

Practice with Children and Their Families: A Specialty of Clinical Social Work

*A position statement of
The Center for Clinical Social Work*



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Introduction

This is a position statement on the practice of clinical social work with children, from infants to pre-adolescents, and their families. It is produced by the American Board of Examiners in Clinical Social Work (ABE), the national certifying and standard-setting organization for the profession of clinical social work.

Under the aegis of ABE, the position statement was developed by a group of clinical social worker practitioners and academics, and it was refined, in drafts, by a national panel of experts. In this position statement, statements are referenced as to sources; in the absence of such citations, the passage or section may be assumed to be general knowledge or the conclusion of ABE, based on expert commentary.

While this paper focuses on the specialty level of practice, it is framed within the overall practice of clinical social work, acknowledging that the specialist's direct-practice work is undertaken within a context of related duties, some of them administrative, that do not rise to the specialty level but are all a part of advanced clinical social work practice. Clinical social work is a distinct profession with its own body of knowledge, practice skills, and approaches to effective mental healthcare. All clinical social workers are educated at the graduate level and trained for years under supervision in order to be able to help people who have bio-psychosocial problems and disorders. Social work graduate students are also educated in cross-cultural issues and are required to explore their own biases and racism (Corvin & Wiggins, 1989). Practitioners enrich their knowledge and skills by continuing education, consultation, and years of relevant experience (ABE, 2003).

Within the profession of clinical social work, various areas of practice may be identified as the province of specialists, whose education, training, experience, and degree of competence set them apart for proficiency (see Section IV. for Competences). Practice with children and their families is such a clinical specialty, requiring that the specialist attain high levels of expertise in children's developmental stages, in types of problems and disorders, in knowledge of settings, and in intervention approaches and techniques.

Since expert practitioners are best able to achieve good outcomes, society requires that competent experts be readily identifiable in order to help the largest number of children in need. Specialty practice involves the masterful application of theory, principles, and methods to prevention, assessment, diagnosis, intervention, case-management, outcome evaluation, termination, and other means of addressing the bio-psychosocial needs of children and their families. Specialty practice requires specific knowledge and skills, or competences, which are essential to the specialist and which, incorporated into practice, can improve the quality of care delivered to children and their families. These competences, described below, are identified against the background of clinical social work practice in this area, and in terms of relevant practice guidelines and approaches. In pursuance of those goals, this paper seeks to:

- identify the contours of clinical social work practice in this specialty
- identify the specific practice components of clinical social work practice in this specialty
- examine this area of practice in the context of the healthcare delivery enterprise and societal needs

- identify practice competences in this specialty at the specialist level of professional development
- make recommendations about improving this field of practice and the outcomes for children and their families
- serve as a resource for a national credential for clinical social workers in the specialty area of practice with children and their families.

Note: In general, the term “children” will be understood to include the full range of development from infancy through early adolescence; and “families” will be understood to refer to those who have legal responsibility for the child’s nurture and welfare. The specialist clinical social worker in this field will be identified as the “specialist,” and any references to “he” or “she” are intended to include the other gender. Terms like “caregiver”, given in the singular, may also be assumed to plural.

I. Clinical Social Worker Specialists and Children & Their Families as Clients

A. Attributes of the Clinical Social Worker Specialist in Practice with Children and Their Families

The specialist must be highly competent in providing care to children and their families. Unlike the non-specialist, who may have a general understanding of children's developmental processes, the specialist has detailed knowledge of the biological, emotional, psychological, cognitive, and behavioral processes that affect children's functioning individually and in their family and peer interactions. The specialist applies theory and technique with effectiveness and flexibility in ameliorating bio-psychosocial disorders and addressing environmental influences.

The specialist's knowledge-base is built upon education and training derived from years of relevant experience, theoretical constructs, practice methodologies, guided practice, and findings from research and outcome studies. Given the prevalence of children treated by medication, it includes knowledge of the effects of psychotropic medication and presumes a relationship with a psychiatrist with a child-oriented practice.

The specialist's expertise in child dynamics and the familial and relational contexts is matched by a deep knowledge of systems—school, medical, welfare, legal—and by skills and attitudes that make it possible to intervene effectively and to collaborate with other professionals and access community resources. He or she is very knowledgeable about children's developmental processes and about the effects of the social and care-giving environment on the child's functioning.

The specialist is highly skillful in creating a therapeutic alliance (Biestek, 1957; Klein, 2003; Mishne, 2000; Oaklander, 2000, pp. 28-29; Perlman, 1979; Richmond, 1965; Woods & Hollis, 2000), in conducting clinical assessments, in diagnosing (in psychotherapeutic situations), in devising treatment plans, in clinical case-management, in applying effective practices for ameliorating bio-psychosocial problems, and in evaluating outcomes. The specialist's self-monitoring (including use of consultation) is essential to developing and maintaining appropriate therapeutic alliances and treatment plans.

The specialist excels in the following:

- forming and maintaining a therapeutic alliance with the child
- integrating understanding of the physical, mental, and emotional difficulties that may arise in childhood
- advocating for the child and family
- collaborating with other professionals and collateral resources
- helping children at various levels of their development
- working with the three systems—family, school, community—that most affect child development
- addressing issues pertaining to caregiver while respecting their values, culture, and relationship with the child
- recognition as an expert by colleagues who make referrals, seek consultation
- serving on professional boards and community organizations

- continuously seeking and integrating new knowledge in field and bio-psychosocial theories into clinical practice.

B. Distinctive Characteristics of Children & their Families as Clients

Children do not follow a linear sequence in their development. Developmentally, there is a broad “course” or outline to children’s growth, within which the individual may vary widely, for children are constantly developing physically, cognitively, psychologically, behaviorally, and socially. Younger children’s development is intermixed with periods of regression and failure to master appropriate skills and to control impulses. Early adolescents may appear more mature at one time and less mature at another. The specialist must be adept at discerning these variations and adjusting their methods and interventions accordingly.

In general, the younger the child, the more the clinical social worker specialist focuses on the family. Young children do not initiate treatment, caregivers do; and caregivers must provide it, as a part of the legal obligation to nurture and support the child. While a specialist may elect to work directly with a child, caregivers are usually crucial to effecting change in children, and are capable of supporting or undermining the process of change or refusing to participate in the intervention. In working with them (or other family members), the specialist may offer parent education and support, direct parent counseling and therapy, family therapy, or other family and community interventions and advocacy.

The change-making process includes those non-family persons and organizations important in the child’s life, such as pediatricians, teachers, guidance counselors, clergy, coaches, peers, and peer groups. Some may have law-oriented roles (e.g. protective services, courts, probation offices) in which treatment of children is mandated, even against the wishes of the family. Those with legal roles may make demands upon children, family, practitioners, and others collaterally involved. In this context, the specialist may work directly and indirectly with such service-providers on behalf of children, including education, consultation, brokering, case management, and advocacy.

II. Background of Clinical Social Work with Children and Their Families

A. Contemporary Context

In the landmark case of *Jaffee v. Redmond*, the U.S. Supreme Court held that “the mental health of our citizenry, no less than its physical health, is a public good of transcendent importance” (1996). Children under the age of eighteen make up 25 percent of the population of the United States, or more than 80 million people. Despite our high overall standard of living in the U.S., the well-being of many children, and many groups of children, is discouragingly low. The issues affecting their well-being have long been studied. They relate to family structure and functioning, poverty, and access to care. *The solution is a matter of society’s commitment to care for the most vulnerable among us.* Clinical social workers are educated, trained, and able to provide services to the millions of children in need, including the millions who have not been assigned for service and have not received care. The damage to those children—including abuse, injury, and death—and the toll taken on society, constitutes a national mental health crisis.

As a profession, clinical social work is committed to serving those who are most in need of mental healthcare and often least able to afford it, children foremost. The profession’s history has its roots in this area of practice, beginning in the 1900s when social work developed clinical capabilities in working with children in settings like homes, orphanages, and settlement houses. In the 1920s the federal government’s funding of child-guidance clinics led to the employment of clinical social workers on multi-disciplinary psychotherapeutic treatment teams (Jones, 1999). Over the decades, clinical social workers, most notably Selma Fraiberg and Virginia Satir, contributed to the literature on practice with children. By 1980 society had become aware of the special nature of mental-emotional problems and disorders affecting children, as the American Psychiatric Association first devoted a section of its *Diagnostic and Statistical Manual of Mental Disorders* to Child & Adolescent Disorders.

