

A Successful Failure: Difficult Questions for the Interface between the Adoption and Safe Families Act and the Therapeutic Process

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Abstract

This case study describes an effective psychosocial treatment of a female client who had been traumatized both in her family of origin and in the child welfare system, and who presented for therapy having had her own children taken following her maltreatment of them. This client became a mother before the psychotherapy could alter her caregiving and, predictably, was unable to care for her own children. The treatment process occurred in a not-for-profit, faith-based agency providing outpatient services for clients in the public child welfare system. Because the client's needs for care were so profound, the treatment process included mobilizing resources to help the client with homelessness, chemical dependency, child neglect, and, ultimately, the process of open adoption. The theoretical framework used to understand and conduct the treatment was object relations theory, specifically the work of Winnicott and attachment theorists. The client's treatment process was powerfully influenced by the new legislation of the Adoption and Safe Families Act. This case study reveals how the larger systems impact on the therapeutic process, particularly when clients must comply with child welfare staff and when services are limited by public laws such as the Adoption and Safe Families Act.

Key Words: Psychotherapy, Reunification, Adoption and Safe Families Act, Single Case Study Design, Attachment Theory, Object Relations.

Introduction

"The children need to belong, and they do – to all of us" (James, 1994, p.xiii).

The federal government enacted the Adoption and Safe Families Act (ASFA) in 1997 to help states move children in foster care to safe and permanent homes in a timely manner (P.L. 105-89). ASFA was a response to a nationwide awareness that many children remained in foster care far too long, while

other children were reunified into unsafe families (Gendell, 2001). ASFA goals are to prevent children from being returned to unsafe homes and to find safe loving and permanent homes for children who cannot be reunified with their families (Gendell, 2001, p.25). ASFA has two key provisions: 1) It allows states to bypass efforts to reunify families in certain egregious situations, and 2) it requires states to file a petition to terminate parental rights when a child has been in foster care for fifteen of the previous twenty-two months.

ASFA changed and clarified the prior policy, The Adoption Assistance and Child Welfare Act, which had been enacted in 1980 (P.L. 96-272). One basic, paramount change is an emphasis on child safety over and above the emphasis on family reunification. Time-limited reunification services are provided. After five years of implementation, the actual results of ASFA are inconclusive, according to a study conducted by the United States General Accounting Office (www.gao.gov GAO-02-585).

The study reported a fifty-seven percent increase in adoptions since the enactment of ASFA, through fiscal year 2000. Insufficient pre- and post-ASFA data render it difficult to determine with certainty whether ASFA is responsible for this increase. The law is the best effort of legislators to respond to the difficult challenge of attempting to balance the rights of parents to raise their children, while simultaneously seeking to meet the needs of children who have been abused or neglected.

This case study will illustrate efforts to reunify a mother and child who entered the child welfare system about eighteen months prior to the passage of the Adoption and Safe Families Act in November, 1997. The mother's treatment process will be examined through the multiple lenses of psychodynamic, developmental, attachment and object relation theories. A window will be provided into the internal world of this adult "child,"

who did not have access to stable and empathic care, and for whom all early attachment relationships were disrupted. This paper will begin with a review of the relevant literature related to attachment theory and child development. An explanation for the rationale of a single study case design will be provided. The overarching agency setting and its impact on the Department of Children and Family Services (DCFS) case management and therapy will be explored. The background of the case, theoretical and clinical dynamics, the treatment process, and implications for child welfare policy will also be examined.

Review of Relevant Literature

The care provided by primary caregivers has a significant impact on a child's early development and future relations. The literature draws our attention to psychoanalytic theory (Freud, S. 1940-64; Freud, A. 1936, 1965; Erikson, 1950, 1980); attachment theory (Bowlby, 1969, 1973, 1980; Ainsworth, 1973; Main, 1985, 1995); developmental theories (Winnicott, 1965, 1971, 1992); and interpersonal relationship theory (Stern, 1985, 1995; Beebe & Lachman, 2002).

Freud's psychosexual stages emphasized the centrality of the mother-child relationship, which he described as the "first and strongest love-object" and as the "prototype of the later love relationships" (1940-64, p. 188). Freud believed this early infant relationship to be highly influential throughout the life span. Freud's drive/conflict model and the role of the object as explained by classical psychoanalysis differ from, but also influenced, contemporary theorists. Anna Freud (1936) extended classical theory to include the psychosocial and emotional development of the child. She provided a framework to think about ego development and mechanisms of defense (Freud, A., 1936). She also provided a framework for lines of development from infancy to young adulthood (Freud, A., 1965). She outlined development as a process extending from dependency for nurturance and care in infancy to a struggle for independence and emotional self-reliance in young adulthood. To move from dependency to self-reliance, the child must develop the capacity to maintain an inner representation of the primary caregiver when that caregiver is absent. The child must also tolerate the ambivalence stemming from the desire for separateness in early childhood. Emotional investment is transferred from parents

to peers prior to the adolescent struggle for independence. Development is dependent upon the quality of the primary caregivers' responsiveness, and is reflected in profiles of normality and risk (Freud, A., 1965).

