A. Mission Statement
B. Forward
C. Note to Facilitators
D. Using the Curriculum
E. Role of the RDC
F. Planning and Task List
G. Bibliography

Session I: Green Introduction and Families in Distress 3 Hours

Trainer Preparation
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Introduction to Session
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  1.1 Topic and Instructor Introductions
  1.2 Participant Introductions
  1.3 Ground Rules
  1.4 Workshop Premise, Goals, and Objectives
  1.5 Preview Workshop Sessions 1-6
Unit 2 Families in Distress
  2.1 Trauma Definition
  2.2 Trauma Individual/Community
  2.3 Trauma Principles
  2.4 Case Study: Marie and Florence
Closure to Session
Trauma: Individual experience with collective implications
Participant Handouts
Overheads

Session II: Yellow Substance Abuse 3 Hours

Trainer Preparation
Purpose, Objectives, and Outline
Introduction to Session
Unit 1: Substance Abuse Jeopardy
Unit 2: Overview of Substance Abuse and Definitions
Unit 3: Family Sculpture or Interactive Theater
Unit 4: Video
Unit 5: Treatment Options
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Thoughts on the Strengths Perspective
Participant Handouts
Overheads
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Session III: Purple Domestic Violence 3 Hours

Trainer Preparation
Purpose, Objectives and Outline
Introduction to Session
Unit 1: Self Assessment
Unit 2: Power and Control Wheel
Unit 3: Interactive Exercise
Unit 4: Risk Analysis
Unit 5: Domestic Violence and Children
Unit 6: Domestic Violence Services
Closure to Session
Battered Woman’s Risk Analysis Chart
Effects of Domestic Violence on Children
Participant Handouts
Overheads

Session IV: Pink Child Abuse/Neglect and Reporting Requirements 3 Hours

Trainer Preparation
Purpose, Objectives, and Outline
Introduction to Session
Unit 1: Definitions of Child Abuse and Neglect
Unit 2: Abuse Continuum and Indicators of Abuse
Unit 3: Reporting Abuse and Working with the Child Welfare System
Unit 4: Child Abuse and Neglect Case Studies
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Overheads

Session V: Blue Mental Health, Family Systems and Similarities/Differences 3 Hours

Trainer Preparation
Purpose, Objectives, and Outline
Session Five Introduction to Session
Unit 1 Mental Health/Mental Illness
   Unit 1.1: Introduction – Why Talk About Mental Health and Mental Illness?
   Unit 1.2: Brainstorm Exercise and Discussion
   Unit 1.3: ‘What is Normal?’ Exercise and Discussion
   Unit 1.4: Impact on Individuals and Families
   Unit 1.5: Connections, Resources and Barriers
Table of Contents (Continued)

Session V: Blue Mental Health, Family Systems and Similarities/Differences (Continued)

- Unit 2 Family Systems
  - Unit 2.1: Family Systems Overview
  - Unit 2.2: Family Systems Exercises and Discussion
- Unit 3: Case Study
- Closure to Session
- Historical Timeline
- Family Systems Theory, Discussion & Summary
- Participant Handouts
- Overheads

Session VI: Cherry Abuse Affected Behaviors, Feelings, & Perceptions 3 Hours

- Trainer Preparation
- Purpose, Objectives, and Outline
- Introduction to Session
- Unit 1: Abuse Affected Behaviors, Feelings, Perceptions – Vignettes
- Unit 2: Case Study: Tina, Theresa, and Terrence
- Unit 3: Participant Action Planning, Workshop Evaluation, and Closure
- Participant Handouts
- Overheads
CROSS DISCIPLINARY TRAINING
MISSION STATEMENT

The Cross Disciplinary Training Project

This training program, which is a collaborative effort among social service professionals in the domestic violence, child abuse and neglect, substance abuse, and early childhood education, care and development, implements an interdisciplinary approach to the training of professionals who work with or on behalf of children and families in order to provide a holistic, integrated delivery system for family support and preservation services. Special emphasis is placed on increasing participants’ understanding and awareness of the effects of these issues on children and their families. The Cross Disciplinary Training Project builds bridges between systems using a two-tiered approach: three-day ‘Training for Trainers’, and local training delivery by teams of trainers in the communities in which the trainers live and work. This project strives to promote collaboration which forms a basis for developing future community-based, interdisciplinary teamwork among social service providers at both the state and community levels.
Forward

The Cross Disciplinary Training Project and the curriculum ‘Caring For The Abuse Affected Child and Family’ is the result of a state-wide collaboration among social service professionals in the areas of domestic abuse/violence, substance abuse, child welfare, and early childhood education, care and development.

The goals of the Project are to:

- deliver a client-sensitive, interactive and integrated training approach that capitalizes on the expertise and experience of both the participants and the facilitator-instructors, and,
- sensitize those who work with children and/or families to the causes, dynamics and results of abuse on the child and family, and,
- promote communication and collaboration among service providers in the hope that it will positively impact professional practice.

The eighteen-hour training provides a unique opportunity for the trainers and participants to routinely collaborate with the expectation that the workshop experience will set the stage for more intense and frequent collaboration in the field through referrals, consultation and other forms of cooperative efforts.
Note to Facilitators

Your Role
You have multiple roles: team member, trainer, instructor, facilitator, and consultant. The workshop was designed so that you can take advantage of your expertise and the way you generally share your knowledge - consultation, advice-giving, in response to a question, or during a referral. **We assume and expect you will acknowledge and use the experience, expertise, and insights of your target audience, who will have a range and wealth of experience of their own to share if you allow it.** This is why there are several opportunities for discussion, problem-solving, and sharing throughout the training. The purpose of the role plays, case studies, and other small group exercises is to facilitate discussion, analysis, and application of relevant knowledge and skills, especially in the context of the participants’ needs and experience. The interactive approach also minimizes lecturing - a skill that only a few of us are able to use to captivate an audience.

Adult Education
Adult education means arranging experiences that are relevant, immediate, and that use skills and experience of the learners. Ideally, everyone will learn, including the instructors.

Implicit in the adult education approach is the notion that people have complementary sets of knowledge and skills. You will be demonstrating how different sets of expertise and points of view can be combined to produce a greater sense of understanding and insight. Like a system, the assumption in this workshop is that the instructors will represent more than the sum of their unique sets of knowledge and experience. For this reason, it is critical for you to show how people with different backgrounds, points of view, and outlooks can work together as a team to benefit a greater good - in this case, helping participants understand, identify, and do something about the causes, interactions, and results of abuse on the child.

Affects of Abuse
The training is also breaking new ground by identifying some of the similar, and key behavioral outcomes that the child and family manifest as a result of domestic violence, child abuse, and substance abuse.

There’s much that’s new about this training. Feel free to share it with workshop participants. They may be helpful in providing feedback for your continuous improvement, reflective practice, self-awareness, and the improvement of the curriculum itself.
Using the Curriculum

The curriculum is a road map for facilitators in delivering the 18-hour Caring for the Abuse Affected Child and Family training course. Over the years, it has gone through updates and revisions, always with significant input from current Cross Disciplinary Project trainers in each of the disciplines. We appreciate the work of revision committees and individuals in helping Project staff maintain an accurate, state of the art training curriculum.

We ask that you read the entire training manual thoroughly; each section is relevant to all trainers. The entire team is responsible for helping to raise awareness, build knowledge, and encourage examination of beliefs and attitudes across all topic areas presented in each session. Familiarity with the flow of the material creates greater comfort and confidence for presenter and participant alike. Co-trainers are better able to offer input and support when they are knowledgeable about and prepared for the information and activities in each section. Some trainers have chosen to attend and observe training for childcare providers, as a way to become familiar with the structure and flow of training sessions. Call Project staff to find out how to arrange this.

Curriculum Structure

The 18-hour curriculum is designed as six three-hour sessions.

Each session is differentiated according to color: Introduction and Families in Distress (Green), Substance Abuse (Yellow), Domestic Violence (Purple), Child Abuse/Neglect and Reporting Requirements (Pink), Mental Health, Family Systems and Similarities/Differences (Blue), and Abuse Affected Behaviors, Feelings, Perceptions and Action Planning (Cherry).

Units within each session contain all of the activities and information in a particular topic area.

Each three-hour session is separated into three distinct parts: Facilitator’s Guide, Participant Handouts, and Session Overheads.

The Facilitator’s Guide in each session provides a table of contents, trainer preparation guidelines, session overview, and detailed instruction and descriptions of all activities, information, and resources for each unit.

Trainer Preparation pages provide guidance on pre-training tasks for facilitators, including advance reading, materials to gather, and flip charts to prepare.

Session Overview pages provide at-a-glance descriptions of the purpose and objectives of the session, as well as all units and sub-units with estimated times. Please note that actual times for activities will vary according to instructor style and participant group needs. Adjust accordingly as needed.
Using the Curriculum (Continued)

Individual Unit description pages inform you of all overheads and participant handouts for the unit, as well as a suggested order of activities, the step by step guideline for delivery of all information and activities for the unit. Throughout the unit description pages you will see boxes with text inside. These provide additional information for you, the trainer. See the example below:

This is a trainer box. It contains information for facilitators, to enhance your discussions and presentation on the unit topic. It may include examples, expand upon existing information, or offer suggestions.

Please use your own words and examples from practice to round out the basic information provided in the curriculum. A Trainer Notes section at the bottom of each Unit’s description page(s), allows space for you to personalize the curriculum.

The Participant Handouts section exactly matches the handouts for the session in the participant handbooks. These are numbered by handout, rather than by page for easy reference. Participant Handbooks are distributed at the beginning of the first training session, to all registered participants. The Handbook is designed with the same color-coded sections as in the Trainer Curriculum Manual. The Handbook exactly matches, session for session, the Handout section in the Trainer Curriculum Manual.

Session Overheads are numbered by overhead, rather than by page for easy reference. Participants do not have copies of the overheads. Not all trainers choose to use the overheads; some do not have overhead projectors available. If you will not be making overheads, please do prepare the information on flip chart pads in large lettering, with dark markers, easily visible from the back of a room. If you have questions about how to create overhead transparencies from the paper copies we have provided in your curriculum manual, please contact us.

The white sections in the front and back of the curriculum manual contain important information for trainers. Please read each section carefully. Included are: Table of Contents, Mission Statement, Forward, Note to Facilitators, Using the Curriculum, Role of the Resource Development Center When Training Childcare Providers, Planning and Task List, Bibliography, and Evaluation Tools and Session Evaluations.

Quality and consistency are the hallmarks of the Caring for the Abuse Affected Child and Family curriculum. Whether you are new to training or regularly speak and work with groups, this manual provides you with the tools you need to effectively co-facilitate discussions and activities, and to provide vital information in an engaging manner. If you are thinking of using different exercises, activities, or lecture topics please consult with Project staff beforehand.
Using the Curriculum (Continued)

The Cross Disciplinary Training Project staff welcomes your input, feedback, and questions. Please contact us:

Maureen Baker, Manager, Cross Systems Projects (207) 780-5869 mbaker@usm.maine.edu
Jolene Twombly-Wiser, Project Coordinator (207) 780-5864 jtwombly-wiser@usm.maine.edu
Donna Johnson, Administrative Assistant (207) 780-5866 dpjohnson@usm.maine.edu
Muskie School of Public Service
University of Southern Maine
PO Box 9300/15 Baxter Boulevard
Portland, ME 04104
Role of the RDC

Role of the Resource Development Center
When Training Child Care Providers

Planning Tips for a Successful Cross-Disciplinary Training

The planning process is vital to a successful offering of “Caring for the Abuse Affected Child and Family”. Team members can be involved in many ways. The important things to remember are a good training is every team member’s responsibility and there is not one perfect planning process.

Each team has different strengths. Talk to each other and utilize them. The following are some helpful suggestions:

1. At an initial meeting, ask each team member what resources they can contribute to the planning process as well as the actual training. For example, a domestic violence team member may have clerical assistance to do a mailing to potential participants, while a Child Care Resource Development Center member may provide mailing labels and some advertisement functions. This may be challenging for some teams, especially if working with an incomplete team. It is important to acknowledge the challenges and establish clear understanding about who is doing what.

2. It is helpful to get a sense of your audience. A survey that targets a specific audience may be helpful in gathering information regarding convenient times and locations of trainings. Some useful questions include preferred times, days or nights of the week, whether a meal or light snacks are wanted, whether or not individuals have or have not had previous education about the disciplines, and what the training involved (if yes). Be sure to have an idea on what would work for team members regarding times, places, etc. (see sample Planning and Task List)..