At present, the vast majority (eighty percent) of all clinical social workers practices in the places where children are likely to be found: the schools and hospitals, the courts, residential treatment centers, and the clinics, agencies, and community mental-health centers funded by the government or by private social-services organizations. Since the 1980s, some clinical social workers (about twenty percent) have also been providing reimbursable bio-psychosocial and behavioral services to children of people whose employers pay for some or all of their healthcare insurance coverage.

Throughout the United States, many of the nation’s 200,000 clinical social workers practice with children of all kinds, providing services ranging from referral and case-management to psychotherapeutic interventions to custody and adoption evaluations to consultation and education. Perhaps no other profession has better training or a deeper commitment to working with children; and none has its client-oriented value system, its person-in-environment approach, and its bio-psychosocial focus on the interaction between the child and the social environment—be it family, community, or culture.

Children receive far too little mental-emotional healthcare, and need much more attention. Among all children aged four to eighteen, 17-22% “suffer significant developmental, emotional, or behavioral problems” and many more may be impaired to a lesser extent (Hibbs & Jensen, 1996;

Mash & Dozois, 2003, pp. 3-71). The U.S. Surgeon General showed that one in ten children suffers from a mental illness severe enough to interfere with normal functioning and development. Only about one-fifth of these millions of troubled youngsters receive specialized mental healthcare in any given year (U.S. Department of Health & Human Services, 2001). Family disruption and an increase in poverty have put children at great risk for having disorders and for developing more-severe problems at younger ages than in the past (Duncan, Brooks-Gunn & Klebanov, 1994). In the poorest families, children suffer a shocking amount of neglect and maltreatment (U.S. Department of Health & Human Services Administration on Children, Youth and Families, 2005).

Society's priorities are not focused on the plight of millions of its children. Clinical social workers are already on the front lines of this overwhelming problem, and are prepared, by education, training, values, and orientation, to do even more, if supported by policies and funding in an area where their expertise can make a huge difference. Therefore, the most important child-oriented question is not clinical but political: *Is the United States prepared to commit sufficient resources to address a problem that is already at a crisis level and getting worse?*

For more on this, see *The Crisis in Mental Healthcare for Children*, Appendix A.

B. Specialty Practice and Settings

The specialist practices in any setting in which the bio-psychosocial problems and disorders of children may be addressed. These settings typically include those associated with mental healthcare, child welfare systems, medical care, schools, and juvenile justice and courts. Other settings are the child's home, private offices, after-school and child-care settings, camp and recreation centers, and programs aimed at violence, substance abuse, and problems with parent or peers. Whatever the role or job title in the setting, the practitioner's work is still clinical social work

For more on this, see *Diversity of Practice and Settings*, Appendix B.

C. Family Context

The family, or primary living group, is responsible for the nurturing and rearing of children. Ideally, the family caregivers respond empathically and help the child develop mastery and a sense of self, and the family introduces the child to values of cooperation and reciprocity and to expectations of social interaction. The family transfers its culture by directing and influencing the child's beliefs, values, attitudes, behavior, and social competence.

The clinical social worker specialist must be able to interpret the child's difficulties and the sources thereof, and to maintain a working alliance with the caregiver, acknowledging that the caregiver may be at the root of the problems. Given their powerful place in the child's life, the caregiver and family must be included in the intervention if it is to have a positive, lasting outcome (Knitzer, Steinberg, & Fleisch, 1993; Kutash & Rivera, 1995; Pfeiffer & Strzelecki, 1990).

For more on this, see *The Family*, Appendix C.

D. Cultural Competences

Working with the child and family, the specialist strives to comprehend salient beliefs, values, attitudes, family lifestyle, and similar cultural factors, to participate in extra-therapeutic settings, and to collaborate with family members, other professionals, and those to whom the child and family attribute authority (Sue & Sue, 2003). This is especially important, in that most social-service systems are not able to address difficult diversity issues (Lynch & Hanson, 2004). The specialist appreciates both the nature of cross-cultural factors in the intervention relationship and the culture of the institutions in which treatment may occur.

Cultural competence is a fundamental value of clinical social work, developed in an ongoing process in which the specialist collaborates with the client or client's family, constantly self-examines for bias, avoids ethnocentrism, and integrates the client's cultural mores into the intervention (Webb, 2001, p.20). Considerations of complex cultural differences are reflected in assessment and treatment planning and in sensitivity to cultural politics in diagnosis and goal-setting and in choosing treatment methods.

III. Child Development and Implications for Practice Approaches

A. Developmental Issues of Children

To be effective in practice with children, the specialist understands the importance of the therapeutic alliance and developmental issues/challenges in terms of the child's age and developmental needs. Children's age groups include: infancy and toddlerhood (0-3 years); preschool and kindergarten (3-5 years); elementary school age (6-10 years); and early adolescence (11-14 years). The specialist has the flexibility to adapt practice approaches to children in each age-group. For example, in helping infants and toddlers the specialist develops a strong working alliance with the caregiver (Erikson & Weinberg, 1999) based on an appreciation for the extent to which love, food, sleep, stimulation, protection, and attachment-to-caregiver will promote the child's healthy development.

The toddler's growth is heavily influenced by the caregiver's ability to foster strong attachment, so the mature specialist will form a therapeutic bond with both a maltreated child and the primary caretaker in order to facilitate affect regulation and a healthy attachment (Becker-Weidman & Shell, 2005). Dyadic Developmental Psychotherapy, using core social work values and methods, holds promise as a treatment of infant, child, or adolescent attachment disorders in the context of the birth or foster family (Becker-Weidman, 2006).

In cases of young children coping with trauma, loss or abuse, specialists should conduct thorough multi-modal assessments and utilize individual or family play therapy, since play is the child's primary "work" and means of self expression (Webb, 1999; McNeil, 1996). Play therapy is an effective technique, since play is the young child's primary "work" and means of self-expression. The caregiver needs help in understanding the child's problems, with guidance as to promoting development, managing sibling, and setting limits so that the child feels protected and safe from his/her own negative impulses. Case management and work with extended family members and collateral resources are often required (Mishne, 2000; Orton, 1996).

Once children have begun school, the specialist might effectively draw on their abilities to think, communicate and problem-solve through behaviorally oriented approaches to improve coping skills and socialization (Webb, 2003). Since the child's relationships reach into the school, neighborhood, and community, the specialist's interventions in problem situations may involve case management and work with collateral personnel on the family's internal and external problems, such as interaction between family and school (Corcoran, 2003).

While there is greater opportunity for "talk therapy" and negotiation about intervention goals with early adolescents, the specialist often experiences difficulty in forming a therapeutic alliance. This arises from the early adolescent's characteristic separation from adults, identity confusion, and identification with the peer group. Specialists may find that a group intervention minimizes threats to the early teen's emerging identity and affords better opportunities for change (Fisher, Masia-Warner & Klein, 2004). Likewise, parent-training to address conduct problems may be a less effective approach in early adolescents, since peers at this age play a central role in promoting and maintaining antisocial behavior (Allen & Land, 1999, pp. 319-335).

For more on this, see Children's Development, Appendix D.

B. Practice Approaches

In all interventions with the child and caregiver, the key to the specialist's success is a strong therapeutic alliance. In working with children, no given practice approach or set of practice approaches is known to be most efficacious except in specific constellations of clients and circumstances (Dill, Vernburg, Fonagy, Twemlow & Gamm, 2002). Bio-psychosocial interventions include a very broad array of techniques, psychotherapies, and medications. Many practitioners tend to choose some theoretical orientations over others as a matter of training or personal preference, but specific theoretical focus need not limit the variety of techniques employed by the practitioner to match the needs of the child and family. The specialist stays abreast of current research in the field of child treatment and incorporates new information from the research into his/her practice repertoire as appropriate.

Child-related psychotherapies may be generally categorized as supportive, psychodynamic, cognitive-behavioral, interpersonal, and family systemic (United States Department of Health & Human Services, Center for Mental Health Services, 1999). The specialist has a broad knowledge of practice approaches, and is expert at selecting from among them in any given intervention. In addition to psychotherapies, primary-modality interventions can be conducted through art, drama, music, movement, and journal-keeping. Relaxation techniques and bibliotherapy can be useful; and parent-guidance and psycho-education are widely valuable adjuncts.

For more on this, see Sample Practice Approaches, Appendix E.

IV. Competences of the Specialist

At the level of *specialty practice*, the clinical social worker must have mastery of the knowledge base and the practice skills specific to an efficacious practice with children and their families. The specialist will also observe the guidelines for activities common to all conscientious clinical social workers at whatever level of practice.