Erikson's (1950, 1980) eight stages of psychosocial crises are founded on an understanding of the social and cultural context of the child's family. The identity of the child is established within relationships with parents, family members and culture. The important stages in early childhood include the development of trust, autonomy, initiative and industry. The relationship with primary caregivers contributes to the healthy resolution of the child's developmental crises.

Bowlby (1969, 1973, 1980), a British psychoanalyst, studied the significance of early relationships in child development and the effect of early separation and loss on the individual's lifelong attachments. Bowlby viewed the infant as an active relationship participant, signaling the mother or caregiver, while the attentive caregiver responds to the infant's needs. The transactions between infant and caregiver that affirm security, consistency and sensitivity for the infant allow the attachment relationship to develop. In turn, the attachment relationship is important for the child's continued development. "Intimate attachments to other human beings are the hub around which a person's life revolves, not only who he is as an infant or a toddler or a school child but throughout his adolescence and his years of maturity as well, and on to old age. From these intimate attachments a person draws his strengths and enjoyment of life and, through what he contributes, he gives strength and enjoyment to others" (Bowlby, 1980, p. 442).

Ainsworth conducted research on attachment relationships through the observation of twenty-four mother-infant pairs in their homes and in a laboratory situation referred to as the "strange situation" (1973, 1978). Through these observations Ainsworth identified two major categories of attachment in infancy: secure and anxious. The anxious infant was described as either avoidant or as resistant. She observed that the parent's sensitivity and responsiveness to the infant's signals were related to the infant's attachment security. Main, a student of Ainsworth, developed the adult attachment interview, a research instrument designed to gather information about an individual's representation of early and current relationships (Main, George & Kaplan, 1985; Main 1995).

Main extended Ainsworth's work to identify four adult attachment classifications: secure autonomous, dismissing, preoccupied, and unresolved/disorganized.

Winnicott's developmental theory emphasized the interpersonal dimension of the "holding environment" provided by the mother's care of the infant (1965, 1971, 1992). Winnicott described three phases of dependence: absolute, relative and toward independence (1965, p. 84). In the developmental phase of absolute dependence, the parent assures the baby of support, protection and safety through an experience of holding, cradling and attending, which leads to the infant's security of attachment (1965). The holding environment begins in utero. The mother becomes naturally preoccupied with the baby, which Winnicott called primary maternal preoccupation (1965, p. 52). The empathic attunement allows for periods of ego integration and un-integration. The mutuality and relatedness between mother and infant allow the infant to discover his or her own identity. Winnicott described the caregiver's face as a mirror to the infant's emerging sense of self. In the developmental phase of relative dependence, the child becomes aware of his or her dependence on the caregiver. An important task for the infant is to manage the anxiety of separation from the mother through transitional phenomena and transitional objects. The child learns to be alone in the presence of the mother, and develops the capacity for ego relatedness. As the child develops an integrated sense of self, he or she moves toward independence. This normal developmental process assumes the presence of what Winnicott called a "good enough mother." Winnicott expands the concept of holding to the family and society. "The family continues this holding, and society holds the family" (1990, p. 107). Winnicott also stated, "One can discern a series – the mother's body, the mother's arms, the parental relationship, the home, the family including cousins and near relations, the school, the locality with its police stations, the county with its laws" (1975, p. 310). Psychopathology is the result of an insufficient facilitating environment. Winnicott's concept of holding also provided a metaphor for the work between therapist and client, as well as for the "good enough social worker."

Beebe & Lachmann's (2002) recent writings represent thirty years of seeking to integrate infant research and adult treatment. Their infant research shows the co-construction of experience between mother and infant through face, voice, orientation, and how the mind is organized through this interac-

tion. The authors use infant research to imagine the client's early history and "to conceptualize the non-verbal and implicit interactive process itself within psychoanalysis. The usual level of psychoanalytic discourse entails an explicit, verbal, and symbolic narrative; but an interactive process that is implicit and nonverbal proceeds in parallel" (p. xii). If the therapist can notice subtle shifts in nonverbal behaviors he or she may have a window into difficulties that are present in the engagement process and further understand the client/therapist interactive regulation.

