	5

b. Client perceived parental competence

None indicated	Low	Medium	High	Exaggerated
1	2	3	4	5

APPENDIX B
VIGNETTES PROVIDED TO PARTICIPANTS

Vignettes Provided to Participants

Vignette 1

Marcus is a 28-year-old Hispanic male currently living with his girlfriend and his two sons, ages 7 and 4. Marcus states that he decided to come to therapy because his AA sponsor suggested he talk to a professional about some of his “issues.” Marcus was a heavy drinker from the time he was 13 years old until 3 months ago when his girlfriend threatened to leave him if he didn’t get sober. Marcus disclosed that he also has a significant criminal history, including assault, robbery and check fraud, but is no longer on probation. Marcus states that since stopping drinking, he has been feeling very down and doesn’t feel like he enjoys anything in his life. He sleeps all the time when he isn’t at work. He also has noticed that he is more irritable with his two sons, and sometimes gets so stressed out with them that “I just lose it.” Marcus also has gained 15 lbs in three months and has trouble concentrating, but attributes all of his symptoms to stopping drinking. When asked why he started drinking so young, Marcus starts to cry.

“It was just hard, my mom dated a lot, and the guys weren’t that nice to me. One of her boyfriends got her into drugs, and I was pretty much on my own from the time I was about two until I was about five. Like, I remember being hungry a lot, and not wanting to wake my mom up for food or to run me a bath. Then her next boyfriend helped her kick the drugs, but he was just mean. Called me names, demeaned me I think they call it. I was never good enough because I wasn’t his son, and he made sure I knew it. I just started to drink because it was a way not to feel bad or hurt or mad.”

Marcus states that he doesn’t have those issues anymore because his mom passed away and he has no contact with any of the men who abused him. He also states that he is proud to say that he has a great relationship with his girlfriend and is a good dad. Reluctantly, he does admit that he does “get a little rough” with the kids sometimes, both when he was drunk and recently when he gets stressed or frustrated. When pressed on what he means by “rough,” he says that he sometimes hits that kids, but will not elaborate, insisting he is a “good dad.”

Vignette 2

Jenna is a 37-year-old African American female currently living with her husband Micheal and four children: two daughters ages 9 and 5, and two sons, ages 15 and 11. Jenna arrives in a sweater and long skirt, despite the hot day, and there is a recent bruise on her throat near her neckline. Jenna states that she has been having a rough time, and wanted to talk to someone about “basic housewife problems that I just can’t seem to handle like I should.” At first she talks about worries over bills or making sure the kids make it to all of their extracurricular activities, but quickly transitions to discussing the anxiety that seems to pervade her life. Jenna has difficulty in most social situations, as she feels that other people can tell that she isn’t a good person. Jenna is fidgety in her seat, and when a car horn honks outside, she involuntarily jumps and her hands start to shake. Jenna states that she’s never done drugs, but that she always feels keyed up and restless. She has a hard time sleeping, and when she can get to sleep, she has terrible nightmares. She says that these issues are worse after she sees or hears things that remind her of “bad stuff, from like being a kid, or even now.” When asked about this, she looks down at her hands and says,

“Look, I grew up in the South, where me and my brothers and sisters each had a switch lined up on the back porch. Everything was fine when I was real young, my daddy would dress me up in big, poufy dresses and call me his princess. But when I started school he decided that I wasn’t his baby anymore, and needed to act like... I don’t know... anyways, I got beat. A lot. All of us kids did, and my mom just kept having kids so that there was at least one baby Daddy was sweet on. I still remember some of the bad ones. He broke my arm and hit my head against the tree in the yard over and over, and I crawled under the porch to try to hide. It was raining and he got all muddy when he dragged me out, and for runnin, I got a beating that kept me out of school for a month. It went on until I was 16, when I ran away with Michael.”

Jenna states that she has never been with anyone but Michael. When asked about her relationship with him, her face shows a flash of fear, and then goes blank. “He is a wonderful father. I am lucky to have him.” Jenna quickly changes the subject to her kids and how much she loves them. Then Jenna starts to cry, “I don’t trust myself to do any of the discipline, I let Michael do all that. I’m always so irritable, and I just worry that I’m gonna lose it, that I’m gonna hit them, that I’m gonna lose control and beat them like I got beat.” She also states that any form of discipline with the kids reminds her of her own abuse, and she avoids being in the room when it happens. When asked how Michael disciplines the kids, Jenna insists that he is always appropriate with them, and a good dad. “It’s me who disappoints him, who isn’t as good as I should be.”