A. Knowledge Competences

The clinical social worker child specialist is expected to have a high level of knowledge about the range and types of problems and disorders that affect children, and of the best approaches to intervening with an individual based on his/her unique circumstances. Such knowledge comes from education and training, and includes insights based on clinical experience, reading, supervision-consultation, multidisciplinary collaboration, academic courses, workshops, and other forms of continuing education.

The specialist's knowledge-base informs every aspect of his/her work and skills, and includes significant learning in the following areas.

Biological

Physical growth and development
Genetics and neurobiology
Medical conditions
Psychopharmacology

Practice Methods

Individual therapy
Family & Group Therapy
Larger systems work
Parent-Infant Therapy
Play-based approaches

Psychological (primary list)

Attachment Theory
Developmental Theory
Diagnostic psychometrics and assessment
Trauma Theory

Regulatory, Legal, and Ethical

Professional codes of ethics
State and federal regulations & legislation (including confidentiality)

Social

Cultural factors
Environmental factors (e.g. economic)
Family system

Peer Group influences

Social systems (e.g. schools, courts, health facilities, religious organizations)

B. Skill Competences

With the specialty practitioner, the level of *knowledge* is matched by excellent practice-related *skills*, in order to create a sustainable therapeutic alliance with clients and to apply relevant theory. A specialist is capable of bringing about good clinical outcomes with a child and will generally have satisfied clients. Furthermore, collateral personnel and colleagues will attest that he/she has achieved a consistent mastery of the following areas: assessment, diagnosis; treatment planning; outcomes evaluation; intervention and termination; and supervision, consultation, teaching, and writing.

While the areas of skill described below are not always unique to the specialist, he/she will execute them in a way that is more accomplished, efficient, and efficacious than is the case with others. Entry-level, intermediate, and advanced generalist clinical social workers may practice in the same skills arena as the specialist, but not with the same level of mastery. Specific skills, reflective of the capabilities and functioning of the clinical social worker child specialist, are described in the following competency areas.

1. Assessment

The specialist's first task is to conduct a thorough bio-psychosocial evaluation of the child, complete with developmental history, cultural and gender issues, family situation, life experience, psychological and behavioral issues, medical condition, and strengths and problems of the caregiver. In developing the assessment, the practitioner observes and interacts with child and parent and, in interviewing, draws from a broad, deep understanding of childhood disorders. Other material, including psychological testing, may be adduced from collateral sources such as other professionals and social, educational, and medical reports and histories. Included in the assessment are the client's strengths, adaptive capacities, and cultural influences, as well as psychopathology, environmental stressors, chronicity, and scope of impaired areas of functioning. With regard to the use of medication, the practitioner should seek additional assessment by a psychiatrist, which may be essential to complete the initial assessment. In the case of children with severe or chronic medical problems, the specialist consults the treating medical practitioner regarding issues relating to the condition. Over the course of the intervention, the practitioner may alter the assessment of the problem itself, as well as needed approaches, based on interactions in sessions, the experiences of the child and caregiver, and the results of interventions from other professionals.

Assessment Skills

- At a preliminary level of assessment, reviews the need for urgent action regarding any trauma and crises and needed referrals to other appropriate resources.
- Conducts assessment based on the presenting problems and on data from history and current functioning using:

- (a) contact and interview with family and caregiver;
 - (b) interviews with and observations of the child;
 - (c) reports of the child's social, educational, and medical histories;
 - (d) information from other involved professionals and
 - (e) relevant diagnostic instruments.
- Factors into assessment:
 - a) family strengths and weaknesses or deficits, socioeconomic issues, cultural values and behavioral patterns; and
 - b) the child's developmental issues, temperament, health and response to stress/trauma.

2. Diagnosis

Expert practitioners are aware that they are intervening in the lives of children, not diagnoses. A diagnosis cannot fully describe an individual; it is a functional “cognitive map” for the practitioner, to be used in sorting through the various presenting issues.

In the case of a psychotherapeutic intervention, a differential diagnosis is conducted, based on the information in the assessment and using one of the three standard diagnostic classification systems: the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000), the International Statistical Classification of Diseases & Related Health Problems (ICD-10) (World Health Organization, 2004), and the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) (Zero to Three: National Center for Infants, Toddlers, and Families, 2005). The DSM-IV and ICD-10 are based on symptom descriptions and inclusion-exclusion criteria, while the DC: 0-3 applies only to early childhood and links symptoms with processes. Since these psychiatric nosologies cannot capture individual variations in a single diagnostic description or category, the expert practitioner will choose from among them once the assessment is complete. Even in circumstances in which formal diagnosis is not required, clear description of the problems and needs is essential to guide the choice of interventions. Scales of global functioning and of symptomatology for specific disorders are useful (Bracken, 2004). The caveat is that a correct diagnosis does not ensure that appropriate interventions or good outcomes will follow.

Diagnostic Skills

- In making a diagnosis, does the following:
 - a) evaluates for co-morbidity;
 - b) is active, and collaborative;
 - c) uses information from both verbal and play-based approaches specific to children.
- Makes differential diagnosis of child and family based on the use of one or more diagnostic systems (e.g. ICD-9) and assessment instruments.

3. Treatment Planning

After completing the assessment (and the diagnosis, in the case of psychotherapy), the practitioner meets with the child and (usually) caregiver, several times if necessary. In these meetings, the practitioner describes what the intervention might be about, and what might be expected as the results. The practitioner conveys preliminary findings, makes recommendations, listens to the responses from the client and caregiver, and obtains consent to the plan from the caregiver or other adult entity legally responsible for the child's well-being. These steps are taken to create a collaborative treatment plan, complete with clear goals and objectives for the intervention, and approaches that will be taken to reach them. The practitioner shares his/her assessments of progress with the client and caregiver as the intervention unfolds.

In planning for the intervention, the practitioner must factor in several variables—setting, financial circumstances, nature of presenting problems, and attitude of the family—before choosing an approach. The presenting problem (which may involve trauma or family crisis), the level of the child's bio-psychosocial development and functioning, and his/her role as a member of a family, culture, and community, are integrated into the plan, which should reflect a balance among the various components of the child's life. Focus areas should include targeted problems of the child (and family), time-frame (frequency of sessions, if relevant; length of treatment, etc.), and overall integration of the components (Mordock, 2002, p. 27). The practitioner may plan to collaborate with the child's primary-care physician, relevant peers, adults, institutions (schools particularly), and community resources, to make referrals to these resources when needed, and to advocate for clients who encounter a gap in an essential service, such as education for a disabled child. In the instance of a court clinic or residential school, the plan must include the setting's limits and the nature of the service request.

Treatment Planning Skills

- Develops a treatment plan based on assessment, to include:
 - (a) unique socio-cultural factors including racial, ethnic, and religious values and beliefs;
 - (b) role, capacity, and involvement of caregiver and family;
 - (c) collateral resources including siblings, extended family and peers, community resources;
 - (d) any required specialized treatment.
- Collaborates with and educates child, caregiver, family, collateral resources, and other involved professionals concerning their roles in the treatment plan, accessibility, level of participation, financial requirements, timelines, objectives and goals, making referrals when indicated.
- Uses a variety of concepts and approaches to address the bio-psychosocial (emotional, cognitive, physical, social, and spiritual) aspects of each problem or situation.
- Uses clinical judgment in choice of interventions, which have a strong conceptual base and demonstrated successful outcomes with the identified problem, client, and circumstance.

- Defines and communicates to the caregiver and child (in a developmentally appropriate manner) the legal, ethical, and regulatory considerations relevant to the treatment plan.

4. Outcomes Evaluation

Outcomes evaluation is used to guide the intervention as it progresses, to ensure that goals are met or modified as needed, and to assess the effectiveness of a given approach or set of approaches. In evaluating outcomes, the practitioner solicits the client/caregiver's opinions about what sort of progress is being made, and is perceived as being made. The practitioner may seek consultation in how to elicit these responses, which may be made directly to the consultant or to the practitioner in writing. Three types of outcomes measures are used: client satisfaction, case-status (proximal), and client-status (distal) (Mordock, 2002, p. 32). Family and child self-report measures of changes in symptoms, target behaviors, and perceptions of alliance with the practitioner, can all be used periodically throughout the intervention to improve outcomes (Duncan, Brooks-Gunn, & Klebanov, 1994). Direct practice evaluation may also be used as a tool (Sheafor, Horejsi, & Horejsi, 2000, pp. 570-592). Behavior changes can also be measured through school grades, attendance records, number of time outs, etc.