Daniel Stern's (1985, 1995) work focused on the early relationship between parent and infant, including reciprocal interactions. Stern defined a framework of four themes to assess a new mother's development. Can the mother 1) sustain and support her baby; 2) enter into a nurturing relationship to protect her baby and develop an attachment; 3) make use of supportive relationships such as parents, husband, siblings, and friends? And can she 4) integrate her identities as wife, daughter, and working mother? Stern also viewed the holding and handling of the baby as important to the development of the attachment relationship. In the holding, feeding, comforting of her own child, the new mother remembers experiences of being cared for as an infant. These awakened memories allow the new mother to identify with her mother and with her baby. This may affect the way she cares for her infant and it may be a catalyst, pushing her to become the mother she wants to be (Stern, 1995).

Single Study Case Design

Case studies are a common way to do qualitative inquiry (Stake, 2000; Yin, 1989; Bogdan and Biklen, 2003). "The purpose of a case report is not to represent the world, but to represent the case" (Stake, 2000, p. 448). Stake (2000) distinguishes the difference between intrinsic and instrumental case studies. An intrinsic case study is undertaken because the case itself is of particular interest. It is not selected to be representative of a particular group of cases. An instrumental case study is an in-depth examination of a particular case that provides insight into an issue and plays a supportive role in understanding something other than the case. While this case is atypical, the in-depth intrinsic study of an extraordinary therapeutic process will nevertheless provide instrumental insights into examining the human condition of child neglect and child welfare policy.

This single case study reviews one family's struggle through the narrative of this mother, who was herself a former foster child. The reader will see her attempt to reconcile the home she started from and the home she longed for in her heart, with all the addresses in between. "Older foster youth and former wards can speak eloquently about their experience and point to powerful new directions for policy development, training and future research" (Johnson, Wells, Testa & McDonald, 2003).

Agency Study

The therapeutic process is influenced by the setting in which it occurs. In this case the agency setting was a private, not-for-profit, accredited, faith-based setting, serving several counties with a variety of social service programs. The outpatient counseling, the addictions treatment program, and the foster care program are the foci of this paper. In cases such as this, where the client is working to regain custody of a child in care, the therapist's and case manager's goals may be in conflict, as the therapist recognizes small changes, encourages continued progress, and advocates for the parent. The therapist must convey faith in the client's capacity for change, whereas the case manager's primary goal is to assure the safety and permanency of the child, with a focus on staying within the time constraints set down by ASFA. The worker may or may not have faith that the parent can make the needed changes within the allotted time frame. The therapist for the child builds a therapeutic alliance with the child using play therapy, to help the child make a satisfactory adjustment to foster care, parent visitation, and developing a relationship with the foster parent. Smooth coordination between programs requires supervisors in each department to recognize the boundaries and differing as well as mutual goals between the case managers, parent therapist and child therapist (Halton, 1994).

An advantage of internal agency coordination between DCFS-contracted programs and counseling programs is that capitation agreements and sliding scale fees allow for continued service delivery after court determination of placement. This additional time may help parents adjust to the possibility of their child being adopted, using the ongoing therapeutic relationship to facilitate a continued growth process. A disadvantage of contracting with therapists to provide services outside the agency is that less coordination between professionals may occur. Contract workers rely on pay-

ment from DCFS programs and may be influenced by the case management team's desire for a unified case perspective. Also, when a decision to terminate parental rights or to place the child permanently occurs, treatment by outside subcontractors may be terminated on the basis of financial objectives rather than on the basis of client need.

Case Background

"What if serial placements for children were identified as the atrocities they are?" (James, 1994, p. 268).

Presenting Problem - Sally is a thirty-two year old, Caucasian, single mother of one child, placed in foster care. The DCFS case manager referred her to therapy. Sally is five feet two inches tall and weighs about ninety-eight pounds. Her slender face, neck, and petite size give the impression that she is much younger. Sally has shoulder length, naturally curly, light brown hair. She does not wear makeup. Her simple, casual clothes are neat. In her first sessions, Sally sat hunched over and resembled a frightened child. She had few words to describe her situation and needed to be encouraged to share her story. There was an inner emptiness that echoed in her descriptions. She was disconnected from family, friends and life. This disconnection paralleled the early stages of the therapeutic relationship. Sally was tearful when discussing her daughter Trinity's foster care placement. She compared her child's placement with her own foster care placement and her own feelings of being hurt and humiliated, when the family chose to adopt her brother but not her.

The allegations that brought Sally and Trinity to the attention of child protective services indicated child neglect. At the time of the investigation, Sally had been residing at a homeless shelter, had not slept for five days, and presented as incoherent and confused. A physical altercation with another resident resulted in the police escorting Sally to a local psychiatric hospital. The description of out-of-control behavior seemed difficult to reconcile with the small, frightened young woman who appeared in my office. The hospital drug screen indicated no illicit drugs in her system. The psychiatric evaluation revealed no need for medication or hospitalization. Sally was discharged to another homeless shelter. In the four years that her case remained in the DCFS system, Sally underwent psychological testing and two additional psychiatric evaluations.