3. If possible, plan and convene regular meetings during the planning process. It may be a good idea to designate one member as the “convener,” or person responsible for mailing notices or contacting others. Each member should have a list of all team members phone and fax numbers, email addresses, etc. These meetings can be an important part of team building as well as to the planning process.

4. Establish a comprehensive time line as you consider realistic goals. Consensus is vital. It can take at least four months to plan and offer a training (see example on page 8).

5. Depending on resources, you may need to do some creative planning. Coordination of resources is key. Are you soliciting food or space? These are as important as the actual content of the curriculum. Utilize members for tasks based on their skills and resources.

6. Build in 10-15 minutes following each training session for the training team debriefing process.
Role of the RDC (Continued)

7. After the training has been offered, you may wish to plan a wrap-up meeting to discuss the training, how it could have been improved, what did and didn’t work, etc. Also ask how the planning process went and what did or didn’t work for members. Lastly, congratulate and thank each other for participating and being team members! Some teams continue to meet in the “off time” to monitor future opportunities for training, to keep in touch regarding updates in their disciplines, and because the team has become important to maintain.

Opening Session I

The Child Care Resource Development Center Representative:

- greets participants
- introduces yourself, introduces trainers and welcomes participants
- takes care of ‘housekeeping’ issues (bathroom location, break schedule, etc.),
- reviews the training schedule
- reminds participants that they must complete the training to receive the certificate
- explains briefly what will be covered and any ‘historical’ thoughts about past trainings, if relevant
- makes some opening remarks to set the tone of the training
- reviews the purpose of the training: To assist child care providers in:
  - the identification of the abuse affected child
  - how to make appropriate referrals for children and adult victims of family violence, for substance abuse services, to child protective services
  - how to access local community information and referral sources.

**Emphasize:** that the training is not designed to make participants into advocates, counselors or child welfare caseworkers.

**Emphasize:** some of the information in the training may raise powerful feelings and thoughts and emotions that are difficult to handle. Participants can consult with trainers at break or leave the room if they feel they need to….take care of themselves if they feel uneasy or overwhelmed.

**Emphasize:** that although they may not be aware of it, they all have abuse affected children in their child care programs. Becoming aware of their presence, learning how to work effectively with diverse families and learning about resources available to them and the families is a first step in making a real difference in the lives of these ‘at-risk’ children. Share a story of a childcare provider who had taken the training and used the information to make a difference in the life of a child/family.

**Emphasize:** that confidential information might be shared; that the information needs to stay in the room.

**Emphasize:** they are often the first line of defense against child abuse in its many forms.
## Planning and Task List for “Caring for the Abuse Affected Child and Family”

<table>
<thead>
<tr>
<th>4 Months before Training:</th>
<th>Role and Task Assignments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact and meet with Team Members:</td>
<td>Coordinate Team Meetings:</td>
</tr>
<tr>
<td>❑ Team building</td>
<td>• notices to Team</td>
</tr>
<tr>
<td>❑ Discuss roles of Team Members</td>
<td>• sets up space</td>
</tr>
<tr>
<td>❑ Discuss training date options</td>
<td>• recording</td>
</tr>
<tr>
<td>❑ Discuss location and space options</td>
<td>• facilitates or leads meetings</td>
</tr>
<tr>
<td>❑ Will food be served?</td>
<td></td>
</tr>
<tr>
<td>❑ Discuss advertising</td>
<td>Logistics:</td>
</tr>
<tr>
<td>❑ Will fees be charged?</td>
<td>• advertising tasks</td>
</tr>
<tr>
<td>❑ Contact Cross Disciplinary Training Project staff to order materials and to initiate contracts with RDC and CPS trainer</td>
<td>• publicity tasks</td>
</tr>
<tr>
<td></td>
<td>• space arrangements</td>
</tr>
<tr>
<td></td>
<td>• order materials</td>
</tr>
<tr>
<td></td>
<td>• registration</td>
</tr>
<tr>
<td></td>
<td>• contact point for information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3 Months before Training:</th>
<th>Role and Task Assignments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue Team meetings:</td>
<td>Coordinate Team Meetings:</td>
</tr>
<tr>
<td>❑ Updating</td>
<td>• notices to Team Members</td>
</tr>
<tr>
<td>❑ Team building</td>
<td>• sets up space</td>
</tr>
<tr>
<td>❑ Review curriculum and “discipline updates”</td>
<td>• recording</td>
</tr>
<tr>
<td>❑ Discuss coordination of roles during training</td>
<td>• facilitates or leads meetings</td>
</tr>
<tr>
<td>❑ Confirm location, space, and dates</td>
<td>Logistics:</td>
</tr>
<tr>
<td>❑ Begin food planning and arrangements (if appropriate)</td>
<td>• writes advertising copy</td>
</tr>
<tr>
<td>❑ Contact Cross Disciplinary Training Project staff with confirmed dates</td>
<td>• contacts to confirm space</td>
</tr>
<tr>
<td></td>
<td>• contacts to confirm dates</td>
</tr>
<tr>
<td></td>
<td>• food planning and solicitation</td>
</tr>
<tr>
<td></td>
<td>• initial recruitment activities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2 Months before Training:</th>
<th>Role and Task Assignments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue Team meetings:</td>
<td>Coordinate Team Meetings:</td>
</tr>
<tr>
<td>❑ Updating</td>
<td>• notices to Team</td>
</tr>
<tr>
<td>❑ Team building</td>
<td>• sets up space</td>
</tr>
<tr>
<td>❑ Continue curriculum review</td>
<td>• recording</td>
</tr>
<tr>
<td>❑ Continue discussion of roles during training</td>
<td>• facilitates or leads meetings</td>
</tr>
<tr>
<td>❑ Begin advertising</td>
<td>Logistics:</td>
</tr>
<tr>
<td>❑ Begin registration</td>
<td>• contact newspapers, add to training bulletins, other means of advertising</td>
</tr>
<tr>
<td>❑ Continue recruitment activities</td>
<td>• perform registration functions</td>
</tr>
</tbody>
</table>
## Planning and Task List for “Caring for the Abuse Affected Child and Family”

<table>
<thead>
<tr>
<th>1 Month before Training:</th>
<th>Role and Task Assignments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue Team meetings</td>
<td>Coordinate team Meetings:</td>
</tr>
<tr>
<td>Updating</td>
<td>• notices to Team</td>
</tr>
<tr>
<td>Team building</td>
<td>• sets up space</td>
</tr>
<tr>
<td>Continue curriculum review</td>
<td>• recording</td>
</tr>
<tr>
<td>Continue discussion of roles during and after training</td>
<td>• facilitates or leads meetings</td>
</tr>
<tr>
<td>Continue advertising</td>
<td>Logistics:</td>
</tr>
<tr>
<td>Continue recruitment activities</td>
<td>• perform registration functions</td>
</tr>
<tr>
<td>Continue registration</td>
<td>• re-confirm training site</td>
</tr>
<tr>
<td>Collect resources from Team Members and community</td>
<td>• re-confirm dates and times of trainings</td>
</tr>
<tr>
<td>Arrange to obtain materials from Muskie</td>
<td></td>
</tr>
</tbody>
</table>

### During Training:
- Check in and processing time with Team Members
- Responsible for storing resources and materials between sessions

### Role and Task Assignments:
- greeting participants
- time keeper
- attendance and sign in sheets
- session evaluations
- CEU paperwork
- coordinate food set up and clean up
- ground rules and introductions
- session facilitator
- scanning participants
- session closure activities

### Post Training:
- Final team meeting to process training, celebrate, and wrap-up
- Organizing all paperwork to return to Cross Disciplinary Training Project staff
- Billing if applicable
- Thank-you notes if applicable

### Role and Task Assignments:
- coordinate Team Meetings:
- notices to Team
- sets up space
- recording
- facilitates or leads meetings
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# Session One
Welcome and Introductions; Families in Distress

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- Overheads
Trainer Preparation

For Introduction to Session:

- Prepare a sheet of flip chart paper with a cheerful welcome message to participants as they are entering the room.

- Team should plan to arrive in plenty of time to prepare the room and all materials before participants begin arriving.

- Read “Note to Facilitators” located in the Introduction section of the curriculum.

- Read “Role of the Resource Development Center When Training Child Care Providers” located in the Introduction section of the curriculum (Training Coordinator and/or Education Specialist).

- Read Evaluation Tools: Instructions for Administration of the Pre-Training Questionnaires located at the back of the curriculum.

- Bring all necessary materials including easels, flip chart paper, markers, overhead projector, screen, participant handbooks, pre-training questionnaires, evaluations, name tags, attendance sheets, and snacks (RDC team member or other designated team members)

For Unit 1:

1.2 Topic and Instructor Introductions

- Team should discuss how all facilitators will model the types of professional behaviors emphasized throughout the curriculum – i.e., collaborating, cooperating, respectfully disagreeing, sharing responsibilities, etc. – for example, sharing leadership in discussions, recording on flip charts, distributing handouts, and listening and responding with empathy.

- Prepare a sheet of flip chart paper by writing the following questions, which participants will answer during their presentations to the group:

  1. Name
  2. Position
  3. How long have you worked with children and families?
  4. What is the biggest barrier you face when interacting with children and their families?
  5. What do you want from this workshop? Or, what are your expectations?
  6. What are your hobbies?
1.3 Ground Rules

- Prepare a sheet of flip chart paper by writing:

  **Ground Rules**

  Spelling and handwriting don’t count
  Confidentiality
  Be on time
  Three Minute Rule: anyone can call; Parking List
  It’s OK to have fun
  If you have a question, don’t be afraid to ask it
  Listen with respect
  Okay to leave the room and to move around
  No “bad guys or women” - no blaming

- Prepare a sheet of flip chart paper by writing at the top of the sheet:

  **Parking List**

1.4 Workshop Premise, Goals and Objectives

- There are overheads available for the workshop Goals and Objectives. If you do not have an overhead projector available, prepare flip chart paper with the following:

  **Goals**

  1. Learn and relate causes of abuse to resulting behaviors of the child and family.
  2. Recognize behaviors associated with abuse.
  3. Be able to react positively and appropriately to the child while s/he is in your care.

  **Objectives**

  1. Identify causes, characteristics, and effects of substance abuse, domestic violence, and child abuse and neglect on the family. Consider the impact of mental health and illness diagnoses, perceptions and other issues on the child and family.
  2. Identify, match with, and refer to community resources that best meet the needs of the child and family.
  3. Learn and apply methods for assisting an abuse affected child and family including interpersonal skills.
  4. Identify and follow federal and state guidelines respecting the rights of children and families.
  5. Apply and practice recognition, referral, and intervention skills.
1.5 Preview Workshop Sessions 1-6

- There are overheads available for Overview of Sessions. If you do not have an overhead projector available, prepare flip chart paper by writing:

  Overview of Sessions

  Session 1:
  Welcome and Introductions
  Families in Distress - Trauma

  Session 2:
  Substance Abuse

  Session 3:
  Domestic Violence

  Session 4:
  Child Abuse and Neglect

  Session 5:
  Mental Health/Illness
  Family Systems
  Similarities and Differences

  Session 6:
  Abuse Affected Behaviors, Feelings, and Perceptions
  Action Planning
  Closure

For Unit 2:

- Read “Trauma: Individual experience with collective implications” in Session 1 Facilitator Guide.

- There is an overhead available for the unit Purpose. If you do not have an overhead projector available, prepare a sheet of flip chart paper by writing:

  Purpose
  Discuss psychological trauma from an ecological perspective, identify the connection between trauma and abuse, and explore individual and collective responses to trauma, including the process of recovery.

2.1 Trauma Definition

- There is an overhead available for the definition of Trauma. If you do not have an overhead projector available, prepare a sheet of flip chart paper by writing:

  Trauma:
  A single event or series of events over time, which may overwhelm one’s ability to cope, and thus make a person feel helpless when confronted with emotional or physical danger.
2.2 Trauma Individual/Community

- Prepare two sheets of flip chart paper by writing Individual Traumas at the top of one and Collective Traumas at the top of the other.

- Prepare three sheets of flip chart paper by writing People at the top of one, Event on the second sheet, and Environment at the top of the third sheet.

- There is an overhead available, An Ecological View of Trauma and Recovery. If you do not have an overhead projector available, prepare a sheet of flip chart paper with the diagram as shown on the overhead.