Outcomes Evaluation Skills

- Utilizes single-subject and group methodologies in designing outcome evaluations.
- Addresses goals set for the child in the treatment plan and shifts intervention approaches accordingly.
- Continuously evaluates symptomatology and levels of functioning of child and family to determine efficacy of intervention.
- Identifies barriers to progress and means of overcoming them.
- Assesses the child's and caregiver's progress in establishing a functional network of social and community resources.
- Assesses and reviews with child and family the efficacy of the intervention (treatment-plan goals, remaining problem areas, follow-up activities) and modifies treatment plan accordingly.
- Determines the need for collateral/adjunct services and referral to other providers.
- Uses objective measures of symptomatology and change throughout the treatment process to assess progress.
- Understands personal practice limitations/skill level and makes referrals as appropriate to address unmet needs.

5. Intervention

Carrying out the treatment plan in an intervention, the specialist practitioner will integrate theory, techniques, and expert knowledge. The practitioner utilizes empathy, warmth, and humor (Baldwin, 2000, p. 195) to form a strong therapeutic alliance that is crucial to the success of the intervention as well as to the child and caregiver's belief in the possibility of "change for the better" (Biestek, 1957; Mishne, 2000; Oaklander, 2000, pp. 28-29; Richmond, 1965; Woods & Hollis, 2000). The intervention is conducted in a supportive, private environment (if possible) with clear behavioral guidelines, but with allowance for intense emotional expression and management of acting out behavior. Since the child may tend to stereotype the practitioner as authoritarian, the practitioner should attempt to elicit the sharing of issues and emotions through the child's natural inclinations to self-expression through play and creative activities (Axline, 1969; Case & Dalley, 1990; Gil, 1994; Malchiodi, 1998, p. 43). The practitioner's activity level and early-interviewing skills are predictive of success in an intervention (Gurman & Kniskern, 1991), as are problem-solving, re-framing, and identifying social supports (Corder & Haizlip, 1989; Galante & Foa, 1986; Gil, 1991; Shelby, 1995; Spirito, Stark, & Williams, 1988).

The practitioner monitors the progress of the intervention, mindful of her own reactions and limitations, and the possible need for supplemental services. The complexity of child and family issues often requires multiple treatment modalities—individual, dyad, family, extended family, sibling group, or peer group. Building on the strengths of the child and caregiver, the practitioner integrates an array of resources and professionals into the intervention. In fully collaborative healthcare, the responsibilities for the child's care are shared among pediatric providers, psychologists, nurses and clinical social workers, collaborating on medication management and jointly developing and implementing a treatment plan incorporating the expertise of each field (Ruddy & Schroeder, 2004, pp. 149-168).

As the intervention approaches termination, the practitioner, child, and caregiver should agree about the achievements of treatment, the remaining problem areas, and the follow-up activities that may be helpful, including referrals to other providers and adjunct services. The practitioner works with the caregiver to identify remaining problem areas, and seeks consultation in outcome issues as part of the evaluative process.

Intervention and Termination Skills

- Identifies and uses treatment modalities (individual, family, extended family, sibling group, peer group) based on the child's age, developmental level, nature and severity of problem, and related symptoms, as well as cultural, environmental, and familial factors that promote competency and healthy self-regulation.
- Skillfully applies a broad knowledge base of normal/abnormal child development.
- Executes treatment plan in a manner that is competency-oriented, flexible, manages a broad range of emotions and behavioral expressions, openly addresses goals and progress, and addresses termination issues.

- Effects positive change within the family/caregiver system, offering guidance as to parenting and normative developmental tasks, and encourage integration of therapeutic work post-termination.
- Facilitates and sustains a therapeutic alliance with the child, caregiver, and other involved parties across a broad range of children's disorders and issues.
- Creates a therapeutic environment for the child that includes privacy, consistency, reliability, availability of materials for play and creativity, and established behavioral guidelines in order to promote safety, mastery and self-expression.
- Understands and gives prominence to symbolic play in working with young children.
- Actively engages in consultation, collaboration, and educational activities with caregivers and collateral personnel.
- Assesses readiness for termination in collaboration with child, family and other allied health practitioners in terms of accomplished goals and objectives of treatment and level of functioning.

6. Supervision, Consultation, Teaching, Writing

It is expected that the specialist will share his/her expertise in order to benefit the public and to advance the profession, whether through supervision, consultation, teaching, writing, or presenting. Conversely, the specialist will seek consultation from others in order to increase his/her efficacy in serving clients.

Supervision, Consultation, Teaching and Writing Skills

- Serves/or is able to serve as consultant, teacher and/or mentor to those engaged in practice with children.
- Assists/or is able to assist supervisees/consultees to improve their professional/clinical functioning and to enhance child's functioning.
- Serves/or is able to serve as evaluator, advisor and/or participator in professional services, programs, committees or boards related to practice with children.
- Engages in activities that enhance professional knowledge and continued scholarship in the area of practice with children, including training, teaching, speaking, researching, or writing about child issues.
- Exercises/or is able to exercise leadership as a clinical social worker child specialist in the public and professional arena.

V. Research Relating to Clinical Social Work with Children

Historically, clinical social work with children was not a major area for research. In 1991 the Task Force for Social Work Research, funded by the National Institute of Mental Health (NIMH), delivered its report, *Building Social Work Knowledge for Effective Services and Policies: A Plan for Research Development*. It identified a critical dearth of published research and made recommendations for building research capacity within the profession. Largely as the result of the report, the Institute for the Advancement of Social Work Research (IASWR) was formed, and the NIMH proceeded to fund seven mental-health research centers in schools of social work to conduct research and to train social work researchers.

Clinical social work with children has been the focus of many of those efforts. In 2002 the NIMH convened a conference on current findings and future research directions. *Moving Forward: Building on Social Work Contributions to Mental Health Research* focused on research relating to children: Mental Disorders in Childhood; Motherhood and Mental Illness; and Service Needs of Delinquent Adolescents were a few of the relevant topics. Presentation abstracts are available on-line (see Reference List of this paper).

In funding other social work research, NIMH has given priority to the development of model interventions, outreach to those in need, and new approaches to research design and measurement. Research into practice-setting variations and client-practitioner dynamic (what happens in the intervention) have also been funded by the NIMH, as have projects in coordinating services among mental-health systems and child welfare, juvenile justice, foster care, public assistance, and substance-abuse treatment programs. Although not specific to clinical social work, neuroscience research is having a significant impact on practice with children (De Bellis, 2001; Heim, Newport, Heit, Graham, Wilcox, Bonsall, et al., 2000; Thomas & De Bellis, 2004). Many other examples of research findings might be cited.

It should be noted that research in “evidence based practice” and “best practices” has proved controversial. There is no agreement within any professional discipline as to the meaning of these terms when applied to bio-psychosocial healthcare, nor is there a body of outcome research of high quality on child treatment. Many clinical social workers, trained in a system-of-care philosophy, view evidence-based approaches as guidelines that do not rise to the level of validated methods that have been adapted to the unique individual or applied to real-world settings and circumstances.

VI. Recommendations to Clinical Social Worker Specialists in Practice with Children and Their Families

Clinical social workers often work in systems and situations over which they have little control; yet, as professionals, they are responsible for the quality and efficacy of their interventions. At the individual and delivery-system levels, specialist clinical social workers should pursue the following activities:

- get continuing education and training to integrate new findings in all areas, including multiculturalism, relating to effective clinical practice with children and their families
- seek out opportunities, such as specialty-level certification, to be recognized for proficiency in this area
- actively collaborate with children and families at highest risk for negative outcomes
- work closely with the multiple systems that impact the lives of children and families, particularly schools and pediatricians
- utilize empirical and systematic methods to document successful outcomes, and not limit those methods to satisfaction surveys
- utilize treatment approaches with established effectiveness, or at least evidence of effectiveness, to the extent possible
- work within their treatment settings and communities to facilitate and advocate for children's services
- seize opportunities for multi-disciplinary collaboration in treatment and research
- advocate at the public and private levels for funding of both effective training and comprehensive and innovative treatment programs
- exercise vigilance and creativity in seeking grants, program development, and other funding opportunities.