However, she was never hospitalized or medicated, nor did she indicate suicidal ideation at any time.

Sally's Background and History - Sally is the youngest in a sib-ship of five. She has two sisters and two brothers. When Sally was eight months old, she and her siblings were placed in foster care after having been abandoned in an apartment for several days. Sally had been found lying in her crib in feces, dehydrated and starving. She was not expected to live. While the older children had cared for each other, Sally's inability to communicate verbally and her restricted mobility in the crib left her vulnerable and dependent on her sibling's ability to notice and respond to her needs.

Sally and her siblings entered the foster care system prior to the 1980 Adoption Assistance and Child Welfare Act (P.L. 96-272). Prior to the implementation of this act, child welfare policy emphasized the prosecution of neglectful parents and establishing child safety. Permanency would not become the focus of policy for nearly twenty years (Gendell, 2001).

As an infant Sally was placed in a foster home with one of her brothers. The other three siblings were placed in other homes. At the age of four, her foster parents agreed to adopt her brother, but not Sally. These early years were marked by neglect, abandonment, unstable foster placements, lack of secure attachments and the loss of a hoped-for adoption. Sally was free for adoption but did not have an adoptive home. This set the stage for a life-long pattern of repeated moves, each time opening the wounds of abandonment. Sally longed for safety, security, nurturance and love. She was moved to a foster home, where she remained until the age of thirteen. Her foster parents had three natural children, ages ten, eight and five. A foster brother, Ken, three years older than Sally, was also placed in the home. Sally and Ken remain in contact as adults. Sally was raised Catholic and attended Catholic grade schools. She describes her foster mother as strict, cold and unaffectionate. Sally recalls being criticized and spanked by her foster mother. She believes her foster mother was alcoholic. Sally describes her foster father as less strict, dominated by his alcoholic wife, and ineffective at protecting the children. The foster parents' oldest daughter was delegated the care of the youngest children. Sally remembers being teased, nearly drowned, thrown across the room, and threatened by the foster parents' natural children. She recalls that she was fed, clothed and educated, but not loved.

The foster parents separated and divorced when Sally was twelve. Ken began acting out and was placed

in a home with his biological uncle. Sally missed Ken and began running away, drinking and having school problems. Sally was placed in an alternate foster home for six months. She cried daily and was unable to connect with the new foster parents. She stated, "I did not feel that I belonged." Another foster placement of three months ended when Sally ran away again.

Sally lived in a group home from the age of fourteen to twenty-one. She developed a close relationship with the mother in the group home. She was allowed to maintain contact with her former foster brother, Ken. Sally's first boy friend, Henry, was a resident in another group home cottage. Their five-year relationship, between the ages of fifteen and twenty, was volatile. Sally gave birth to their son at the age of sixteen and placed this child for adoption. Sally ended the relationship with Henry when she suspected that he was being unfaithful to her. She graduated from high school in the group home and attended two years of junior college. The group home provided a solid, secure base from which she was able to slowly transition to independent living. Sally saw her group home mother as a supportive, loving and available woman who provided acceptance, support, security and direction. She kept in touch with the group home mother until her death.

Sally initially obtained an apartment with friends to share expenses. She held over thirty jobs in twelve years, including office clerk, word processing, shipping and receiving, factory work, food service, waitress, shampoo girl and gas station attendant. Sally also had over twenty residences in twelve years. She shared apartments with friends, lived in hotels, shelters, or rented rooms and even lived on the street. At the time she entered treatment Sally had had nine relationships with men. These relationships all involved patterns of emotional or physical abuse and drug use. Despite the benefits of the solid base at the group home, Sally failed to finish college, obtain stable employment, find creative activities or develop intimate relationships.

Reunion with Family of Origin - Sally's foster brother, Ken, has been a supportive and stabilizing person in her adult life. Ken provided Sally with a place to live when she was homeless, and financial support when she was out of work. He has also been a source of emotional support through the DCFS procedures. Ken accompanies Sally to court appearances and has had a calming effect on her.