![Diagram of Trauma, Therapy, Recovery]

2.3 Trauma Principles

- There is an overhead available for the Trauma Principles. If you do not have an overhead projector available, prepare a sheet of flip chart paper by writing:

**Trauma Principles**

1. Feeling of helplessness
2. Safety
3. Why did it happen?
4. Post traumatic stress responses
5. Changes in the central nervous system
6. Sensory experience
7. Attachments may be severed
8. Shame-based
9. Contagious
10. Perspective

For Closure to Session:

- Bring Session 1 Evaluations for completion by participants (RDC Team member).
Purpose, Objectives, and Outline

**Purpose:**
Introduce trainers and participants to one another, facilitate development of a positive group learning experience through shared articulation of both program and individual goals and responsibilities, and increase participant comfort with speaking in the group. Analyze family roles and dynamics focusing on the sources of abuse and its affects on the abused family members in the context of trauma theory.

**Objectives:**
1. Learn the names and roles of trainers and other participants. Understand one another’s expectations for participating in the training.
2. Establish ground rules.
3. Clarify program premise, goals, and objectives, and become familiar with the flow of the six sessions.
4. Consider trauma from an ecological perspective - not always a singular event, and it can be experienced individually, in families, and in communities.
5. Discuss factors that affect one’s response to trauma and to trauma recovery.
6. Explore manifestations of trauma childcare providers have seen in the children and families with whom they work.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to Session</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Unit 1: Welcome and Introductions</td>
<td></td>
</tr>
<tr>
<td>1.1 Topic and Instructor Introductions</td>
<td>10 minutes</td>
</tr>
<tr>
<td>1.2 Participant Introductions</td>
<td>30 minutes</td>
</tr>
<tr>
<td>1.3 Ground Rules</td>
<td>10 minutes</td>
</tr>
<tr>
<td>1.4 Workshop Premise, Goals, and Objectives</td>
<td>10 minutes</td>
</tr>
<tr>
<td>1.5 Preview Workshop Sessions 1 - 6</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Break</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Unit 2: Families in Distress</td>
<td></td>
</tr>
<tr>
<td>2.1 Trauma Definition</td>
<td>10 minutes</td>
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<tr>
<td>2.2 Trauma Individual/Community</td>
<td>30 minutes</td>
</tr>
<tr>
<td>2.3 Trauma Principles</td>
<td>15 minutes</td>
</tr>
<tr>
<td>2.4 Case Study – Marie and Florence</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Closure to Session</td>
<td>5 minutes</td>
</tr>
<tr>
<td><strong>Total Session Time</strong></td>
<td><strong>3 Hours</strong></td>
</tr>
</tbody>
</table>
Introduction to Session (15 minutes)

Suggested Order of Activities:

1. Welcome each participant upon arrival.

2. Instruct each participant to sign-in, select a seat, and make a name tag.

3. Give each participant a handbook.

4. Encourage participants to enjoy snacks and beverages, if these are available.

5. Begin the training on time, welcoming the entire group to the Caring for the Abuse Affected Child and Family training. (RDC team member).

6. Briefly introduce yourself (RDC team member) and explain that each of the trainers and all participants will have an opportunity to introduce themselves to each other in a few minutes.

7. Explain that the first part of the training involves the participants filling out the Pre-Training Questionnaire. Describe the purpose of the questionnaires and encourage participants to complete the entire form, including the ‘identifying information’ at the beginning. Assure participants of their anonymity, and let them know that their participation in this is a very important part of our ongoing evaluation of the effectiveness of the Caring for the Abuse Affected Child and Family training.

8. Instruct participants to take as much time as they need to fill out the questionnaire, and to sit quietly until everyone has finished. This will usually take about ten minutes. Collect all questionnaires before beginning introductions.

Trainer Notes:
Unit 1: Welcome and Introductions

Purpose:
Introduce trainers and participants to one another, facilitate development of a positive group learning experience through shared articulation of both program and individual goals and responsibilities, and increase participant comfort with speaking in the group.

Handouts for Unit 1:
• Session 1, Handout 1: An Ode to Ground Rules

Overheads for Unit 1:
• Session 1, Overhead 1: Goals
• Session 1, Overhead 2 & 3: Objectives
• Session 1, Overhead 4 & 5: Workshop Overview

Suggested Order of Activities:

Unit 1.1 Topic and Instructor Introductions (10 minutes)

1. Explain that this training has been developed specifically with the adult learner in mind.
   • It provides an interdisciplinary approach to the learning environment,
   • Uses active rather than passive learning methods,
   • Emphasizes your roles as experts too - you will have opportunities to share your knowledge and experience with each other, and with us.
   • We will be facilitating learning - i.e., arranging learning experiences and applying them to the ‘real world’.

2. Describe:
   • We work as a team of instructors, which is a bit unusual but offers all of us many opportunities for learning and sharing.
   • Each of the instructors works in a different discipline: domestic violence, substance abuse, child abuse and neglect, and early childhood education and program development.
   • While we may very well work with some of the same families, we recognize that we have not always worked together as closely as we should, we may speak different languages, and view our clients differently.
   • This curriculum gave us the opportunity to discuss our common challenges and how our relationships affect the families we serve.

3. Explain:
   • We will be facilitating case studies and other exercises which will include analysis and discussion.
   • We will act as consultants and will apply our experiences and knowledge to your world, so that it will be most useful to you in your work with children and families.
   • Facilitating also takes advantage of your experience and expertise, so you will have some responsibility for contributing to each other’s learning.
   • We will emphasize participation, practical knowledge, and skill building for you to learn, apply, and bring back to your work setting.
   • Special Note: The material has been simplified to make it easier to understand and to use; however, we do recognize that human experience is never simple.
Unit 1.1: Topic and Instructor Introductions (Continued)

- Special Note: You may find that parts of the training will bring up difficult emotions or reactions you had not expected. This is common. Feel free to speak in confidence with any one of us about the workshop material, exercises, or about something that may be going on in your work or personal life.

4. Say:

- This workshop is based on the assumption that domestic violence (DV), child abuse and neglect (CA/N), and substance abuse (SA) have some common causes and effects on the child and family.
- Many families coping with abuse may also experience challenges with regard to mental health and illness.
- There are common and effective actions you can take to help the child during the time s/he is in your care.

5. Each trainer should introduce themselves to the group, referring to the questions on the flip chart. After all trainers are finished, move on to participant introductions.

Be sure all trainers are participating, demonstrating cooperation and shared responsibilities.

**Trainer Notes:**
Unit 1.2: Participant Introductions (30 minutes)

1. Refer to the posted questions on the flip chart and inform the group that it is now time for them to say a bit about themselves. Ask, “Who wants to go first?”

2. Expect initial silence, but wait for someone in the group to start. They will, and the ice will be broken.

3. After the first person finishes, they may continue one after another. If they do not, prompt them again: “Who would like to go next?”

Use three flip chart sheets to record responses. One trainer writes down all responses to the question, “What is the biggest barrier you face when interacting with children and families?” Another trainer records all responses to the question, “What do you want from the workshop?” A third trainer keeps track of the number of years individuals have worked with children and families.

4. After participants finish introducing themselves, add up the number of years of experience in the room and emphasize that the room is full of knowledge and experience, and the goal in this workshop is to share with and learn from one another.

Refer back to participants’ responses throughout the six sessions, as this ensures relevancy of discussion. Use responses as the basis for evaluating the session and/or workshop - i.e., did the workshop meet your needs? If space is available, post these responses during each session.

Trainer Notes:
Unit 1.3 Ground Rules (10 minutes)

1. Display the prepared flip chart with Ground Rules. Explain that in any group situation, it is important to agree upon a set of rules for expected behaviors. These “rules of the road” will enhance communication, consideration, cooperation, and respect for each other’s opinions, suggestions, ideas, and other contributions.

2. Review the list:
   - **Spelling and handwriting don’t count**: minimizes disruptive corrections; reduces anxiety for participants (and trainers) when recording on flip chart paper during exercises.
   - **Confidentiality**: examples, names, and any and all sensitive information do not leave the room; probably the most important ground rule.
   - **Be on time**: Training will begin and end on time. Special circumstances may arise. Notify the RDC team member ahead of time when possible.
   - **Three Minute Rule**: (a) Time Out - called when participants go off on a tangent, when emotions are boiling over, when there’s an impasse, or when there’s a disruption and the group needs a few minutes of respite; (b) Anyone Can Call - any group member or facilitator can invoke a time-out (making a “T” with your hands and saying, “time out.”); (c) Parking List – an ongoing list of questions or ideas raised by participants or trainers for consideration as time allows.
   - **It’s OK to have fun**: Although these are serious topics, we need to have a sense of humor as a catharsis or for a release.
   - **If you have a question, don’t be afraid to ask**: If you’re questioning something, chances are someone else is too. We encourage questions and information sharing. Everyone has areas of ignorance as well as expertise.
   - **Listen with respect**: We can disagree without being disagreeable or verbally attacking one another.
   - **OK to leave the room**: You don’t need permission. Move around, stand if you’ve been seated too long or are feeling uncomfortable.
   - **No “bad guys or women”**: No blaming.

3. Ask participants if they agree with the ground rules. Do they need to make any changes to these rules? Would they like to add any others at this time? Remind them that the rules can be changed, revised, deleted, or added to any time during the workshop if needed.

4. **Special Note**: Batterers and sex offenders are most often referred to as “he” throughout the training, but this is not intended to be blaming. It is a reflection of reported numbers.

5. Refer participants to Session 1, Handout 1: An Ode to Ground Rules.

   Post Ground Rules during each session prominently, so both participants and facilitators can refer to them when needed.
Unit 1.4: Workshop Premise, Goals, and Objectives (10 minutes)

You may want to re-emphasize why there are facilitators representing each of the disciplines of DV, SA, and CA/N and a representative from their own profession as well to help apply this information to their work setting.

1. State the workshop Premise:
   - Child abuse and neglect, domestic violence, and substance abuse have some common causes and effects on the child and family.
   - While there are differences in how abuse is shown or manifested, their root causes are connected.
   - Many families coping with abuse may also experience challenges with regard to mental health and illness.
   - We will be talking about the causes of abuse, their effects, identification, and the actions you can take to help.

2. Post Session 1, Overhead 1: Goals, or display prepared flip chart. Inform participants that the goals of the workshop are that:
   - You will be able to see how some of the causes of abuse lead to the kind of behaviors you may see in both the child and family,
   - You’ll know how to observe and recognize that a child may be living in an abusive home environment, and
   - You will be able to do something to help that child and/or family.

3. Post Session 1, Overheads 2 & 3: Objectives, or display prepared flip chart. Tell participants that accomplishing the objectives will help answer these questions:
   - What abuse issues affect the family?
   - How do you refer? What are the guidelines? Which agencies?
   - What kinds of options do you have available to help the child and family?
   - What are your legal obligations to the child and family and to your own profession?
   - How do you apply this knowledge at work? When do you let go? How much can you do? What are the limits?

**Trainer Notes:**
Unit 1.5: Preview Workshop Sessions 1 - 6 (10 minutes)

1. Post Overheads 4 & 5: Overview of Sessions, or display prepared flip chart pages. Inform participants that you will now briefly describe the objectives for each of the six sessions, so that they will have a sense of the flow of the entire workshop.

2. In Session 1, our goal is to become familiar with one another and with the purpose, goals, and structure of the workshop. After the break, we will move into Unit 2: Families in Distress, and we will answer:
   • What is trauma?
   • What are some common individual and collective responses to trauma?

3. In Session 2, we will answer:
   • What is substance abuse and what impact does it have on the child and family?

4. In Session 3, we will answer:
   • What is domestic violence and what impact does it have on the child and family?

5. In Session 4, we will answer:
   • What is child abuse and neglect and what impact does it have on the child and family?
   • How do you report abuse and to whom?

6. In Session 5, we will answer:
   • How do issues of mental health and illness impact children and families that are also experiencing abuse? What are common myths and misperceptions surrounding mental illness that affect our ability to work meaningfully with children and families?
   • What is a family system, and what are the effects of abuse and trauma on that system?
   • What similar effects do the abuses (DV, SA, and CA/N) have on the child’s behavior and on the family as a whole? What are the differences among the abuses?
   • How do we acknowledge and then integrate these differences when working with an abuse-affected child and family?

7. In Session 6, we will answer:
   • What are the key and common behaviors that abuse-affected children and adults tend to display?
   • What are the ways you can respond?
   • How do you apply this knowledge in your work with children and families?

This would be an excellent time to refer to the list participants came up with during introductions regarding what they hoped to get out of the workshop. Most of their stated expectations will likely fit into one or more of the Sessions’ objectives.