Appendices

Appendix A: The Crisis in Mental Healthcare for Children

Despite the high overall standard of living in the United States, the well-being of many children, and many groups of children, is discouragingly low. The issues affecting their well-being have long been studied. In the broadest terms, they relate to family structure, poverty, and access to care. The solution is not a matter of practitioners' willingness and ability to provide effective services; it is a matter of society's commitment to care for the most vulnerable among us.

Among many studies and reports that call for a better societal response, the 2004 *America's Children in Brief: Key National Indicators of Well-Being*, by the Federal Interagency Forum on Child and Family Statistics, concludes that we fall short in getting help to the children who need it. The Children's Defense Fund (www.childrensdefense.org) advocates for improvements in mental health management, juvenile justice, and other areas. The Annie E. Casey Foundation (2004), in its *Kids Count Data Book* (www.aecf.org/kidscount), identifies benchmarks in areas like rates of infant and child mortality; rate of teen deaths by accident, homicide, and suicide; teen birth rate; and percent of teens that drop out of school.

Children's mental-emotional well-being is associated with their family structure as well as with the resources—parental, economic, community—available to them. For example, those who live with married-couple parents have the highest levels of mental health and material comfort (Biblarz & Raferty, 1999). However, in 2004, 32 percent of our children—more than 24 million—did not live with married-couple parents (Federal Interagency Forum on Child and Family Statistics, 2005). Of these 24 million, 71.9 percent live with mother only, 15.6 percent with father, and 12.5 percent with neither (ibid). The number of children living with a relative in poverty is increasing: up to 17.2 in 2004 from 16.3 the year before (U.S. Census Bureau, Current population Survey, 2003-2004). Fully 42 percent of children in female-headed families (no husband present) live in poverty, compared with 9 percent of children in married-couple families (Federal Interagency Forum on Child and Family Statistics, 2005). In 2003, in all settings, Hispanic children had a poverty rate of 30 percent and Black children 34 percent, compared to 10 percent among White non-Hispanic children (ibid). Poverty, of course, carries with it increased risks to children's development (Brooks-Gunn & Duncan, 1997). A good deal of current research focuses on connections between families and children's psychological functioning and well-being (McLoyd, 1998).

Today, due to family disruption and an increase in poverty, children are at great risk for having disorders and for developing more-severe problems at younger ages than in the past (Duncan, Brooks-Gunn & Klebanov, 1994). In addition, diagnostic tools and skills have been developed in recent years to identify learning disabilities earlier and with greater sensitivity. In the poorest families, children suffer a shocking amount of neglect and maltreatment (U.S. Department of Health and Human Services' Administration on Children, Youth and Families, 2005). Like poverty, family-diversity issues are high risk-factors. Homelessness, addiction, education levels, culture (color, race, ethnicity, language), sexual preferences, behavioral customs, and other elements can place children in danger (Federal Interagency Forum on Child and Family Statistics, 2004). Most social-service systems acknowledge the importance of cultural competence, but are not able to address these

difficult diversity issues (Lynch & Hanson, 2004). Further, the rate of mental-health impairment varies by ethnicity, with non-White children at highest risk (National Center for Health Statistics, Office of Minority Health, 2004), and with non-White families under-utilizing existing services, with obvious adverse affects for the children of those groups (Jackson, 1999).

Children receive far too little mental-emotional healthcare, and need much more attention. Among all children aged four to eighteen, 17-22% “suffer significant developmental, emotional, or behavioral problems” and many more may be impaired to a lesser extent (Hibbs & Jensen, 1996; Mash & Dozois, 2003). The U.S. Surgeon General showed that one in ten children suffers from a mental illness severe enough to interfere with normal functioning and development. Only about one-fifth of these millions of troubled youngsters receive specialized mental healthcare in any given year (U.S. Department of Health & Human Services, 2001). Timeliness of intervention is crucial, as data suggest that families with younger children in treatment are more likely to continue to get help and to benefit from it than are families with older children in treatment (Patterson & Chamberlain, 1994)

Although not primarily practice-settings, our public schools play a very large part in the delivery of mental-emotional health services. In 1999, only 30% of children with a diagnosed mental health disorder were being treated, and schools were the only provider of services for half of all emotionally disturbed children (U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, 1999). The Center for Health and Health Care in Schools (2002) finds that only 16% of mentally impaired children receive mental health services, and schools provide services to 70-80% of them.

Children in need of treatment include those who may not have diagnosable disorders but who are in challenging developmental, medical, family, and social circumstances. About 6.7 million children have disabilities ranging from physical impairments to disorders affecting their ability to learn and succeed socially in school (U.S. Department of Education, Office of Special Education, 2001).

Frequently, pediatricians are the first professionals to identify emotional and behavioral problems in the children they treat. Up to 80 per cent of mental health issues are treated in the pediatric setting (Schroeder, 1996, pp. 265-284), while, at the same time, only 16% of children identified by pediatricians as having emotional or behavioral problems were referred for follow-up specialty care, of whom nearly a third received no intervention (Horowitz, Leaf, Leventhal, Forsyth & Speechley, 1992).

Many children needing treatment are in custody of a child welfare agency—over 550,000 on any given day, 20% of whom will remain in care for more than five years (Levy & Orlans, 1998). These children, almost all of whom have suffered severe neglect and physical or sexual abuse, have psychopathology rates between 40% and 80% (Schneiderman, Connors, Fribourg, Gries & Gonzales, 1998). Children who have been abused and neglected are at significant risk of developing Post Traumatic Stress Disorder (PTSD) as adults (Allan, 2001). The families of many of these high-risk children have histories of mental illness, substance abuse, incarceration, or life-threatening illness. Of children entering foster care, 75 percent had such a family history (Chernoff, Combs-Orme, Risley-Curtiss & Heisler, 1994). Most of these high-risk children have received services from more than one agency, yet they continue to have serious disturbances (Stroul, McCormack & Zaro, 1996, pp. 313-336). Over the past ten years, funding from the federal Child Mental Health Services

Program has allowed many states to develop community-based care systems providing “wraparound” services to keep these children in their homes and communities and out of restrictive treatment environments (ibid; Virginia Commission on Youth, 2002). These programs are ideally suited to the orientation and skills of clinical social workers, and school social workers in particular (Constable, McDonald & Flynn, 2002, p. 394); however, the programs are often unavailable or may have long waiting lists for admission.

Society has not kept pace with the problems resulting from increasing numbers of troubled families and children. Instead of providing more and more-effective programs for all children, the level of funding and the number of programs have not increased, so desperate needs go unmet. Limited experiments with lower-cost systems in place of the “traditional” child services appear to have failed (Stroul, McCormack & Zaro, 1996, p. 334; U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, 1999). It is very clear, however, that, as funding becomes scarcer for children’s services, society will pay ever-higher costs in terms of demands on community resources, need for repeated and long-term interventions, increased violence and crime, incarceration, and other social disruptions (Mash & Barkley, 1996). *Achieving the Promise: Transforming Mental Health Care in America*, a report by the President’s New Freedom Commission on Mental Health (2003), identified unmet needs and barriers to care for children and youth, including fragmentation, gaps in care, and lack of a national priority for mental health and suicide prevention. It recommended the use of early mental health screening, assessment, and referral to services; it did not, however, result in a new national effort, well funded and organized, to bring about change.

Society’s priorities are not focused on the plight of millions of its children. Clinical social workers are already on the front lines of dealing with this overwhelming problem, and are prepared, by education, training, values, and orientation, to do even more, if supported by policies and funding in an area where their expertise can make a huge difference.

Appendix B. Diversity of Practice and Settings

The specialist practices in any setting in which children are helped with bio-psychosocial problems and disorders. These settings typically include those associated with mental-emotional healthcare, medical care, schools, and child welfare systems. Other settings are the child's home, juvenile facilities, courts, private offices, after-school and child-care settings, and camp and recreation centers. Other settings include programs aimed at ameliorating violence, substance abuse, and problems with parents or peers. Whatever the role or job title in the setting, the practitioner's work is still clinical social work.

1. Mental Emotional Healthcare

In mental health settings, clinical social workers help children to improve their mental-emotional functioning. This is the practice area in which the largest number of clinical social workers provide services, and in which the full array of their education, training, value-system, and experience may be brought to bear, including diagnosis, psychotherapy, psychoeducation, and community referrals. They assess and diagnose their clients' conditions, conduct therapeutic counseling and case management, arrange for access and connection of children and families to community resources, and advocate for clients. Collaboration and teamwork with psychiatrists, psychologists, pediatricians, educators, and other professionals is essential. Such work is done in schools, community mental health centers, private practice, psychiatric units of hospitals, day-treatment/partial hospitalization programs, and residential treatment centers.