Vignette 3

Krystal is a 23-year-old Caucasian female currently living with her boyfriend Jason and 3-year-old daughter Rachel. Krystal says that she is having a difficult time managing her moods and it is impacting her relationship and her ability to care for herself and her daughter. Krystal discloses that she is five months pregnant, and just found out that she is having another girl. Krystal states that her OB Dr. Stockford referred her to therapy, because he was concerned about the fact that Krystal's older daughter was born methamphetamine exposed. Krystal has been taking voluntary drug tests for her doctor and has not come up dirty once. Krystal states that while she wants to be as happy as her boyfriend is to be having another baby, she is so unstable with her moods that she has "had enough." Krystal states that she has "flip-out periods and zombie periods." During her "flip-out periods," she starts out happy and bubbly, but by day two she is irritable and yelling at everyone, and by day four she is packing her bag, and moving out. "The 5th day is always the worst: I drain our back account, or I sleep with some creep from a bar. I crashed my car once because I decided to race some teenager in a sports car. But Jason always takes me back, and holds me while I cry and apologize." Her "zombie periods" usually follow her manias, where she feels sad and cries most of the day, every day. She stops eating and sleeps much of the day while Rachel watches TV beside her, "but Jason steps up and takes such good care of our daughter when I can't. He tells her 'mama is sick' and they go on ice cream dates or he thinks of ways she can help him cook dinner." She also states that while she has been having these kinds of symptoms since she was a teenager, they have never been this bad, even during her last pregnancy. Whereas before she would have a few weeks to a couple months of calm between these kinds of mood shifts, now she feels like she is back and forth every few days to a week. Krystal starts to appear agitated and her speech becomes pressured, but when the topic is shifted away from her symptoms and to her daughter Rachel, Krystal seems to suddenly deflate and then starts to cry.

"She's great, but I never wanted a daughter. I prayed for a boy, but I got Rachel. I had an uncle who messed with me, and I didn't ever want that to happen to my daughter... No one really knows when he started up with me because he watched me so much when my mom had work, but my first memory is him on top of me though. He wasn't having sex with me, not yet at least, but rubbing himself on my pjs. We started having sex when I was 11, and he made it seem like it was my idea, like I was the one who wanted him and we were in love. I'd get jealous of his wife every time he went home. God, I was such a brat to my aunt, because he said she was why we couldn't be together... He was so cruel sometimes. When I was 13 he picked me up from school and we went to a hotel. I made him mad somehow, and he punched me in the face, and then left so I was stranded there for 8 hours, until I hitchhiked home. He had the nerve to get mad I hitchhiked because the trucker could have been a child molester. Sometimes he was rough during sex, and he always talked about us

having a threesome with another girl my age, but he never said who. But then other times he was so sweet... [Krystal pauses, and looks at her hands lying in her lap] I turned him in. I found out he was doing the same things with his daughter, my cousin Sammy, who was 7. I wish I could say it was because I wanted to protect her. That's what I told my family... but really, it was because I was jealous. Jealous that he was doing it with her and not just me. That's messed up, right?"

When asked if, in all the times she's been having these difficult mood shifts, she has ever thought of hurting herself, Krystal looks suddenly calm and nods, "of course, all the time. Jason doesn't deserve someone broken. And Rachel doesn't deserve a mama who can't get out of bed, or who spends all our money and sleeps around on her Daddy when her head gets messed up. And this baby, what kind of person would I be if I brought her into a world where little girls get touched, and they grow up into mamas who are too sick to be mamas?"

APPENDIX C
INFORMED CONSENT

INFORMED CONSENT

The study in which you are asked to participate is designed to investigate LCSWs beliefs about assessing parents abused as children. This study is being conducted by Emma Duarte under the supervision of Dr. Ray Liles, Social Work Practice Lecturer in the School of Social Work at California State University, San Bernardino. This study has been approved by the School of Social Work Subcommittee of the Institutional Review Board at California State University, San Bernardino.

PURPOSE: The purpose of this study is to examine LCSWs beliefs about assessing parents abused as children.

DESCRIPTION: Participants will receive a typed hypothetical case vignette, and the interview will consist of four open-ended questions about the “client” presented in the vignette. Interviews will be audio recorded and transcribed for analysis.

PARTICIPATION: Participation in this survey is completely voluntary and refusal to participate will involve no penalty. Participants may discontinue participation at anytime without penalty. If you choose to participate, your participation will be under you LCSW license rather than through your affiliation with any agency.

CONFIDENTIALITY: Participant confidentiality will be maintained through the duration of the study and thereafter. No identifying information will be collected. Audio recordings, informed consent forms and any other confidential research material will be transported and stored in locked cases. Research materials will be destroyed upon completion of the project.

DURATION: It will take approximately 15-30 minutes to complete the interview.

RISKS: There are no foreseeable risks in participating in this survey.

BENEFITS: Participants will receive a \$5 gift card for participation in this study. Participants will also contribute to the body of literature about parents abused as children and the process of assessing this population

CONTACT: If you have any questions or comments about this study please contact Dr. Ray Liles at (909)537-5557 or reliles@csusb.edu.

RESULTS: Once the study is complete, findings can be obtained at California State University, San Bernardino Pfau Library after December 2015.

I have read and understand the consent form and agree to participate in this study.

I consent to have my interview audio recorded.

Please place an X here: _____ Date: _____

APPENDIX D
DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

The study you have just participated in was designed to investigate LCSWs beliefs about assessing parents abused as children. Particular attention was paid to diagnostic and risk assessment elements, as well as beliefs about parent stress and competence. As a LCSW, your experience with assessing this population offers critical insight to guide future research.

Thank you for your participation. If you have any questions about the study, please contact Emma Duarte or Dr. Ray Liles at (909) 537-5557. Results of this study will be available at California State University, San Bernardino's Pfau Library or online at CSUSB.edu in Summer of 2015.

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