Trainer Notes:
Unit 2: Families in Distress

Purpose:
Discuss psychological trauma from an ecological perspective, identify the connection between trauma and abuse, and explore individual and collective responses to trauma, including the process of recovery.

Handouts for Unit 2:
• Session 1, Handout 2: Trauma
• Session 1, Handout 3: Trauma Principles
• Session 1, Handout 4: Case Study: Marie and Florence

Overheads for Unit 2:
• Session 1, Overhead 6: Purpose
• Session 1, Overhead 7: Trauma
• Session 1, Overhead 8: An Ecological View of Psychological Trauma and Trauma Recovery
• Session 1, Overhead 9: Trauma Principles

If you have not already done so, it is important to read the article, “Trauma: Individual experience with collective implications,” prior to facilitating this unit. The article is located at the end of the facilitator guide for Session 1.

Suggested Order of Activities:

Unit 2.1: Trauma Definition (10 minutes)

1. Post Session 1, Overhead 6: Purpose, or display prepared flip chart page. Read the purpose statement out loud.

2. Explain:
   • We are starting with trauma because many adults and children you see may be victims of trauma. It is important to pay attention to this common ground between domestic abuse, child abuse, and substance abuse.
   • In Session 5, we will talk about mental health and mental illness and its impact on families also experiencing abuse. In recent years, we have begun to understand that histories of abuse and trauma may contribute to both short and long term mental health problems for some people; however, experiencing trauma or abuse does not necessarily cause mental health problems.
   • Many survivors of abuse show great strength and resilience, even crediting their response to the trauma as a catalyst for helping them to grow.
   • Most of us have experienced some type of trauma over the course of our lives, and our responses and recovery processes are all different, based upon various factors in our lives.

3. Post Session 1, Overhead 7: Trauma, or display prepared flip chart page. Refer participants to Session 1, Handout 2: Trauma, for the definition of trauma. Read the definition of trauma out loud.

4. Explain the three types of trauma (this information also on Session 1, Handout 2: Trauma):
   • INDIVIDUAL TRAUMA: An event or events that affect one person.
   • COLLECTIVE TRAUMA: An event or events that affect communities.
   • HISTORICAL TRAUMA: Many experiences of trauma in families have been carried through the generations but have never been resolved or treated. These “historical” traumas can set the stage for new traumas in later generations.
Unit 2.2: Trauma Individual/Community (30 minutes)

The purpose of the following exercise is to raise participant awareness of the fact that trauma is not always the result of a singular event and that we can experience traumatic events in our personal lives and in our communities.

1. Using prepared flip chart paper, ask the group to brainstorm examples of events that might result in trauma. Participants will offer examples, and will then indicate whether they believe that trauma would be considered an individual or a collective trauma. After the list has been generated, review and discuss.

Note: Many traumatic events can be placed under both categories. For example: wars are full of many individual traumas or a car accident that kills a well known community member can affect an entire community. Try not to let the group debate too much where an example fits, rather focus on the variety of examples and how we can all experience trauma in our personal lives and communities.

Sample:

<table>
<thead>
<tr>
<th>Individual</th>
<th>Collective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape</td>
<td>War</td>
</tr>
<tr>
<td>Assault</td>
<td>September 11th Attack</td>
</tr>
<tr>
<td>Car Accident</td>
<td>Ice Storm</td>
</tr>
<tr>
<td>Insult</td>
<td>Serial Rapist/Murderer</td>
</tr>
</tbody>
</table>

The purpose of the following exercise is to get the participants to discuss all of the factors in our lives that will affect our reaction to trauma. Our age, culture, and time of the event are only a few of the variables that affect how individuals and families respond to trauma in different ways.

2. Provide this information: How an individual reacts to trauma depends on a number of variables in their lives. Three of these variables are:

   • The person - age, ethnicity, gender.
   • The event - When it happened, where it happened, were there others around, what was the impetus to the event (hate crime?).
   • The environment - Where they live, support systems they have, the relationship to the abuser.

3. Using prepared flip chart paper, ask the group to brainstorm specific examples related to Person, Event, and Environment that will affect our reactions to trauma.

   Examples:

<table>
<thead>
<tr>
<th>Person</th>
<th>Event</th>
<th>Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>sex</td>
<td>time</td>
<td>urban/rural</td>
</tr>
<tr>
<td>age</td>
<td>location</td>
<td>geography</td>
</tr>
<tr>
<td>ethnicity</td>
<td>single event</td>
<td>police response</td>
</tr>
<tr>
<td>race</td>
<td>series of events</td>
<td>family response</td>
</tr>
<tr>
<td>sexual orientation</td>
<td>alone</td>
<td>legal response</td>
</tr>
<tr>
<td>religion</td>
<td>witnesses</td>
<td>community response</td>
</tr>
<tr>
<td>education</td>
<td>weapons</td>
<td>housing availability</td>
</tr>
<tr>
<td>family structure</td>
<td>hate crimes</td>
<td>relationship to abuser</td>
</tr>
<tr>
<td>past traumas</td>
<td>injuries</td>
<td>medical response</td>
</tr>
</tbody>
</table>
**Unit 2.2: Trauma Individual/Community** (Continued)

4. Referring to Session 1, Overhead 8: An Ecological View of Trauma and Recovery or prepared diagram on flip chart, discuss recovery from trauma (information also available in Session 1, Handout 2). Stress the point that recovery from trauma differs greatly between individuals. Some need therapy while others find their own way to recover.

5. Discuss how people, events, and our environment reflect how we will respond to trauma and also how we will recover.

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*Trainer Notes:*
Unit 2.3 Trauma Principles (15 minutes)

1. State this:
   Now we will look at some of the ways trauma might manifest, or show up, in people’s lives. We must always remember though, that these are just a few of the responses; we learned earlier that we all respond differently, according to who we are and where we have been.

2. Post Session 1, Overhead 9: Trauma Principles, or display prepared flip chart page. Also refer participants to Session 1, Handout 3: Trauma Principles.

Discussion of the Trauma Principles is enriched by all of the team members offering examples from their own work with individuals and families.

3. As you read each principle, describe and provide examples for each:

   • **Feeling of Helplessness:** The feeling of helplessness reorganizes the lives of trauma victims; memories and cues maintain the helpless feeling.

   • **Safety:** Trauma destroys the victim’s sense of safety; if it happened once, it can happen again. Victims of trauma may expect the worst and view the world that way.

   • **Why did it happen?:** A victim of trauma may be driven to search for an explanation of why it happened to them: What could I have done differently? Did I deserve it? Could I have stopped it? Can I prevent it from happening again?

   • **Post Traumatic Stress Responses:** Many survivors of trauma develop Post-Traumatic Stress Disorder (PTSD) similar to war veterans - e.g., flashbacks, hyper-vigilance, startle responses, etc.

   • **Changes in CNS:** The experience of trauma may temporarily or permanently change the central nervous system; may result in “hyper” behavior seen sometimes in adults and children who have been traumatized.

   • **Sensory Experience:** Trauma is primarily a sensory experience.

   • **Attachments may be severed:** Trauma can threaten to or actually eliminate attachments; children wonder why the person who is supposed to protect them is hurting them; trust is lost.

   • **Shame-based:** Trauma is shame-based; trauma victims feel that they should have been able to prevent it.

   • **Contagious:** Trauma is contagious; people who hear details of the trauma may experience similar responses, as though they themselves experienced the trauma; other children may get hooked into the ‘post-trauma’ play of the child victim.

   • **Perspective:** The experience of trauma can be put into perspective; people develop strengths that carry them through life. Therapy may be helpful for many people, but others rely on resources and supports from friends, family, and other types of service providers.
Unit 2.4 Case Study: Marie and Florence (20 minutes)

1. Explain that the next exercise will give participants an opportunity to identify possible trauma principles by studying a “case” involving children who attend a child care program.

This is the first small group activity, so introduce it positively!

2. Divide participants into two or three small groups.

3. Participants will read Session 1, Handout 4: Case Study: Marie and Florence.

4. Small groups will identify where the ten trauma principles appear in the case study. Give about ten minutes for this.

5. Discuss results as a large group. Ask: Why is this important to know? Or, how can knowing about trauma help you in your child care setting?

6. The case study follows:

Mrs. Parker, a child care provider is worried about Marie, one of her five year old girls. Marie seems to fall apart pretty quickly when she’s frustrated. She’s also noticed that Marie seems terrified of loud noises; while the other children don’t pay much attention to loud sounds, Marie sometimes jumps and then hides under the table. Marie usually plays “dolls” with her friend Susie, often resulting in what Mrs. Parker thinks is rather odd behavior. She’s noticed that Marie seems to spend a lot of time making believe that the “daddy” doll is punching, slapping, and then throwing the “mommy” doll against the wall. Marie gets extremely agitated during the play, especially when she has the baby doll trying to stop the daddy doll. When she doesn’t allow the baby doll to succeed, Marie hangs her head and says sadly, “The baby is bad,” or “Daddy smells bad,” or “Mommy’s nose is bleeding.”

At times, Marie gets so worked up over these games that it is difficult to get her back to reality. She often cringes or draws back when she’s touched or when help is offered. Susie’s mother has called Mrs. Parker’s to ask her if she knows why Susie is having nightmares and whimpering in her sleep.

When Mrs. Parker first spoke to Marie’s mother, Florence, about the way her daughter played, Florence didn’t seem to show much concern or avoided the topic altogether. When Mrs. Parker persisted, Florence finally broke down and begged Mrs. Parker not to mention any of this to her husband, Bernie, a lawyer. She explained that she was worried about her husband’s rough behavior and drinking but she had never thought it was hurting her daughter. Concerned about Marie’s behavior and her mother’s concerns, Mrs. Parker called Child Protective Intake and spoke with a worker who recommended that she encourage Florence to contact a domestic violence agency, which she did. The advocates helped Florence get an Order for Protection from Abuse that included a supervised visitation agreement with the father monitored by a mutual friend. Florence then left her husband and found an apartment with her daughter. She started to attend Al-Anon meetings to begin dealing with the effects of both her father’s and husband’s drinking. She also began attending a support group for battered women. Marie received play therapy and no longer seems to be playing those doll-destructive games although she still seems more hypersensitive to noise than most other children. She seems especially anxious about the supervised visits with her father, who continues to deny that he has a substance abuse problem. Marie’s friend Susie no longer has nightmares.
Closure to Session (5 minutes)

1. Thank the group for their participation.

2. Conduct a brief check-in with group members and encourage them to use self-care strategies between this session and the next one. Explain that participants often feel a range of emotions throughout the training, and that it is important to stay on top of this. The trainers are available to help process, if necessary.

3. Distribute Session 1 Evaluations and encourage participants to be candid and thorough. Remind the group to keep voice tones low as they are leaving so that others may concentrate.

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Trainer Notes:
"Trauma: a single event or series of events over time, which can tax or overwhelm a person or community’s resources and sense of wellbeing."

In the discussion of domestic abuse, substance abuse, and child abuse, trauma is the common ground. In each type of abuse, individuals experience trauma as a series of events over time, a daily ordeal of doing ordinary things while protecting themselves from abuse, often through extraordinary acts of survival.

None of us is immune to experiencing trauma, however much we may try to protect ourselves. We are differentiated by the specific traumas we experience, the personal resources we possess, and the context in which we live. For some, trauma results in devastation of the spirit that is never repaired, with or without therapeutic intervention. For others, a similar trauma, while initially devastating, is blended into the person’s totality of experience and they recover successfully, with or without therapeutic intervention.

Many of us have watched someone go through a traumatic experience. We are often surprised by their response, perhaps because it is different from how we believe we would respond ourselves or because we would expect that person to act differently based on what we know about them.

An ecological analysis of trauma provides a framework for thinking about trauma in a more holistic way. It places all of us in the experience as part of the environment, even if we were not witnesses to a particular experience. This is our opportunity to support individuals’ resilience to trauma and to reduce further incidents from happening through a collective response. It also helps us understand why people respond to trauma so differently.

1 An Ecological View of Psychological Trauma and Trauma Recovery”, Journal of Traumatic Stress, Vol. 9, No. 1, 1996, Mary R. Harvey.
Trauma: Individual experience with collective implications (Continued)

As ‘helpers’ with the intent of responding appropriately and helpfully to people who have been traumatized, it is important that we keep in mind that many factors influence a person’s response to trauma. While millions of people have been raped, assaulted, and subjected to emotional degradation, their responses vary widely. Individuals can not be held to a particular standard for how to respond. Such a standard gets in the way of helpers being able to hear what the person they are helping feels, thinks, wants, and fears.