2. Child Welfare Systems

The "child welfare system" is operated by government agencies that have a legal mandate to protect the safety of the child and to investigate allegations of child-abuse and child-neglect, and that have oversight of adoptions, children in foster care, and reunification of children with their families. These services require practitioners (often private consultants) with expert competence in evaluating the child client, the relationship between the child and caregiver, parent, and extended-family members. If the agency decides to keep the child in the family, the specialist might provide intervention services directly or supervise others in monitoring the child and caregiver. If the child is placed outside of the family, the specialist should assist in the selection of the adoptive or foster home or institutional setting or other options. The specialist is truly necessary in these settings to guide children toward developing secure attachments, without which the child is at risk for depression, anxiety, and acting-out symptoms (Lyons-Ruth, 1996).

3. Medical Healthcare

In medical healthcare, clinical social workers treat children—sometimes children who are quite ill or injured—in public health clinics, general and specialty hospitals, and the offices of private pediatric and family-practice groups. Pediatricians are often the first healthcare professionals to recognize that a child has a mental-emotional problem; and pediatricians often serve as "gatekeepers" for subsequent care, making referrals to clinical social workers or practitioners from other disciplines. The clinical social worker conducts assessments (developmental and family-needs), case-manages

and integrates services, counsels or provides therapy, consults to and with other professionals, and advocates for individuals and for classes of children with chronic diseases. Many children need “integrated” care from an entire team, ranging from medical-surgical professionals to clinical social workers. A specialist interprets the medical experience (including jargon) to the child and family, and gives them emotional support, while also informing the team about the clients’ responses to treatments and to the illness itself. The practitioner is knowledgeable about trauma, acute and chronic medical illness, biological and genetic impacts, indications for psycho-pharmacological interventions, and the effects of medications on the child’s functioning. In the area of genetic screening and testing, the specialist provides caregivers with guidance and support in dealing with findings relative to inherited disease and in caring for an affected child and siblings.

4. Schools

Of children with diagnosable mental disorders, 50-80 percent receives professional services in school. Public schools are responsible both for educating children in basic academic areas and for fostering their emotional and social growth toward productive life in society. Most schools have programs in nutrition, school daycare, screening and interventions for health and mental-health issues, and cultural enrichment and development of social competence. Practitioners’ interventions with a student can address individual issues, peer groups, a classroom, or an entire school. The practitioner tends to focus on children for whom education has not been effective or is problematic, ranging from special-education students to immigrants and the homeless to truants and substance abusers. Children’s developmental and familial needs are assessed, and therapeutic counseling may be provided to both children and their families (Woodruff, Osher, Hoffman, Gruner, King, Snow, et al., 1999). Public school-based practitioners facilitate cooperation between home and school (Constable & Walberg, 2002, pp. 371-382) and between schools and the community through activities like consulting with teachers, administrators, and other mental-health professionals, and assisting families to access resources for their children’s well-being and success in education (Constable, McDonald, & Flynn, 2002). Clinical social workers in schools also develop and implement behavioral intervention plans for students.

5. Juvenile Justice and Courts

In the field of juvenile justice, clinical social workers help children who become involved in some context of crime or violence. While these children, like those in the child welfare system, can be removed from their families and placed in state facilities or foster care, often they are assigned to probation in the community. In that case, the practitioner may provide direct and indirect services, often mental-health-related, to the targeted child and his/her family.

In court-related interventions, often initiated with children whose parents are divorcing, the practitioner may conduct custody evaluations of the child and his/her caregiver and family situation in order to advise the judge. A specialist practitioner might serve as a mediator who works with the caregiver in the child’s best interest, or might (in some states) serve as guardian *ad litem* to represent the child’s interests when caregivers cannot agree about what is best for the child. Having decided on custody and living arrangements, some courts appoint practitioners to serve as “parent coordinators” to work with the parents to meet their children’s needs and to advise the court while keeping the parents out of the legal proceedings.

Appendix C. The Family

1. Family Structure and Roles

The family, or primary living group, is responsible for the nurturing and rearing of children. Ideally, the caregiver responds empathically and helps the child develop mastery and a sense of self, and the family introduces the child to values of cooperation and reciprocity and to expectations of social interaction. The family transfers its culture by directing and influencing the child's beliefs, values, attitudes, behavior, and social competence.

Beyond the nuclear model, family structures include extended, multi-generational households; blended families; created families, in which adults act as surrogate parents; single-parent and same-sex-parent families; adoptive families, foster families, and families governed by older siblings. Some children are raised by people in communal settings of multi-family households or by designated adults not necessarily related to each other. Community resources, such as day-care or recreational settings, provide functions and services, including nurturing, formerly provided only by families and extended families.

Through the family, children are introduced to their respective culture and in turn influence it in a unique way (Holloway & Minami, 1996, pp. 164-176). Families may be monocultural, bicultural, or multicultural, based on race, ethnicity, and geography. Families may belong to one or more sub-cultures based on age, gender, sexual orientation, socio-economic status, religion, or differing abilities. Families develop patterns of family structure which govern and regulate the function of all of their members, including children (McGoldrick, 1998; Minuchin & Fishman, 1981, p.11). A child develops within the context of familial and cultural values, implicitly and explicitly communicated, that shape his or her behavior (Webb, 2001, p.20); however, the family's central role as an imparter of culture and values may be supported or diminished by the influences of extended family, the school, peers, or the media (Keats, 1997).

Families play six broad roles in an intervention: contributors to the environment in which a child resides, recipients of service and therapy, partners in the treatment process, service providers, advocates, and evaluators and researchers (Friesen & Stephens, 1998, pp. 231-260). The practitioner works to help them to understand their child better and to make supportive changes.

2. Family in Context

The practitioner must be able to interpret the child's difficulties and the sources thereof, and to maintain a working alliance with the caregiver, although it may be that the caregivers are at the root of the problems. Given their powerful place in the child's life, the caregiver and family must be included in the intervention if it has to have a positive and lasting outcome (Knitzer, Steinberg, & Fleisch, 1993; Kutash & Rivera, 1995; Pfeiffer & Strzelecki, 1990). The nature of this work varies with the family circumstances, caregiver mental-health status, and the developmental level and needs of the child. Services to the caregiver may be provided by the practitioner who sees the child or by a colleague. By striving to understand the family members' attitudes and beliefs about their role, practitioners can guide them to change their behaviors with the child.

In all families, there is a wide range of individual capacities and family variables, including similarities and differences in physiology, personality, temperament and environmental context (Dugan and Coles, 1989, p.10). Caregivers, and other family members have developed their cultural goals through identification with their own parents, with the idealized images of their parents, their unique cultural styles, and have also incorporated a sense of sex-role competence, national identity and character (King & Noshpitz, 1991, p. 124). The family, which functions as the main organizer of the child's life experiences and development of inner capacities, can best do so by identifying and empathizing with its children, being adaptable and flexible in child-rearing, and being resilient in negotiating both internal and external forces. In dysfunctional family relationships caused by child or family problems, the specialist's intervention can be crucial to the self-regulation, growth, and well-being of the child and family.

The family is not a static entity; it is always in the process of change, as are its social contexts. Over time, the family evolves, demonstrating both continuity and adaptability in the face of demands for maintenance and the need to deal with new life-events (Minuchin & Fishman, 1981, pp. 20-21). Intervention with the family in times of crisis and struggle is sometimes necessary and often productive in helping the family meet its challenges.

Appendix D. Children's Development

1. Infancy and Toddlerhood (0-3 years)

In helping infants and toddlers, the practitioner develops a strong working alliance with the caregiver (Erikson & Weinberg, 1999). Development in the first three years is dominated by the child's needs for love, food, sleep, stimulation, protection, and attachment to caregiver in order to promote bodily, neurological, and psychological growth. Parent-child interaction is the basis for achieving basic human trust and feelings of security: love and nurturance from the caregiver is essential for normal development by the infant, who is biologically predisposed to use the caregiver as a secure base for exploring and as a refuge when threatened (Erikson, 1963; Bowlby, 1982). As time passes and the infant becomes more expressive, the caregiver-regulated relationship should evolve into one of mutual regulation or attunement (Stern, 1985; Tronick, 1989).