Sally learned that her biological mother died when she was seven years old. She believes the death was

related to alcohol, drugs and pneumonia. At the age of nine she met her biological father and her oldest sister, who maintained inconsistent contact with her throughout her adolescence. When Sally was twenty-three, her sister Ellie reunited the siblings with the help of an adoptive service program. Alex was the only sibling who had been adopted, but his adoptive family discouraged contact with his biological siblings. Alex had a stable life and was a car mechanic. Tommy was raised in a foster home with nine siblings. He never married. He attended a modeling school and worked in a nursing home. Sally believes her brother Tommy is gay. Ellie had run away from her foster home at the age of sixteen after having been sexually abused by her foster father. She has a history of prostitution and is now a "born again" Christian and recovering drug addict. Brenda was removed from her foster home at the age of eleven, following the sexual abuse of older siblings in the home. Brenda was raised in an orphanage. Brenda currently lives with a cocaine dealer. Brenda and Sally have a conflictual relationship in which they alternately blame, criticize and save each other from their respective crises. Their biological father is a dry alcoholic, residing in a nursing home. He has been treated for cancer and arteriosclerosis. His larynx was removed as part of the cancer treatment.

A Question to Ponder

How does the state "legally" terminate family bonds? Most individuals remain emotionally connected to the family of origin, even in cases where there has been longstanding separation. In their efforts to find each other and remain connected as adults, these siblings affirm the depth of the bond that existed in that small apartment years ago, where all were abandoned, yet they struggled to maintain a life in common.

Treatment Process

"Can we hang in there for as long as it takes?"

(James, 1994, p.267)

Sally's case entered the DCFS system in May 1996, 18 months prior to the passage of the Adoption and Safe Families Act. The adjudicatory hearing occurred approximately four months after Trinity was taken into temporary custody. Sally, like many parents facing allegations of neglect, believed the charges were unfounded and that Trinity would be returned to her at the hearing. Sally did not initially follow the recommendations and referral by her case manager to attend therapy. She made her

initial appointments just prior to the trial, hoping that would make a positive impression in court. It was not until the judge instructed Sally to cooperate with the service plan recommendations that she began to acknowledge the evidence pointing to neglect. Several months of potential therapeutic progress had been lost due to her denial and disbelief that the allegations would be substantiated.

The treatment process included a variety of services, beginning with outpatient therapy and building a relationship that encouraged her acceptance of an inpatient addiction program. The therapist had to strike a delicate balance between being empathic and helping Sally recognize the need to make a decision and commitment to an alcohol/drug-free life. Since Sally had lived much of her life in the shadow of crises, she had a very high tolerance for self-destructive behavior. Just as she did not believe that she had neglected Trinity, she also did not believe she had an addiction. Furthermore, she did not readily trust others or have faith in the future. This crisis was not enough to motivate her desire for treatment. Sally needed someone to believe in her so that she could have hope. Building a relationship was the first step in helping Sally develop faith in herself and then in the treatment process.

The engagement process involved creating a holding environment in which empathic listening and non-judgmental acceptance allowed Sally to share her story and become acquainted with herself as the narrative of her life unfolded. A supportive presence was crucial to the development of a trusting relationship, as Sally shared her disbelief that she was seen as a neglectful mother. It was important to validate the substantial difference that she noted between the neglect Sally experienced as a child and her current neglect of Trinity, while still recognizing both situations as neglect. Sally remembered her own experience of foster care and the feeling of betrayal when her biological parents did not fight for her return. It was this longing to have been reunited with her biological parents that emerged as the motivating factor for Sally to do all that she could to regain custody of her own daughter. In an honest, consistent, and firm manner the therapist began to relay the importance of following all the criteria in the DCFS service plan. Education on addictions was balanced with empathic reflection on the need to obtain gainful employment to support an apartment, day care, food and clothing. Parallel to Sally's addiction was

the addiction of her biological mother and her foster mother.

The only way that her addiction treatment would succeed was if Sally desired a change for herself. She was able to reflect on what she would have wanted as a child and what Trinity now needed. Ultimately, Sally's desire to recover became more important than what Trinity needed. As Sally experienced the therapist's belief in her, she eventually began to believe in herself and in her future. After four months of outpatient therapy, Sally accepted a referral to an inpatient addiction program. She was encouraged to make the phone call for the initial intake from the therapist's office. Unfortunately, there was a four-week waiting list. Sally was to call the program several times per week to be informed of her status on the wait list.

One year after Trinity was removed, Sally completed a twenty-one-day inpatient program. Sally consistently attended the weekly aftercare program for an additional six months, Alcoholics Anonymous (90 meetings in 90 days), and eighteen weeks of parent education while attending outpatient therapy. Sally thrived in the community provided by the program, although she had a more difficult time maintaining stable employment, a stable living arrangement, and she continued to struggle with outbursts of anger.