Differences among persons, events, and environments

People differ in color, age language, religion, family structure, history, education, gender, perceived class, and any number of other ways. The relationship, if any, between the victim and perpetrator is important. Betrayal by a loved one, being assaulted by one’s intimate partner is different from being mugged on the street by a stranger and has different long-term implications.

Trauma is sometimes a single event, a car accident, a house fire, an ice storm. Sometimes it is a series of events; a parent coming home drunk every Friday and binging until Sunday night for ten years – being locked in your room while your father hurts your mother – being beaten by a new love, having believed you had found someone better than the last person in your life, who nearly killed you. Traumatic events differ according to where, when, and how they happened. How often did the events occur and over what period of time? Important differences include the presence and actions of witnesses, physical injuries, use of weapons, and characteristics of the perpetrator.

Environmental factors include both the physical realities of location and resources and the more intangible realities of a community’s response and shared beliefs. The quality of the response of the police, prosecutor, and judge in a criminal case may increase or decrease a victim’s sense of well being. Similarly, a lesbian who has been assaulted by her lover may be reluctant to reach out for help if her family, coworkers, and others have shown intolerance for homosexuality. If a woman’s doctor has never asked about abuse, she may think he does not want to know or that he would think badly of her for what she is going through. Resources for the disabled, for communicating across languages, for housing, transportation, legal representation, employer flexibility all may play a part in one’s ability to repair their life following trauma.
Differences in trauma response

We all have ideas about how people would or should respond to trauma and we are sometimes surprised when victims respond differently. For example, people who have never been abused by their intimate partner often say, “If my partner ever hit me, I would walk straight out the door and never look back.” From an ecological perspective, we see that responses differ widely given the dynamic among the person, event, and environment. The following illustrates some possible responses to trauma.

<table>
<thead>
<tr>
<th>Symptoms of Harm</th>
<th>Elements of Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wide range of feelings; from helplessness to rage</td>
<td>Ability to remember or set aside memories</td>
</tr>
<tr>
<td>Destroyed sense of safety</td>
<td>Overcoming intensity of emotions and reactions</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder</td>
<td>Positive self esteem</td>
</tr>
<tr>
<td>Changes in central nervous system</td>
<td>Ability to engage in supportive relationships</td>
</tr>
<tr>
<td>Severed attachments to others</td>
<td>Placing trauma in perspective, internalizing self-</td>
</tr>
<tr>
<td>Need to explain why event happened</td>
<td>and life-affirming interpretation of events</td>
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Creating an environment which supports resilience

Fundamentally, most people share a hope that someday the world will be a kinder place, that trauma will not be suffered by vast numbers of people every day. For those who are traumatized, we hope that they will have the support and resources readily available to recover their sense of well-being and wholeness, converting their experience of trauma into new strength and perspective.

“Applied to the realm of psychological trauma, the ecological analogy understands violent and traumatic events as ecological threats not only to the adaptive capacities of individuals but also to the ability of human communities to foster health and resiliency among affected community members. Thus, growing urban violence can be viewed as the inner-city counterpart of “acid rain” – i.e., an ecological threat to the community’s ability to offer it’s members safe haven.”

Racism, sexism, and all forms of discrimination are excuses for hatred and contribute to violence. If we wish to both provide assistance to traumatized people and reduce trauma caused by one person against another, we must examine our attitudes and the messages we promote in our community.

2Symptoms of Harm are based on Lesley Devoe’s “Trauma Principles” in “Caring for the Abuse Affected Child”, Maine Child Welfare Training Institute, 1993. Elements of Recovery are based on Dr. Harvey’s multidimensional definition for recovery discussed in her previously cited article.
3Harvey, 1996.
“Just as violent events can tax and overwhelm community resources, so community values, beliefs and traditions can bulwark community members and support their resilience in the wake of violence….If misogyny and patriarchy are seen as environmental contributors to sexual violence and as ecological threats to the well-being of women, then community-based…crisis centers…and community-wide intolerance of…violence can be recognized as ecological supports to women’s safety and well-being.”

**From individual tragedy to the collective conscience**

Over the years, a number of traumatic experiences once viewed as isolated, regrettable incidents came to be understood as widespread problems requiring a community-wide response. A community-wide response includes everyone, regardless of their personal connection to individual events. It requires that we perceive that we each have a role to play in fostering attitude changes in the community.

By helping to create a community environment in which emotional and physical violence, discrimination, and denial are not tolerated, a community in which people actively explore better ways to be in relationship with one another, we help all victims of trauma.

In order to be effective agents of change,

- Increase one’s understanding of abuse and violence
- Take responsibility for one’s own behavior, and change behaviors that are harmful to others
- Become knowledgeable about community resources available for referral and support, including crisis intervention services
- Work to change the community tolerance of abuse, both within the congregation and in the larger community
- Learn how to assess one’s effectiveness and maintain accountability as part of a coordinated community response to abuse.

Francine Stark, Spruce Run, Bangor, ME
AN ODE TO GROUND RULES

Spelling and handwriting aren’t important to us,
if you misspell a word, we won’t make a fuss,

If you discuss personal subjects that require privacy,
take comfort that we strive for confidentiality,

Please be on time, and don’t arrive late,
respect is a virtue, we should all celebrate,

Three minute rule, timeout and free parking,
we can’t get off subject, or get tempers to sparking,

But, if you have an issue, that can be addressed later,
just mark it down on the list, it’s a huge time saver!

There are no stupid remarks, no stupid questions,
we are open and eager, to hear all your suggestions,

If you listen with respect, then others will follow,
friendships will emerge, and continue beyond tomorrow,

Don’t feel that you have to stay glued to your chair,
get up, move around, and grab some fresh air,

And last but not least, please let there be no blaming,
because harm only comes from patronizing and shaming.

by Vanessa Santarelli
**TRAUMA**

**Trauma:** A single event or series of events over time, which may overwhelm one’s ability to cope, and thus make a person feel helpless when confronted with emotional or physical danger.

- **INDIVIDUAL TRAUMA:** An event or events that affect one person.
- **COLLECTIVE TRAUMA:** An event or events that affect communities.
- **HISTORICAL TRAUMA:** Many experiences of trauma in families have been carried through the generations but have never been resolved and/or treated. These “historical” traumas can set the stage for new traumas in later generations.

![Diagram of Ecological View of Trauma and Recovery]

1. FEELING OF HELPNESS

2. SAFETY

3. WHY DID IT HAPPEN?

4. POST TRAUMATIC STRESS RESPONSES

5. CHANGES IN THE CENTRAL NERVOUS SYSTEM

6. SENSORY EXPERIENCE

7. ATTACHMENTS MAY BE SEVERED

8. SHAME-BASED

9. CONTAGIOUS

10. PERSPECTIVE

*From Lesley Devoe, 1993
Mrs. Parker, a child care provider is worried about Marie, one of her five year old girls. Marie seems to fall apart pretty quickly when she’s frustrated. She’s also noticed that Marie seems terrified of loud noises; while the other children don’t pay much attention to loud sounds, Marie sometimes jumps and then hides under the table. Marie usually plays “dolls” with her friend Susie, often resulting in what Mrs. Parker thinks is rather odd behavior. She’s noticed that Marie seems to spend a lot of time making believe that the “daddy” doll is punching, slapping, and then throwing the “mommy” doll against the wall. Marie gets extremely agitated during the play, especially when she has the baby doll trying to stop the daddy doll. When she doesn’t allow the baby doll to succeed, Marie hangs her head and says sadly, “The baby is bad,” or “Daddy smells bad,” or “Mommy’s nose is bleeding.”

At times, Marie gets so worked up over these games that it is difficult to get her back to reality. She often cringes or draws back when she’s touched or when help is offered. Susie’s mother has called Mrs. Parker’s to ask her if she knows why Susie is having nightmares and whimpering in her sleep.

When Mrs. Parker first spoke to Marie’s mother, Florence, about the way her daughter played, Florence didn’t seem to show much concern or avoided the topic altogether. When Mrs. Parker persisted, Florence finally broke down and begged Mrs. Parker not to mention any of this to her husband, Bernie, a lawyer. She explained that she was worried about her husband’s rough behavior and drinking but she had never thought it was hurting her daughter. Concerned about Marie’s behavior and her mother’s concerns, Mrs. Parker called Child Protective Intake and spoke with a worker who recommended that she encourage Florence to contact a domestic violence agency, which she did. The advocates helped Florence get an Order for Protection from Abuse that included a supervised visitation agreement with the father monitored by a mutual friend. Florence then left her husband and found an apartment with her daughter. She started to attend Al-Anon meetings to begin dealing with the effects of both her father’s and husband’s drinking. She also began attending a support group for battered women. Marie received play therapy and no longer seems to be playing those doll-destructive games although she still seems more hypersensitive to noise than most other children. She seems especially anxious about the supervised visits with her father, who continues to deny that he has a substance abuse problem. Marie’s friend Susie no longer has nightmares.
GOALS:

1. Learn and relate causes of abuse to resulting behaviors of the child and family.

2. Recognize behaviors associated with abuse.

3. Be able to react positively and appropriately to the child while s/he is in your care.
Objectives:

1. Identify causes, characteristics, and effects of substance abuse, domestic violence, and child abuse and neglect on the family. Consider the impact of mental health and illness diagnoses, perceptions and other issues on the child and family.

2. Identify, match with, and refer to community resources that best meet the needs of the child and family.
Objectives (Continued):

3. Learn and apply methods for assisting an abuse affected child and family including interpersonal skills.

4. Identify and follow federal and state guidelines respecting the rights of children and families.

5. Apply and practice recognition, referral, and intervention skills.
Overview of Sessions:

Session One:

Welcome and Introductions
Families in Distress

Session Two:

Substance Abuse

Session Three:

Domestic Violence
Overview of Sessions (Continued):

Session Four:
Child Abuse and Neglect

Session Five:
Mental Health/Illness
Family Systems
Similarities and Differences

Session Six:
Abuse Affected Behaviors, Feelings and Perceptions
Purpose:

Discuss psychological trauma from an ecological perspective, identify the connection between trauma and abuse, and explore individual and collective responses to trauma, including the process of recovery.
Trauma:

A single event or series of events over time, which may overwhelm one’s ability to cope, and thus make a person feel helpless when confronted with emotional or physical danger.
AN ECOLOGICAL VIEW OF TRAUMA AND RECOVERY

Person
Event/s
Environment

Trauma

Therapy → Recovery
No Therapy → No Recovery

Trauma Response

Recovery
No Recovery

No Recovery
SESSION 1
Caring for the Abuse Affected Child and Family

TRAUMA PRINCIPLES

1. FEELING OF HELPLESSNESS

2. SAFETY

3. WHY DID IT HAPPEN?

4. POST TRAUMATIC STRESS RESPONSES

5. CHANGES IN THE CENTRAL NERVOUS SYSTEM

6. SENSORY EXPERIENCE

7. ATTACHMENTS MAY BE SEVERED

8. SHAME-BASED

9. CONTAGIOUS

10. PERSPECTIVE

*FROM Lesley Devoe, 1993
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• Participant Handouts
• Overheads
For Introduction to Session:

- There are overheads available for the session Overview, Purpose and Objectives. If you do not have an overhead projector available, prepare 3 sheets of flip chart paper with the following information.
  - **Overview:**
    - Units 1 & 2: Overview of Substance Abuse
    - Units 3 & 4: Substance Abuse and the Family
    - Unit 5: Substance Abuse Treatment Options
    - Unit 6: Role Plays
  - **Purpose:** Identify basic knowledge and facts about substance abuse including its prevalence in Maine and its impact on the family system and the child’s development.
  - **Objectives:**
    1. Understand the difference between substance use, abuse, dependence and addiction.
    2. Recognize the potential impact of substance abuse on the entire family.
    3. Understand the process that individuals go through when attempting to make changes in their lives.
    4. Know how to contact local substance abuse treatment programs.

For Unit 1:

- There is an overhead available for the definition of substance abuse. If you do not have an overhead projector available, prepare a sheet of flipchart paper with the following information:
  - **Substance Abuse:** The term most commonly used to describe “problem-causing use” of alcohol and other drugs.
- Visit the OSA website at www.state.me.us/bds/osa/ to print out a list of agencies that provide substance abuse services within the county in which you are training. You will need the names of these agencies to answer one of the Jeopardy questions.
- Post Jeopardy game questions to the wall with the point value for each question facing out.
- Bring in noise makers or flags for the teams to use to answer the questions.
- Ask one trainer to be the score keeper, and one to be the judge. The score keeper records each team’s score on a flip chart. The judge will watch the groups and decide which group first buzzed in or raised their flag.