When poorly cared for, the infant tends to become poorly attached (Greenberg, 1999, pp. 469-496). Anxious or disorganized patterns of infant attachment prevent a sound development of a sense of self and block the development of mechanisms for coping with various affects. The ability to soothe oneself does not develop. These impairments are associated with later behavior problems and emotional disturbances (Dozier, Stovall & Albus, 1999, pp. 497-519; Sroufe, Egeland, & Carlson, 1999, pp. 241-261). The toddler's progress in cognitive and socio-emotional growth and physical capabilities (walking, talking, exploring, etc.) is heavily influenced by the caregiver's ability to foster strong attachment (Erikson, 1963). Practitioners must be aware of the extent to which culture, as well as development, impacts their work with infants and toddlers (Webb, 2001, p. 20).

2. Preschool and Kindergarten (3-5 years)

In the three-to-five-year age group, children tend to brim with ideas, chatter, and activity. They try new things and test their physical and emotional skills. Ideally, the caregiver supports and affirms a child's curiosity, sense of self, positive self-regard and growing physical, social, emotional, and intellectual competence. The caregiver must guide the child closely to assure safety and skills-mastery—alone and in small groups—preparatory to school entry (Shonkoff & Phillips, 2000).

3. Elementary School Age (6-10 years)

For children in the early school-grades, play remains important for fostering cognitive development, especially in small groups under adult guidance. Children are keenly interested in friends—making, becoming, and having them. Through interaction with peers, children develop a repertoire for problem-solving, communicating, and forming relationships that reach into their school, neighborhood, and community. They tend to become goal-directed toward a state of greater independence (Allen & Marotz, 2003). In the age range of nine to twelve, most children hunger for knowledge and understanding, drawing on a new ability to think in the abstract, to apply logic, and to understand cause and effect.

As they enter school, children organize their physical and socio-emotional skills to accomplish complex tasks. The beginning of the child's schooling often raises separation issues for the child and

the caregiver, with which the specialist can be helpful (Bailey, 2000, p. 195). In the early school grades, play, friends, problem-solving, goal formation, and increased independence are developmental issues.

4. Early Adolescence (11-14 years)

In early adolescence, children enter a state between dependence and independence, complete with biological, psychological, and interpersonal transitions. Adaptation to a changing body, concerns about compliance with group norms, and exploration—social, sexual, and self—are major themes. As they assume greater independence, early adolescents tend to be more goal-directed and more disorganized (Allen & Marotz, 2003).

They challenge adult authority, draw sharper distinctions between self and non-self, and begin making their own decisions (Garbarino, 1992). They engage in physical, social, and emotional risk-taking, and become vulnerable to the consequences. The early adolescent may deal with complex identity issues (Rice & Dolgin, 2004). A parent may loosen controls, often ambivalently, allowing the child to explore his/her identity, interests, and ambitions. The child often feels torn between family and the world of peers and of other adults. The social world, external to family, begins to have a profound impact on the adolescent's self-perception, cognitive development, behavior, and emotional life. Variations in the cultural context, and social and physical environment can profoundly affect development during this period.

Appendix E. Sample Practice Approaches

The approaches described below are a sampling (listed alphabetically) of those that are frequently applied in specialty practice with children.

A. Cognitive-Behavioral Therapy

Cognitive-Behavioral Therapy (CBT) is based on the theory that an individual's affect and behavior are largely determined by the manner in which he/she constructs the world (Beck, Rush, Shaw & Emery, 1987, p. 3). Its practitioners target the cognitive processes that underlie maladaptive feelings and behaviors, and seek to alter the child's cognitive content (memory, and schemas for encoding new experience), cognitive process (e.g. social problem-solving), or cognitive product (distortions in thoughts or feelings, or negative ideas about the self) (Bedrosian & Beck, 1980). By changing the way a child thinks about an experience, the practitioner aims to help the child learn to master problems and situations and to achieve greater emotional stability. The behavioral side involves mastering problem-solving, goal-setting, and adapting to stressors. Play-based approaches, in particular, are intended to help the child become an active participant in change (Knell, 1999, pp. 385-404).

B. Family Therapy

Family Therapy's goal is for family members to improve their understanding and functioning with regard to the child or children who depend on them. The approach assumes that the family is willing and able to engage in the intervention. In Family Therapy, the family may be seen as mired in a problem situation that it can not or will not change and that leads it to focus on the stress of one of its child members and to brand him/her as deviant (Minuchin & Fishman, 1981, p. 269). The practitioner assumes that the child's behavior is part of the family system as a whole, and that change in any member's functioning will affect the entire family. The members are helped to identify problematic patterns of communication and interaction and to understand their meanings and consequences. The healing capacities of the family are encouraged: caregivers are allies in treatment, and the entire family can become the client (Cohen & Mannarino, 1997; Deblinger, McLeer & Henry, 1990; Webb, 1999).

C. Group Therapy

Group Therapy's purpose is to enable the child to use the help of a group to address difficulties such as inadequate socialization, divorce, or abuse. Practitioners use the Group approach to examine the factors that keep a child from forming the relationships and developing social skills that are seen as critical to his/her long-term social and emotional adaptation and success in school and jobs (Cowen & Smith, 1973; Hartup, 1992, pp. 175-205; Kohn, 1977; Parker & Asher, 1987; Vandell & Hembree, 1994). The Group modality can be very helpful to children experiencing bereavement or dealing with divorce (Garvin, Leber & Kalter, 1991; Stolberg & Mahler, 1994; Trebing, 2000, pp. 144-174). A parent-training component to Group work is used to improve children's social skills and behavior in home and school (Ducharme & Holborn, 1997; Pfiffner & McBurnett, 1997). The Group

approach is often used in residential treatment centers. It is also used in helping shy, anxious children over age six to develop social skills (Schaefer, Jacobsen & Ghahramanlou, 2000, p. 296-344; Rapee, Wignall, Hudson & Schniering, 2000), and in helping children who have Post Traumatic Stress Disorder, or who are conduct-disordered (Feldman, Caplinger & Wodarski, 1982).

D. Multisystemic Treatment

Multisystemic Treatment (MST), a home- and community-based treatment program for deeply troubled children, focuses on enabling the caregiver to help the child and modify any system (e.g., family, school, peer, community) that supports a child's problem behavior (Borduin & Henggeler, 1990, pp. 63-80; Henggeler, Schoenwald, Borduin, Roland & Cunningham, 1998). In the intervention, the practitioner sets a round of daily tasks that are done intensively by the child and caregiver until a good level of functioning is achieved. Interventions, which may involve other important persons in the child's life, are based on nine MST treatment principles and utilize skill-building modules. MST is used as an alternative to out-of-home placement (e.g. incarceration and hospitalization), and, in that instance, has the advantage of promoting improved psychosocial functioning (Henggeler, 1999; Henggeler, Schoenwald, Borduin, Roland & Cunningham, 1998). [It should be noted that Multisystemic Treatment is also a term, unrelated to the above, that refers to treatment involving a combination of medication and psychotherapies.]

E. Narrative Therapy

In Narrative Therapy, the practitioner helps the client create a narrative about self, concerns, world view, and relationships, complete with gaps, inconsistencies, and contradictions. In resolving the latter elements, the client is guided to consider meanings for experiences and relationships (West & Bubenzer, 2001, p. 363; White & Epston, 1990, p. 38). In theory, Narrative Therapy helps the client to change through an ongoing process in which problems are objectified, problem-saturated narratives are deconstructed, and narratives are re-framed to support preferred outcomes (Bubenzer, West & Buoughner, 1994). Family interviews and children's verbal story-telling are utilized, often with drawing, in which the child can externalize a problem, convey metaphors, present world views, and create images for explication (Malchiodi, 1998, p. 43).

F. Parent-Infant Therapy

The goal of parent-infant therapy is to encourage a healthy attachment between baby and parent/caregiver, which in turn is fundamental to the infant's development of a sense of self. Because infants are pre-verbal and driven primarily by biological urges and needs, the parent should strive for "communion" with the infant through body-language as well as communication. The caregiver's playing with the infant is critical to baby's growth and learning and is helpful to families (Muir, 1992; Weatherston, 2001). The practitioner seeks both to unfold the infant's potential for normal emotional and cognitive growth and to foster parental attunement toward the baby by promoting the caregiver's competence and confidence, and the infant's. Interventions may be short-term or longer, and may involve ongoing parent guidance, infant-parent observation, or family

advocacy. Many techniques are available to the practitioner, including videotaping of caregiver-infant interactions; “floor time” (Greenspan & Weider, 1993); role-modeling; home visiting during which caregiver and baby are helped to play together (Sunley, 1968); and “theraplay” utilizing the practitioner in an active short-term intervention (Booth & Lindaman, 2000, pp. 194-227). Practitioners with expertise in this area may consult effectively to family-centered intervention programs, court systems, and child-care and home-visit programs (Heffron, 2000).