Sally's normally passive nature vacillated with angry outbursts and lack of impulse control. Her feelings of abandonment from childhood were re-experienced within the context of her daughter's placement. This inner rage would emerge when Sally became frustrated or felt dependent upon others. Her rage was initially focused on an inexperienced case manager, who had trouble maintaining professional boundaries. Sally had three different case managers over the four years due to staff turnover. She had more success with the male worker who took her case over, and found that she felt more emotionally stable while working with him. This may have been because the men in her early life, her brother Ken and her foster father, had been more benign, allowing her to form a less conflicted transference bond. Sally experienced a sense of loss and abandonment when this male case manager left the agency to return to school. She developed a working relationship with the third case manager after several months, but it was not without volatile outbursts.

Sally had more success regulating her intense anger within the therapeutic relationship. Listening to the outbursts, providing a calm atmosphere and setting appropriate limits helped Sally modulate her emotions. Sally had two significant decompensa-

tions following relatively stable periods of consistent employment, independent living and emotional stability. These decompensations, and the therapeutic process around them, will be examined to illustrate how a change in object relationships resulted in a new integration of self.

Two years after Trinity had been removed, Sally had one year of sobriety, was employed as a shampoo girl and receptionist in a unisex hair salon, and had rented a room in a friend's home. She was dating the owner of the hair salon, whom she had met in the AA program. Initially, the relationship had the effect of enhancing Sally's ability to be socially congenial. She enjoyed the attention, dinners, motorcycling and movies. Conflicts later developed over his relapse and abusive remarks. Sally began taking his Valium. Her unexplained missed therapy appointments and missed visitations with her daughter, both uncharacteristic, prompted the case manager to order a series of random drug screens. Sally then had a volatile argument with her landlord, which resulted in her being asked to leave. She stayed in a hotel, lost her job and lost the relationship on which she had become dependent. She returned to drinking when the Valium was no longer available. Sally began calling the agency collect, leaving messages of desperation on the therapist's voice mail, saying that she had no money for food and was losing weight. The messages were scattered and confused. "Why are you doing this to me?" "You will never give me my daughter back." "I am starving." "My mother left me to die. I don't know why she did that." The therapist encouraged Sally to obtain a meal at a soup kitchen or food pantry, attend an AA meeting, and then call back. Searles states when the:

" . . . patient's ego functioning is at a symbiotic, pre-individuation level . . . very frequently it is the analyst who, through relatively ready access to his own unconscious experiences, is first able to feel in awareness, and conceptualize and verbally articulate, the patient's still-unconscious conflicts. Though these conflicts inherently 'belong' to the patient, they can come to be known to and integrated by him only through his identification with the analyst into whom they have been able to flow, as it were, through the liquidly symbiotic transference" (1979, p. 311).

Sally's early experience of being left in a crib to die was now being relived, emotionally and symbolically, in the therapeutic relationship. She had come close to attaining the stability she needed to have her daughter returned. Her relapse and loss of housing, job, money and friends expressed an inner fear of the loss of the most important goal, to have her child returned. It also re-enacted the significant abandonment by her mother, who left her "to die." Sally's greatest fear was to be abandoned by the agency through the loss of her daughter. The agency simultaneously provided nurturance and symbolized punishment and loss.

The therapeutic process focused on these feelings of past abandonment by her mother and fears of her current situation resulting in a failure to meet the goal to have her child returned. Sally recognized the need to return to the addiction program to regain stability and begin again. Sally reentered the intensive outpatient program for addictions, and made a firmer commitment to a twelve-step recovery program. She obtained employment, found a small efficiency apartment and remained stable for one year. The case manager continued to work with Sally on returning Trinity to her.

Three and one half years after Trinity had been removed, Sally's apartment was robbed by neighborhood teens that she had allowed to use her phone. Sally filed a police report, but felt the police were suspicious of her involvement with these "gang members." The youths began harassing her and seeking shelter in her apartment. Sally was terrified and sought further police support. The police attempted to elicit Sally's cooperation in a staged arrest of the gang members.

Sally was terrified. She began to decompensate again, with outbursts of anger, nightmares, intense fear and paranoid ideations that had some basis in real losses. She was seen in an emergency room following a physical altercation with gang members who hit her in the chest. She reported inconsistent and incoherent stories about the incident. She refused to return to her home out of fear. Unfortunately, the failure of the police to protect her adequately from retaliation of the gang members tapped into her early experiences of having been abused, abandoned, and not protected; and, predictably, she decompensated further.

Four days later, she arrived at the agency unkempt and hungry. In an angry outburst, she stated, "You don't know what it is like to be hungry. You don't know what it is like to be left for dead. My mother

didn't want me. Why are you doing this to me?" It was as if she were back in the crib, abandoned and starving. "One characteristic of the transference at this stage is the way in which we must allow the patient's past to be the present. . . The present goes back into the past, and is the past. . . There is now . . . an opportunity for the development of an ego, for its integration . . . and also for its repudiations of an external environment with the initiation of a relatedness to objects" (Winnicott, 1992, p. 297-298).