For Unit 2:

- Prepare a sheet of flip chart paper by drawing a line across the center with an “N” on the left side of the line like this:
For Unit 3:
• Depending on which activity you choose, the preparation follows:

**Option 1: Family Sculpture**  
• Trainer may choose to use props to enhance each family member’s role as they take their position. If you choose to do this, you will need to bring props. The following are suggested:
  • The Alcoholic may hold an empty beer bottle,
  • The Enabler may hold a cardboard bottle cutout with the word “tranquilizer” written on it,
  • The Hero may hold a cutout of a blue ribbon or a gold badge
  • The Scapegoat may hold a huge “joint”,
  • The Lost Child may hold a bag of cookies,
  • The Mascot may hold a cardboard cutout bottle marked “Ritalin”.

**Option 2: Interactive Theater**  
• Contact the Cross Disciplinary Training Project Staff for a directory of Interactive Theater groups throughout the state.  
• This will need to be done at least one month in advance so that there is time to write a contract for the Interactive Theater group.
• Skip Unit 4

For Unit 4:
If using interactive theater, please skip Unit 4.
• Order video, “Living a Lie,” from the Office of Substance Abuse.

For Unit 5:
• Have pamphlets from local substance abuse agencies available for the participants. Also have available the most updated Maine Alcohol and Other Drug Abuse Services guide, which is published by OSA.

For Unit 6:
• No advanced preparation is necessary.

For Closure to Session:
• Bring Session 2 Evaluations for completion by participants (RDC Team Member).
• Bring plenty of your business cards (optional) to distribute to participants.
**Purpose, Objectives, and Outline**

**Purpose:**
Identify basic knowledge and facts about substance abuse including its prevalence in Maine and its impact on the family system and child development.

**Objectives:**
1. Understand the difference between substance use, abuse, dependence and addiction.
2. Recognize the potential impact of substance abuse on the entire family.
3. Understand the process that individuals go through when attempting to make changes in their lives.
4. Know how to contact local substance abuse treatment programs.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Estimated Time</th>
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<tbody>
<tr>
<td>Introduction to Session</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Unit 1: Substance Abuse Jeopardy</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Unit 2: Overview SA - Definitions – Abuse vs. Addiction</td>
<td>35 minutes</td>
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<tr>
<td>Unit 3: Family Sculpture or Interactive Theater</td>
<td>30 minutes or</td>
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<td>Break</td>
<td>15 minutes</td>
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<tr>
<td>Unit 4: Video – Living a Lie (Skip if using Interactive Theater)</td>
<td>45 minutes</td>
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<tr>
<td>Unit 5: Treatment</td>
<td>15 minutes</td>
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<tr>
<td>Unit 6: Role Play (Optional)</td>
<td>30 minutes</td>
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<tr>
<td>Closure to Session</td>
<td>5 minutes</td>
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**Total Session Time** 3 Hours
**Introduction to Session** (5 minutes)

**Overheads for Introduction:**
- Session 2, Overhead 1: Overview
- Session 2, Overhead 2: Purpose
- Session 2, Overhead 3: Objectives

**Suggested Order of Activities:**

1. Welcome the group back.

2. Briefly present Session Two Overview, Purpose, and Objectives in your own words. There are overheads for each of these if you would like to use them.

3. Remind the group of the sensitive nature of this topic and encourage self care.

4. Go over the ground rules if it would be helpful.

5. Remind participants to de-identify any personal examples.

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**Trainer Notes:**
Unit 1: Substance Abuse Jeopardy (20 minutes)

Purpose:
Break the ice and begin thinking about the issue of Substance Abuse.

The Jeopardy Game is a nontoxic way to start to explore some of the issues surrounding substance abuse. It is just the tip of the iceberg in regard to the variety of substances being used and different types of problems people encounter with drug use.

Suggested Order of Activities:

1. Divide participants into equal teams (up to three teams). Choose one team to go first. They should pick a category and a value. For example, “Myths and Facts for 100.”

2. Read the question. The first team to raise their flag has the opportunity to answer the question.

3. If the team answers correctly they earn the number of points the question was worth. If the team answers incorrectly, they lose the points and the next team has the opportunity to answer the question.

4. Play until all of the questions have been asked.

5. The team with the most points wins the game.

If a participant mentions that Jeopardy questions are supposed to be written in the form of answers, you can offer this reason for the change in format: “We chose to ask questions in this game because in counseling we always respond to a question with another question. We learned that in Counseling 101.” - Just a little humor to lighten our spirits!

Trainer Notes:
Unit 2: Overview of SA, Definitions, Abuse vs. Dependence (35 minutes)

Purpose:
Define substance abuse, dependence and addiction. Show participants the progression of the disease of addiction and demonstrate how experimental use, abuse and addiction follow a path.

Handouts for Unit 2:
• Session 2, Handout 1: Criteria for Substance Dependence
• Session 2, Handout 2: Criteria for Substance Abuse
• Session 2, Handout 3: A Chart of Addiction and Recovery Curve (E.M. Jelinek)
• Session 2, Handout 4: Addiction and Recovery Curve for the Family

Overheads for Unit 2:
Session 2, Overhead 4: Substance Abuse

Suggested Order of Activities:

1. Present the definition of Substance Abuse as “the term most commonly used to describe problem-causing use of alcohol and other drugs.” Read from either your prepared flip chart or the overhead.

2. Ask: Have you heard of any other terms to describe substance abuse (alcoholism, addiction, chemical dependency)? Brainstorm a list together and begin to discuss the difference between some of these terms.
   As part of this discussion, you may want to refer to the DSM IV criteria for substance abuse and dependence in the participant handouts 1 & 2.

3. Present the following:
   “Abuse Vs Addiction”

   The following exercise was designed to help illustrate the difference between substance use, abuse, and addiction. The text is offered as an example of how to tell the story of one person’s struggle with substance use.

   N

   1) Start out with this line that you will refer to as the “feeling line”. This is a normal feeling line. Explain to the participants that we have a full range of feelings throughout our day without the use of artificial stimulants.
   Talk about how sometimes in our lives someone offers us an artificial stimulant or drugs or alcohol that will change our feelings. Tell the group that for this exercise we will say that someone has offered us alcohol for the first time.
Unit 2 (Continued)

Make a mark on the line that is a little above the normal range.

N

This may be a good time to offer some information and statistics on alcohol use in Maine. For some, the first time they use a drug could be at the age of 10, for others it is in their teens or older. Also, this is a good time to discuss that the age of first use of alcohol and drugs is getting younger. Historically, males started using substances at a younger age than females but today, females are quickly catching up. This is also a good place to talk about how until recently, alcohol was the most common drug used first but more and more, marijuana or inhalants are the first substance of use for young adults.

2) Now explore with the group how that first drink felt. You may have felt a little giddy, or maybe you felt more grown up but it really wasn’t a big deal. Then make a mark back to the normal level and share that the next day you got up and you felt fine with no after effects.

N

3) Somewhere along the way you thought if one beer, drink, or glass of wine made you feel good, then 5 or 6 would make you feel GREAT. Draw a line that is much higher than the first one. Discuss how you might feel like you were the “life of the party”, how you felt comfortable or maybe your depression disappeared or you forgot your troubles.

N

4) Ask the group to brainstorm how you might feel the next day. Talk about that first time you got sick, hugging that toilet and praying, “I will never do this again”. Talk about that first hangover and how miserable you felt. Draw a line that extends way below the normal line. Then after a couple of days you went back to normal. Now draw the line back to normal.
5) Share with the group that some of us learn after that first time that we can’t drink that much. For others it takes us several times before we learn our limits and stop when we need to. For some, from the very beginning the high is so great that we want this feeling over and over. Some of us are willing to risk everything to keep that high. For some of us the high gave us more self-esteem, or maybe stopped the hurt or maybe helped with our depression. Whatever the reason, certain individuals keep striving for this high. (Draw a few more lines on the chart). As they keep trying for this high, a tolerance begins to develop and often this is when you start adding extra drugs and sometimes a combination of drugs.

6) Draw a line in the middle of the feeling line and talk about how, on the left side of the line, individuals are abusing drugs and alcohol. You can refer to the DSM criteria for abuse and dependence. We sometimes have periods in our lives that we abuse substances. But for some, they cross the line onto the right side, which is addiction.

7) Discuss what happens to individuals when they cross this line. Draw below the feeling line and then go back up to the feeling line but do not go above it. When you are addicted you are now using alcohol and drugs to “feel normal”. You need this drug or alcohol to be like everyone else - to work, to be a parent, or to function as a human being. Without the drug or alcohol you are sick, shaking and without confidence to continue to function physically or psychologically. Talk about how an addict might be able to get somewhat high but for the most part, they are using to feel like you and I on a daily basis. Discuss that although you may see the addict as out of control when using, their perception is that they are in control when they are using, but out of control when they are not.

This is a good time to discuss the progressive nature of substance abuse. Use the “Jelinek Addiction and Recovery Curve” and the “Addiction and Recovery Curve for the Family” to illustrate that discussion. You may also want to touch on the disease model and other theories of substance abuse. Lead a group discussion about how the path to addiction and recovery might look different for each person.
Group Discussion:

Ask participants: Have you had any experiences with substance abuse in your professional work with families? What was it? What did you do? How did you recognize it? In retrospect, what would you like to have known how to do during the described episode?

This group discussion provides you with an opportunity to let participants know how you might handle situations and how others with different SA “philosophies” might act differently in the same situation. Provide examples from your own professional experience of situations that may occur and ask them to brainstorm how they might handle them.

Trainer Notes:
Unit 3: Family Sculpture (30 minutes) or Interactive Theater (1 hour 15 minutes)

Purpose:
Provide a basic knowledge about potential impact on the children and child development. Understand that we all have roles in our family but in homes where substances are abused those roles are more pronounced. Dramatize the positions of each member of the addicted family.

Handouts for Unit 3:
• Session 2, Handouts 5-10: Family Roles
• Session 2, Handout 11: Family Illness in Children
• Session 2, Handout 12: Co-Dependency and the Family System
• Session 2, Handout 13: Comparing Co-Dependent and Abuse Affected Behaviors
• Session 2, Handout 14: Stages of Substance Abuse in the Home: Effects on Children
• Session 2, Handout 15: Facts About the Children of Alcoholics
• Session 2, Handout 16-18: Alcoholism: Family Dynamics
• Session 2, Handout 19: Alcoholism and the Family

Suggested Order of Activities:

There are two options you can choose from to help illustrate the roles in a chemically dependent family. You may facilitate the family sculpture exercise (Unit 3, Option 1) which is described below, and then view the video “Living a Lie” (Unit 4), or you may use Interactive Theater (Unit 3, Option 2). If you choose to bring in an Interactive Theater group, please skip Unit 4.

Option 1: Family Sculpture (30 minutes)

Exercise 1: Family Roles

Ask the participants to think about their own role in their family. Ask all the participants who are first born to stand. Then ask everyone who is sitting to give descriptive adjectives to describe this person’s role in the family. You usually get responses such as “pushy, responsible, etc.” Ask those standing to have a seat, and then repeat the exercise for the middle children and the youngest children.

Discuss with the group the significance of our family birth order. We do not choose our birth order, but there are certain roles that we often fall into because of the place we hold within our families. Relate this to the roles in the alcoholic family.

Trainer Notes:
Unit 3 (Continued)

Exercise 2: Family Sculpture

Needed for the exercise: Six volunteers, called for one at a time; a sturdy chair for one person to stand on (props optional).

When asking for a volunteer to play the role of an alcoholic parent, ask for a woman. This may create an atmosphere where you can discuss stereotyping and cultural diversity. You will also want to let participants know that this can be a difficult exercise for those who have personal experiences with substance abuse. Participants should be encouraged to take care of their own needs and if necessary take a break to take care of themselves. Offer the support of the team to anyone who requests assistance.

1. Ask one participant to volunteer to be the alcoholic parent. Place that person upright in the chair, facing the group, and point out that this is the sickest and thus the most important person in the family. If using props, hand the participant the beer bottle.

2. Ask another group member to play the spouse of the alcoholic and other parent to the kids in this family. Place this volunteer at the right hand of the alcoholic, standing on the floor. The alcoholic places one or both hands on the spouse, leaning on this person for support. If using props, hand the volunteer the “tranquilizer” bottle.

Point out that the alcoholic must have a Chief Enabler in the family to take over all of the responsibilities so that the addict can drink. In passing on all of this responsibility the alcoholic puts a lot of weight on the enabler’s shoulders.