G. Play Therapy

Play is commonly used in conducting therapy with children as a natural medium for the expression and enactment of the child’s concerns and conflicts (Erikson, 1963; Fraiberg, 1996; Gil, 1991; Nickerson, 1973; Sandler, Kennedy & Tyson, 1986; Schaefer & O’Connor, 1994; Webb, 1999; Kaduson & Schaefer, 2000). Play Therapy’s goals are to relieve symptoms and remove obstacles to growth (Webb, 1999), to help the child develop a sense of competence and mastery (Schaefer & Reid, 1986), and to provide a corrective emotional experience (Enzer & Goin, 1978). Its advocates believe that it can be effective with many problems and settings (Webb, 1999). At the practitioner’s office, the child is invited to play with toys, games, puppets, art and other materials through which the child expresses him/herself. Most Play Therapy, even with very young children, is a mixture of play and words.

H. Psychodynamic Psychotherapy

In Psychodynamic Psychotherapy, practitioners apply a range of accepted methods and approaches in an effort to remediate the child’s emotional and behavioral disturbances. This approach focuses primarily on psychic processes rather than overt symptoms. Based on psychoanalytic theory, this modality aims to free the child to express thoughts, wishes, feelings, and fantasies that point toward underlying psychological difficulties. Through transference phenomena, the practitioner strives to become aware of the child’s expectations of his/her relationships and aims to help the client understand the dynamics of his/her experience, to correct distortions and modify feelings, and to improve relationships and experiences. In longer forms, the goal is to help the client to be less rigid and more free in the use of self, while in briefer forms (12-15 sessions) the client is guided to improve self-understanding and ego-strength (Friedman, 2001).

I. Solution-focused Therapy

Solution-focused Therapy is a brief (15 sessions or less, usually), behavior-specific, solution-focused model in which, among other things, the practitioner strives to facilitate disruption of or change in problem patterns; to evoke solution patterns; and to keep change going between sessions by assigning homework (letters, tasks, etc.) (O’Hanlon & O’Hanlon, 2002, pp. 213-214). The practitioner creates a picture of how things will be once the client no longer suffers from the presenting complaint. Problems are treated as patterns, and not as manifestations of pathology. The patterns of talk, thought, and action, are changeable; and the child’s (and family’s) expectation of change depends mainly on the practitioner’s ability to inspire belief about what can be accomplished

in the intervention (O'Hanlon & Weiner-Davis, 2003). This approach gives the child a voice in his/her treatment and in his/her own lives, and it includes larger systems in which the child is involved (Selekman, 1997).

Appendix F. Clinical Social Worker Practice Guidelines

The specialist's knowledge and skills are informed by certain activities common to all conscientious clinical social workers at whatever level of practice. These include vigilant use-of-self and a disciplined bio-psychosocial approach to the practice environment, and the use of consultation when appropriate, and the use of a bio-psychosocial perspective on the environment in which treatment is conducted and which the client inhabits. The practitioner does all in his/her power to remove barriers to treatment and to help clients to secure their rights to effective care and to leverage community resources.

Core clinical social work values connect the specialist to other clinical social workers and help to maintain professional identity. They are expressed by the following commitments:

- to honor the dignity and well-being of the individual and his/her right to self-determination, privacy, confidentiality, and informed choice
- to advocate for clients in service provision, access to care, and program evaluation
- to practice ethically and legally, with competence, integrity, and respect for culture and diversity
- to contribute to a society that offers opportunities to all of its members in a just and non-discriminatory fashion
- to deliver the treatment and level of care that best accords with client needs.

Like all clinical social workers, the specialist is also expected to comply with the laws that govern practice and the ethics that inform professional conduct, in all matters relating to clinical social work and especially in terms of confidentiality of records and privacy of communication, as well as the obligation to practice within the area of competence. These matters are reviewed below.

A. Licensure and legal compliance

State licensure at the highest clinical level is to be held by all advanced clinical social workers; and specialists must be familiar with laws and regulations, both state and federal, that are particularly relevant to working with children. A thorough knowledge of these laws and regulations ensures that the public is protected. In making referrals or providing services across state lines, it is important to be familiar with the variations in the statutes of the states.

B. Ethical Responsibilities

Clinical social workers must adhere to the codes of ethics of their professional organizations. Ethical concerns are heightened in working with vulnerable populations. Since children generally lack autonomy and legal authority for consent, the practitioner must attend to the child's understanding of the intervention plans and contract, and must closely monitor the child's responses as a client. Since children generally are referred for an intervention because someone else has decided that their behavior is problematic, the practitioner's first job is to determine the advisability of an intervention. The best ethical judgment is based on the fullest range of information about all parties—caregiver included—and their motivations and capacities, so that the child's best interest is always foremost.

C. Competence

Legally and ethically, practitioners must maintain high standards of conduct, recognize the boundaries of their competence, and provide services only in areas in which they are competent to achieve good results. General training in clinical social work does not, *per se*, qualify one to offer expert services to children. Competence in specialty practice is achieved by a combination of education, training, supervision and consultation, empathic attunement, focused practice over time, continuing education, and wisdom.

D. Confidentiality

Confidentiality of records and privacy of communications are governed by professional ethics and by state and federal laws. In interventions with children, the practitioner may not (barring emergencies) share confidential professional communications without the caregiver's written permission. The practitioner is advised to discuss confidentiality with the child (when practicable) and caregiver to clarify the extent to which information can be kept private. In custody cases especially, there is a high risk of mistrust and misunderstanding. In schools, agencies, and most institutions, practitioners usually share "child treatment reports" with other professionals working with them, subject to the consent of the caregiver or the child when allowable. State laws vary regarding the age at which adolescents can determine the confidentiality of their communications.

Glossary

Children

For ease of reference, the term “children” includes (unless otherwise noted) the full range of development from infancy through early adolescence.

Clinical Social Worker Specialist in Practice with Children and Their Families

Clinical Social Workers who practice with children and their families are adept at using relevant theory and proven techniques to assess and ameliorate symptoms and environmental factors that interfere with the healthy developmental, psychological, physical, behavioral, social, and cognitive functioning of children. Competent practice in this area requires high levels of specialized knowledge and skill. The specialist’s expertise in individual child dynamics and familial and relational contexts is matched by a knowledge of systems—educational, legal, medical, welfare—and skills that make it possible to intervene effectively. Competent practice also requires an ability to collaborate with other professionals and access community resources that support a child’s development and empower the caregiver. The specialist’s self-awareness and self-monitoring (including use of consultation) are essential for developing and maintaining effective therapeutic alliances and treatment plans.

Collateral Resources

Collateral resources are people and groups important in the child’s life, such as pediatricians, teachers, guidance counselors, clergy, coaches, peers, and peer groups. Some collateral/adjunct resources may have law-oriented roles (e.g. protective services, courts, probation offices) that mandate treatment, and may even be perceived as countering the wishes of parent or other caregiver. Collateral resources with these legal roles may make treatment demands upon children, caregivers, other collateral resources, and practitioners. The clinical social worker may work directly and indirectly with collateral resources on behalf of children, including education, consultation, brokering, and advocacy.

Competence

Competence is the clinical social worker’s ability to combine high levels of acquired knowledge, cognitive skills (conceptual, experiential), interpersonal skills (communication, accurate empathy), and motivation in actions that yield effective clinical outcomes and that differentiate between average and superior professionals.

Family

The child’s family is comprised of those who serve in the parental/guardian role as caregivers. As a part of the legal obligation to nurture, educate, and support the child, caregivers initiate the process of arranging for children to receive the care they need.

Knowledge

The clinical social worker specialist’s knowledge-base is built upon education and training derived primarily from three theoretical constructs—biological, psychological, and social—practice methodologies, guided practice, independent studies (e.g. cultural norms and legal-ethical

regulations), and research findings. This cumulative knowledge-base is enhanced and enriched through supervision-consultation, continuing education, and practice experience.

Skill

Skill is proficiency that is developed through training and experience. A clinical social worker specialist's practice consists of multidimensional, highly specialized practice skills that encompass the following functions: bio-psychosocial assessment and diagnosis; treatment planning; outcome evaluation; intervention, and termination. Skills are enhanced and enriched through supervision-consultation, continuing education, and practice experience.

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