The therapist acknowledged to Sally that it was true that she had never experienced the helplessness, fear and deprivation of being abandoned in a crib. But rather than talking about Sally's very real experience of early starvation when she was hungry in that moment, the therapist provided a sandwich, soup and milk, as well as food vouchers. The concrete experience of being fed, while experiencing emotional nurturance through recognition of past and current deprivation, allowed for a new relationship experience. Winnicott views himself, in the therapy process, as having "some of the characteristics of a transitional phenomenon," by being "a subjective object for the patient" (1965, p. 166). He goes on to state that the therapist "displaces environmental influences that are pathological, and we gain insight of the kind that enables us to know when we have become modern representatives of the parent figures of the patient's childhood and infancy" (Ibid, p. 168).

The next stage of the therapeutic process represented a productive engagement by Sally to symbolically resolve past traumas through the therapeutic relationship. "When the development of the transitional process is understood and fostered in the facilitating clinical partnership, the client moves toward a deepened capacity for reflective consideration of the complexity of his or her situation . . . through the vehicle of the transitional process the client transports aspects of the supportive clinical holding environment inside" (Applegate & Bonovitz, 1995, p. 177).

Sally described a nightmare of being in a church and asking for help and no one would help her. The church bells rang. The congregation assembled and sang. The words of Scripture were read. Sally remained afraid, alone, screaming for help, with no response from anyone in the congregation. In the therapeutic relationship, this dream was related to the current reality of seeing that the police would not protect her. The dream was extended to feelings of not being protected and responded to by the foster family and not being "chosen" for adoption. Sally then related the dream to being abandoned in a crib,

crying for help and left to die. Sally talked of her helplessness in all these situations. It was acknowledged that she was a child in need of protection and that the child within continued to cry for help and protection. Sally referred to the therapeutic relationship as responding concretely and symbolically to her needs. The therapeutic processes began to focus on how Sally, as an adult, might begin to soothe, nurture and protect her child within.

Simultaneously, as the therapeutic process was moving Sally toward a new integration of self, the DCFS process began moving toward termination of parental rights. Sally's case had been in the system for over four years. The Adoption and Safe Families Act allowed for a phase-in process for families in the system prior to 1997. ASFA also provided financial incentives to agencies that exceeded the average number of adoptions from prior fiscal years (P.L. 105-89). The progress expected in Sally's case had not been achieved in the time allowed. The current therapeutic progress, that could not be evaluated in concrete terms, promised to change Sally's life and her future relationships forever, although this could not be guaranteed or measured.

The case manager informed Sally that adequate progress had not been made and that termination of parental rights would be recommended at the next permanency hearing. Sally responded with anger, disbelief and tears as her child's permanency goal changed to termination of parental rights and adoption. The next several months involved working with Sally's grief. She expressed a sense of failure at not being able to sufficiently stabilize her living arrangements and job in order to prepare for Trinity's return. Sally was afraid that Trinity would be hurt and disappointed. She processed her sadness that her own parents had not secured her return home. Sally recognized that Trinity was happy, stable, well taken care of, and loved, and that she was thriving in her current foster/adoptive home. Sally processed her own desire to have been adopted by her foster parents. She recognized how difficult it would be for Trinity to leave her foster mother and the opportunity for a stable, loving home. Sally was able to develop a "capacity for concern" (Winnicott, 1965) and defer her own needs to those of her daughter.

The option of an open adoption was discussed with Sally. She was given the opportunity to sign consents for her daughter's adoption rather than having her parental rights terminated through a trial by the state. The symbolic act of signing over her parental rights created a fear that Trinity would feel abandoned, and

rekindled memories of the baby boy she surrendered for adoption. As Sally processed her continual flow of grief and remembrances, she found gratitude for the open adoption, which allowed her continued visitation. She processed her pain of not knowing her son or his fate. Sally, in her wisdom, gave Trinity a chance to grow up in a loving home, while maintaining a connection to her, and she unconsciously healed her own longing for an adoptive home.

In January of 2001 some sessions were held jointly with Sally, Trinity, the therapist and the adoptive mother. Guidelines were discussed for visitation, phone calls, holidays and for an adjustment to the new arrangements. The successful adoption arrangements opened the door for a new level of individuation and a new level of cohesive self-formation for Sally. Sally's sensitive reflection on her own vulnerability shows the compassion and durability of the human spirit and the potential of a treatment relationship to heal severe trauma.