3. Ask a third volunteer to play the Hero child in the family. This person stands at the right side of the Enabler supporting the Enabler by holding the Enabler’s left arm. If using props, hand the volunteer the blue ribbon or the gold badge.

The Hero is a perfectionist, “the little helper”, makes straight “A’s”, tries to bring esteem to the family through good works. Is often bulimic, depressed.

4. A fourth volunteer plays the Lost Child. This child stands alone with her back to the group and her hands over her ears. If using props, hand her the bag of cookies.

The Lost Child is so overwhelmed by the chaos in the family that she hides and seeks comfort in animals and food.

5. The fifth volunteer is the Clown or Mascot. This is often the youngest child who feels a lot of tension in the family, doesn’t understand it, and attempts to diffuse it with humor. Sculpt this child jumping up and down with his thumbs in his ears and his fingers waving at the family. If using props, hand the mascot the “Ritalin” bottle.
The Clown or Mascot is often diagnosed as hyperactive and placed on medication for hyperactivity or ADHD.

6. Ask the final volunteer to be the “bad guy,” or the scapegoat in the family. The Scapegoat stands in front of the family, facing them. If using props, hand him the “joint”.

The Scapegoat takes drugs, gets into trouble with the law, acts out in school, and otherwise diverts attention in the family from the alcoholic. The family needs him to act out so that they can avoid the real problem.

7. Once all of the members of the family are in place, ask them, on the count of three, to all point to the Scapegoat and yell “it’s all your fault!” and then freeze.

**Discuss with participants**
- After a few moments, ask the volunteers in the sculpture to come out of their characters and one at a time, tell us what it was like to be a member of this family.
- Ask the audience: What were you observing about this family?

**Discuss each role and refer to Handouts 7 – 16.**

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**Trainer Notes:**
Option 2: Interactive Theater (1 hour 15 minutes for performance and discussion)

You may use Interactive Theater to demonstrate the roles in a family where there is chemical dependence. To do so, contact the Cross Disciplinary Training Project staff for a directory of Interactive Theater groups throughout the state. If you choose to use this option, please skip Unit 4: Video.

1. Introduce the Theater Director and Group. They will then proceed to explain the process of interactive theater.

2. The performance and process will take about one hour.

3. Interactive Theater group will take the time to process the skit.

4. After the theater group leaves, ask the participants if they have any questions about what they just observed.

Trainer Notes:
Unit 4: Video – “Living a Lie” (45 minutes)

Purpose:
Provide a basic knowledge about potential impact on the children and child development. Dramatize the positions of each member of the addicted family.

Handouts for Unit 4:
• Session 2, Handout 16-18: Alcoholism: Family Dynamics
• Session 2, Handout 19: Alcoholism and the Family

Suggested Order of Activities:
1. Introduce Video: Before the video begins please remind participants that sometimes watching this can bring up painful memories.

2. Show Video (takes 30 minutes).

3. Process: Ask the group to share their thoughts and feelings about the video.

4. Discuss Handouts 16-19.

Trainer Notes:
Unit 5: Treatment (15 minutes)

Purpose:
Give participants a basic knowledge about substance abuse treatment for the individual and the family. Promote the understanding that it is difficult to change even when the behavior has a negative impact on our lives or our families.

Handouts for Unit 5:
- Session 2, Handout 20: Types of Treatment Services
- Session 2, Handout 21: Barriers to Treatment for Women
- Session 2, Handout 22: Self Help Groups
- Session 2, Handout 23: Maine Alcohol and Other Drug Abuse Services
- Session 2, Handout 24-25: Stages of Change
- Session 2, Handout 26: Learning to Let Go

Suggested Order of Activities:

1. Discuss overview of treatment and the continuum of care available for chemically dependent individuals and families.
   Briefly review:
   - Individual Outpatient Counseling
   - Intensive Outpatient Treatment
   - Detoxification
   - Inpatient
   - Residential Treatment
   - Self Help Groups

2. Discuss local treatment availability and how to access the Office of Substance Abuse for information.
   Show the overhead with the address, telephone number and e-mail for OSA, or write them up on a flip chart. Also note the resources/ informational brochures that you brought.
   Give the participants time to ask questions about treatment and how to interact with the children they work with.

   While discussing the types of treatment services available in Maine, plan to touch on the issue of Mandated Treatment. Discuss the fact that many people are mandated to receive substance abuse treatment, through the Department of Human Services, and Department of Corrections. You may also want to point out and discuss the handout on Barriers to Treatment for Women.

3. Exercise: Making Changes
   a. Ask the participants to sit back and think of a time that someone they knew (family, friends, co-workers, etc.) asked them to change a behavior. Now ask them to make a list of the feelings that they felt when someone asked them to change.

   b. Process this list of feelings and reactions to someone else making decisions for us.

   c. Now ask the participants to think about something that they currently want to change in their lives or think about something in their lives that they recently made the decision to change.
**Unit 5 (Continued)**

d. Refer to the handout on Stages of Change and ask the participants where they are in changing this behavior. Process and relate this to substance abuse.

In debriefing the stages of change exercise, it may be helpful to refer participants to the handout on “Learning to Let Go”. We want participants to understand the often long and difficult process of making life altering changes and to encourage them to take care of themselves within their own families or when working with children or families who may be exhibiting abuse affected behaviors.

4. Discuss the importance of using a strengths perspective when working with individuals and families affected by substance abuse.

In your facilitator’s guide there is an essay entitled “Thoughts on the Strengths Perspective”. Read through this before the session. It might help to frame the discussion on the importance of working with clients from a strengths perspective.

**Trainer Notes:**
Unit 6: Role Plays (Optional, 30 minutes)

Purpose:
Illustrate the difference in the way child care providers respond to inebriated fathers versus inebriated mothers; an exploration into values.

Handouts for Unit 6:
• Session 2, Handout 27: Group Role Play (A)
• Session 2, Handout 28: Group Role Play (B)

Suggested Order of Activities:

1. Divide participants into two groups, and assign each group a different Role Play

2. Ask each group to recreate the following: an inebriated parent picking up his/her child. Each group must decide how they will handle this situation and then recreate it in the role play. The roles should include at least (a) a parent and (b) the child care provider. They can add other roles if they choose (for example a police officer, other children, or other parents).

3. The conditions for each scenario are slightly different and are described on the role play sheet.

4. Every member of the group does not have to play a role. Those group members without roles should be available to advise and consult with the players during the role play.

5. Take 8-10 minutes to prepare for the role play; 5 – 8 minutes each to enact them.

6. Bring the group back together for a large group discussion.

   Ask:
   - What was the difference between the groups?
   - How (if at all) did the sex of the parent affect our response to the situation?
   - How should the child care provider respond?
   - Have you ever been involved with this type of a situation, and what did you do?
   - Does your agency have policies in place regarding how to handle similar situations?

The large group debrief is an important part of this exercise. It can be used to create a discussion about both the values and beliefs we carry into our interactions with children and families and the policies and procedures our agencies have to help us deal with difficult situations. Encourage the participants to bring the information back to their agencies.

Trainer Notes:
**Closure to Session** (5 minutes)

1. Thank the group for their participation in this session.

2. Conduct a brief check-in with group members and encourage them to use self care strategies between now and the next session. Remind them that the information they received today was an overview, and it is not the intention of the training to make them counselors.

3. Distribute your business cards (optional) and encourage participants to contact you or your office any time they have questions.

4. Distribute Session 2 Evaluations and encourage participants to be candid and thorough. Remind the group to keep voice tones low as they are leaving so that others may concentrate.

**Trainer Notes:**
Social work, like so many other helping professions, has constructed much of its theory and practice around the supposition that clients become clients because they have deficits, problems, pathologies, and diseases; that they are, in some critical way, flawed or weak. This orientation is rooted in a past where certainties and conceptions about the moral defects of the poor, the despised, and the deviant held thrill. More sophisticated terms prevail today, but the metaphors and narratives that guide our thinking about our clients are essentially negative constructions that are fateful for their future. The diction and symbolism of weakness or deficit shape how others regard clients, how clients regard themselves, and how resources are allocated to groups of clients; in the extreme they may lead to punitive sanctions.

The language of pathology and deficit gives voice to particular assumptions and leads to certain ends.

**CLIENTS HAVE MANY STRENGTHS**

Individuals and groups have vast, often untapped and frequently unappreciated reservoirs of physical, emotional, cognitive, interpersonal, social and spiritual energies, resources, and competencies. These are invaluable in constructing the possibility of change, transformation, and hope. It is clear that individuals sometimes do not define some of their attributes or experiences as resources. It is likewise true that individuals sometimes are unaware of some of their own strengths, that some of their knowledge, talents, and experience can be used in the service of recovery and development — their own and that of others (Saleebey and Lan. on, 1980; Weick et al., 1989.)

**THE SOCIAL WORKER IS A COLLABORATOR WITH THE CLIENT**

The role of “expert” or “professional” may not provide the best vantage point from which to appreciate client strength. A helper may be best defined as collaborator or consultant; an individual presumed because of some specialized education, training, and experience to know some things, but definitely not the only one in the situation to have relevant, important, even esoteric knowledge. Clients are usually the experts on their own situation and we make a serious mistake when we subjugate their knowledge to official views. There is something liberating about genuinely connecting with clients and their hopes, fears, stories; much more liberating, perhaps, than trying to stuff them into the narrow confines of a diagnosis or assessment category. As we have said, to appreciate the strength of the individual is to begin to understand the uniqueness of that individual.
Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following occurring at any time in the same 12-month period:

(1) tolerance, as defined by either of the following:
   (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   (b) markedly diminished effect with continued use of the same amount of the substance

(2) withdrawal, as manifested by either of the following:
   (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
   (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms

(3) the substance is often taken in larger amounts or over a longer period than was intended

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects

(6) important social, occupational or recreational activities are given up or reduced because of substance use

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

*DSM IV
CRITERIA FOR SUBSTANCE ABUSE*

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

   (1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
   (2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
   (3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
   (4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

*DSM IV
A Chart of Alcohol Addiction and Recovery
Adapted by E.M. Jelinek

Enlightened and interesting way of life opens up with road ahead to higher levels than ever before.

Group therapy and mutual help continue
Rationalizations recognized
Increasing tolerance

Care of personal appearance
Contentment in sobriety
Increase of emotional control

First steps toward economic stability
Appreciation of real values
Facts faced with courage

New circle of stable friends
Natural rest and sleep
Desire to escape goes

Realistic thinking
Return to self-esteem
Diminishing fears of the unknown future

Regular nourishment taken
Appreciation of possibilities of new way of life
Start of group therapy

Onset of new hope
Physical overhaul by doctor
Meets former addicts normal and happy

Spiritual needs examined
Meets former addicts normal and happy

Stops taking alcohol
Told addiction can be arrested

Honest Desire to receive help
Learns alcoholism is an illness

Continues in vicious circles

Facts faced with courage
Rebirth of ideals

New circle of stable friends
Natural rest and sleep
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Honest Desire to receive help
Learns alcoholism is an illness

Continues in vicious circles
Enlightened and interesting way of life opens up with road ahead to higher levels than ever before.

Increasing

Group therapy and mutual help continue
Rationalizations recognized early
Care of personal appearance
First steps toward self-reliance
Contentment not based on substance abuser's behavior
Confidence of children regained

Increase of emotional control
Is assisted in personal stock-taking
New circle of stable friends
Realistic thinking
Healthy self-interest develops

Desire to escape goes, as ability to say “no” increases

Attends group meetings regularly
Obtains help for own drug, alcohol or behavior addiction
Appreciation of possibilities of new way of life
Onset of new hope
Right thinking begins

Faces powerlessness
Told recovery is possible whether substance abuser gets help or not
Learns “loving too much” is an illness
Honest desire for help no matter what substance abuser does

Willingness to seek help

Curves for the Family

Overly responsible, overly nurturing behavior developed in dysfunctional family of origin

Attracted to those who need her/him

Tries to “love” partner as well as she/he tried to “love” sick parents

Increasing emotional dependency on partner

Feeling of guilt

Begins to doubt perceptions

Increasing focus on substance abuser’s behavior

Obsession with covering up problems

Aggressive behavior toward partner's desire for revenge

Efforts to control substance abuser fail repeatedly

Tries geographical escapes with substance abuser

Family and friends avoided

Unreasonable resentments

Nervous disorders manifest

May develop alcohol or drug dependency

Onset of lengthy depressions

Impaired thinking, depression

Indefinite fears, paranoia

Complete obsession with partner

All attempts to control are exhausted

OBSESSION WITH SUBSTANCE ABUSER CONTINUES IN VICIOUS CIRCLES

Source: Adapted from M.M. Glatt M.D., D.P.M

January 2004

Session 2, Handout 4
FAMILY ROLES: THE CHEMICAL OR BEHAVIOR ADDICT

The “Addict” seeks comfort and escape from what feels like a tremendous burden of responsibility. They haven’t acquired the skills to cope with pain any other way.