The termination agreement left the door open for Sally to return to the agency for individual therapy if needed. It also meant that either Sally or the adoptive mother could request sessions with each other or with Trinity, and that these sessions would be provided by the child therapist. Three years after the adoption, Sally continues in the same job and the same living arrangements and visits Trinity regularly. Sally has been employed part time at a convenience mart for four years. She lives with her fiancé. The couple gave birth to a baby girl in January of 2003. Sally has had occasional joint sessions with Trinity's therapist, one of which was to introduce her fiancée to Trinity and later to ease the transition of the birth of the baby. Sally has been included by the adoptive mother in celebrations of special occasions for Trinity. Sally has also included Trinity's adoptive mother in some festivities she has planned.

Theoretical Understanding of Sally's History

Sally's psychosocial well being had been compromised by early trauma, environmental deprivation and developmental vulnerabilities. An infant's relationship with the primary caregiver, through being held, fed and comforted, gives organization to the child's world and influences current and future development (Stern, 1985). The child's relationship to that caregiver is the major contributor to the child's well being. These experiences affect the child's sense of security, expectations of others and future social relationships. In the early building of the therapeutic relationship, Sally found it difficult to articulate and

reflect upon her inner experience. Current stressful circumstances rekindled feelings of helplessness and vulnerability from her traumatic past. The therapeutic relationship helped Sally give voice to these feelings. Within the context of the relationship, Sally experienced the therapist's ability to tolerate and remain present to the rage and sadness associated with her early trauma. The experience in the therapeutic encounter mobilized Sally's innate tendency toward self-reparation.

Implications for Child Welfare Policy

"What if the world's leaders committed to a policy of cherishing all the world's children and their families? And what would happen if we, as a society, recognized that our future lies in the dance we dance with these children who belong to us all?" (James, 1994, p. 268).

What does success in the child welfare system look like? This single case study portrays an extraordinary therapeutic process within two generations of child neglect. It presents a close-up view of what can happen when policies such as those created by the Adoption and Safe Families Act create tight time frames for a parent's recovery. ASFA is child-centered, but not family centered. "ASFA is about outcomes. Specifically, it is about producing better outcomes for children than the last system provided" (Gendell, 2001, p. 36). This successful therapeutic process did not result in a successful reunification. The barrier to reunification for this mother and child was in some measure a product of the time frames set down by ASFA. The therapeutic treatment process that unfolds within the context of a client/therapist relationship does not respond according to a federally mandated time frame. Severe psychological disorders and addictions cannot be thoroughly and effectively treated in the 18-month time frames that ASFA allots (Gendell, 2001; Smith, 2002). Predicting a successful treatment outcome for this client would not have been easily accomplished. Predicting the effect of the stress for this mother, had the child been returned, is also not easily done. Is it possible to see this parent's individual recovery as a greater success than if the mother/child pair had been reunified? A successful reunification would have required more time than ASFA would allow. During that period Trinity may have been traumatized, and Sally may also have been retraumatized vicariously as she experienced her beloved Trinity's unmet need for a stable adoptive family.

This case study challenges society to examine some potent questions. Does society have an obligation to the current DCFS mothers who were themselves victims of the system? How long can the system "hang in there" when progress is slow? How does one know when the potential for significant change exists? Recognizing that treatment for psychological disorders and addictions cannot be successfully completed in the time frames that ASFA has established, how does one discern when it makes sense to expand those time frames and when it is better to hold firm to the original time frames?

If researchers conceptualize success in treating abusive and negligent parents based on successful family reunification, they will clearly not be able to capture the effective service that is represented by cases such as this. If policymakers and program managers uphold overly narrow concepts of effectiveness (e.g., the number of successful family reunifications), they may deprive parents like Sally of needed services, and perpetuate the cycle of child abuse and neglect. The only known way to remediate the cycle of abuse and neglect in parents who have been traumatized is through a sustained process of intensive therapeutic care that heals the trauma and its aftermath.

We need to strike a balance between reunification of the family and honoring children's needs for permanency. We must also come to discern which parents have the potential and motivation to pursue their therapeutic goals. We need case managers who are trained in theories of psychotherapy so that they can identify and respond therapeutically to the needs of the child, the parent and the system. We need therapists who are able to integrate attachment and object relations theories and implement them in the treatment process. We need objective and open case coordination between DCFS, agency staff, and juvenile court staff.

"The spirit of ASFA is expediting permanency" (Gendel, 2001, p.25). In the process of expediting permanency, the system will hopefully avoid the atrocities of multiple failed placements that Sally experienced. But it is important that implementing the ASFA does not cause us to overlook the commitment to people like Sally, who have been so badly traumatized in their families of origin and in the child welfare system. These parents deserve an opportunity for psychological healing that they can clearly use for the betterment of themselves, their children, and society.

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