The Addict’s Job: Create the chaos to which everyone else reacts.

<table>
<thead>
<tr>
<th>ROLE</th>
<th>WHAT IS OFTEN SEEN</th>
<th>WHAT IS HIDDEN</th>
<th>WHAT IS NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHEMICAL OR BEHAVIORAL ADDICT</td>
<td>THE MASK Charming Grandiose Aggressive Self righteous Rigid Blaming</td>
<td>SHAME Worthlessness Fear Guilt Loneliness Despair</td>
<td>LOVE Supportive confrontation Being held accountable Acceptance Private space and time Validation</td>
</tr>
</tbody>
</table>

The true feelings are surrounded by the wall of protection, which traps the Addict into a rigid, painful denial system. Typical compulsive behavior includes: workaholism, religious addiction, rageaholism, gambling addiction, and/or sex addiction.
The “Reactor” is the person upon whom the “Addict” relies most heavily, although often this is a hidden dependency. As the disease progresses, Reactors become more and more enmeshed – their lives revolve around the Addict – they become consumed with their efforts to change, control, manipulate or compensate for the addict’s destructive behavior.

**The Reactor’s Job:** Maintain control at any cost

<table>
<thead>
<tr>
<th>ROLE</th>
<th>WHAT IS OFTEN SEEN</th>
<th>WHAT IS HIDDEN</th>
<th>WHAT IS NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>REACTOR “The Chief Enabler”</td>
<td>THE MASK</td>
<td>SHAME</td>
<td>LOVE</td>
</tr>
<tr>
<td></td>
<td>Super responsible</td>
<td></td>
<td>Supportive confrontation</td>
</tr>
<tr>
<td></td>
<td>Martyrdom</td>
<td></td>
<td>Detachment</td>
</tr>
<tr>
<td></td>
<td>Wimpish</td>
<td></td>
<td>Meeting their own needs</td>
</tr>
<tr>
<td></td>
<td>Virtuous</td>
<td></td>
<td>Depending on their own identity</td>
</tr>
<tr>
<td></td>
<td>Shaming</td>
<td></td>
<td>Attending to their own feelings</td>
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<tr>
<td></td>
<td>Manipulating</td>
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</table>

Reactors, despite all efforts to the contrary, are “out of control” because they are usually totally out of touch with their own feelings, being trapped behind their wall of focusing on everyone but themselves. Along with relationship addiction, this person often suffers with eating disorders, religious addiction, over spending, chronic illness (often with medication addiction), and/or co-sex addiction.
The “Family Hero” is often, but not always, the oldest child in the family. This child takes on the responsibility for “fixing” the family’s pain. They become hyper-vigilant to everything that’s happening, and seek approval and self-worth through their successes. They often do succeed courageously outside the family, but continue to feel worthless and defeated when all their efforts fail to arrest the progression of the family’s dysfunction.

**The Family Hero’s Job:** Fix everything and make the family look good.

Because they appear strong and capable, Family Heroes often are given the role of “surrogate spouse” to their opposite sex parent. When they finally, often despairingly leave home, Family Heroes frequently suffer “survivor guilt” and continue their efforts to save the family. This hook interferes with their ability to participate fully in their own relationships.
This child perceptively picks what appears to be the “safest” role in the family—remaining mostly unnoticed by being “very good” and “very quiet.” They fade into the background of the chaotic family arena, masking their pain and loneliness behind the wall of disengagement. Because they don’t “squeak”, they receive little of the family’s time, attention or direction. They learn to rely on their own limited resources to survive.

**The Lost Child’s Job:** Being the Person No One Has to Worry About.

<table>
<thead>
<tr>
<th>ROLE</th>
<th>WHAT IS OFTEN SEEN</th>
<th>WHAT IS HIDDEN</th>
<th>WHAT IS NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE LOST CHILD</td>
<td>THE MASK</td>
<td>SHAME</td>
<td>LOVE</td>
</tr>
<tr>
<td></td>
<td>Mellow</td>
<td>Loneliness</td>
<td>Invitation to risk</td>
</tr>
<tr>
<td></td>
<td>Loner</td>
<td>Rage</td>
<td>Active participation</td>
</tr>
<tr>
<td></td>
<td>Super independent</td>
<td>Valueless</td>
<td>Encouragement</td>
</tr>
<tr>
<td></td>
<td>Retreating</td>
<td>Fear of exposure</td>
<td>Positive attention</td>
</tr>
<tr>
<td></td>
<td>Reticent</td>
<td>Powerlessness</td>
<td>Reassurance</td>
</tr>
</tbody>
</table>

Lost children have great difficulty contacting and sharing their emotions, so their relationships tend to be shallow and unfulfilling. Their carried shame can grow to overwhelming proportions. Their loneliness may drift them to depression and severe withdrawal, often with suicidal tendencies.
FAMILY ROLES: THE MASCOT

The Mascot is often, but not always, the youngest child. No one takes this child too seriously, and he or she is often shielded and protected from the unacknowledged “battleground” of the system. The Mascot provides amusement, affection, and/or distraction, giving the family a semblance of normalcy.

The Mascot’s Job: Provide diversion with “Monkey Business.”

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<thead>
<tr>
<th>ROLE</th>
<th>WHAT IS OFTEN SEEN</th>
<th>WHAT IS HIDDEN</th>
<th>WHAT IS NEEDED</th>
</tr>
</thead>
</table>
| THE MASCOT    | THE MASK
               Peacemaker
               Non-serious “Monkey Business”
               Lovable
               Attention-seeking
               Fragile | SHAME
               Confusion
               Feeling “left-out”
               Terror of being alone
               Helpless
               Looking “little” | LOVE
               Inclusion
               Consultation
               Affection taken seriously
               Affirmation |

Behind their wall of being cute, charming, and unaffected, Mascots acutely sense the insecurity of the family system, and feel excluded and unable to fend for themselves. They struggle with emotional immaturity and dependency throughout their adult lives. They tend to live out the self-fulfilling prophecy of being clumsy, inadequate, and needy.
The “Scapegoat” absorbs the blame for the family’s dysfunction. They are hypersensitive, and learn early that the Family Hero is in a no-win position. They react oppositionally, and look for their validation and support outside the family, usually with peers who are also Scapegoats from other dysfunctional families.

**The Scapegoat’s Job:** Provide a “Dumping Ground” for the family’s anger—enabling everyone else to feel superior.

### The Scapegoat

**“I’ll Show You!”**

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<tr>
<th>ROLE</th>
<th>WHAT IS OFTEN SEEN</th>
<th>WHAT IS HIDDEN</th>
<th>WHAT IS NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THE SCAPEGOAT</strong></td>
<td>THE MASK “Forbidden behaviors” Defiance Acting out Loyalty to peers Blaming</td>
<td>SHAME Rejection Worthlessness Loneliness Confusion Fear of trusting</td>
<td>LOVE Supportive confrontation Structure Acceptance Positive attention Consistency Opportunity for successes</td>
</tr>
</tbody>
</table>

Scapegoats react to the family’s rejection with anger and defiance. Negative attention is seen as better than being ignored. Forbidden behaviors may include: acting out sexually, use of chemicals, truancy, fighting, etc. Their anger often gets generalized to all authority figures, so they usually have trouble with money, the legal system, employers, etc. Spiritually, they rebel against their perception of a blaming and angry God.
# FAMILY ILLNESS IN CHILDREN

**Designed by:** Linda Mix  
**Information taken from:** “The Family Trap” by Sharon Wegscheider, Johnson Institute, 1976

<table>
<thead>
<tr>
<th>FAMILY</th>
<th>VISIBLE QUALITIES</th>
<th>INNER FEELINGS</th>
<th>REPRESENTS TO FAMILY</th>
<th>CHARACTERISTICS</th>
<th>POSSIBLE FUTURE CHARACTERISTICS</th>
</tr>
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<tbody>
<tr>
<td>HERO</td>
<td>VISIBLE SUCCESS</td>
<td>INADEQUATE</td>
<td>SELF-WORTH</td>
<td>HIGH ACHIEVER</td>
<td>WORKAHOLIC</td>
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<tr>
<td></td>
<td>DOES WHAT’S RIGHT</td>
<td></td>
<td>(FAMILY CAN BE PROUD)</td>
<td>GRADES FRIENDS</td>
<td>NEVER WRONG</td>
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<td></td>
<td></td>
<td></td>
<td>SPORTS</td>
<td>RESPONSIBLE FOR EVERY-THING</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MARRY DEPENDENT</td>
</tr>
<tr>
<td>SCAPEGOAT</td>
<td>HOSTILITY</td>
<td>HURT</td>
<td>TAKES THE FOCUS OF THE ALCOHOLIC</td>
<td>NEGATIVE ATTENTION</td>
<td>UNPLANNED PREGNANCY</td>
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<tr>
<td></td>
<td>DEFIANCE</td>
<td>Guilt</td>
<td></td>
<td>WON’T COMPETE WITH “FAMILY HERO”</td>
<td>TROUBLE MAKER IN SCHOOL &amp; LATER IN OFFICE</td>
</tr>
<tr>
<td></td>
<td>ANGER</td>
<td></td>
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<td></td>
<td>PRISON</td>
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<tr>
<td>LOST CHILD</td>
<td>WITHDRAWN</td>
<td>LONELINESS</td>
<td>RELIEF</td>
<td>“INVISIBLE” QUIET</td>
<td>LITTLE ZEST FOR LIFE</td>
</tr>
<tr>
<td></td>
<td>LONER</td>
<td>UNIMPORTANT</td>
<td>(ONE CHILD NOT TO WORRY ABOUT)</td>
<td>NO FRIENDS FOLLOWER</td>
<td>SEXUAL IDENTITY PROBLEMS</td>
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<td></td>
<td></td>
<td></td>
<td>TROUBLE MAKING DECISIONS</td>
<td>PROMISCUOUS OR STAY ALONE</td>
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<td>OFTEN DIES AT EARLY AGE</td>
</tr>
<tr>
<td>MASCOT</td>
<td>FRAGILE IMMATURE</td>
<td>FEAR</td>
<td>FUN &amp; HUMOR (COMIC RELIEF)</td>
<td>HYPERACTIVE LEARNING DISABILITIES</td>
<td>ULCERS, CAN’T HANDLE STRESS</td>
</tr>
<tr>
<td></td>
<td>NEEDS PROTECTION</td>
<td></td>
<td></td>
<td>SHORT ATTENTION SPAN</td>
<td>COMPULSIVE CLOWN</td>
</tr>
<tr>
<td></td>
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<td>MARRY “HERO” FOR CARE</td>
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<td>REMAINS IMMATURE</td>
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</table>

**Without Help**

**With Help**

- ACCEPT FAILURE
- RESPONSIBLE FOR SELF, NOT ALL GOOD
- GOOD COUNSELORS
- COURAGE
- ABILITY TO SEE REALITY
- INDEPENDENT
- TALENTED
- CREATIVE
- IMAGINATIVE
- SELF-ACTUALIZED
- TAKE CARE OF SELF
- NO LONGER CLOWN
- FUN TO BE WITH
- GOOD SENSE OF HUMOR
CO-DEPENDENCY AND THE FAMILY SYSTEM

1. Co-dependency is an unhealthy way of living and problem-solving that is maintained by unspoken rules within the family system and consequently makes it difficult to achieve healthy growth and change.

Some common characteristics include:
- difficulty with identifying feelings
- difficulty with expressing feelings
- difficulty with forming or maintaining close relationships
- perfectionism or high expectations for self and others
- rigidly adheres to attitudes and behaviors that he/she knows are counterproductive and unhealthy
- has difficulty accepting and adjusting to change
- feels overly responsible for another person’s behavior or feelings
- constantly needs another person’s approval to feel good about self
- difficulty with making decisions; over-analyzes and excessively worries
- feels powerless and believes that he/she can make no difference
- sense of shame, low self-esteem based on perceived failures

2. Some co-dependent people appear to be self-sufficient, strong, and in control. Underneath this image are the opposing feelings of insecurity, self-doubt, and confusion.

In infancy, our private and public selves are equal. As we learn to deny who we are to live up to other people’s expectations, our “real” or private self gets stuck and our public self becomes distorted. These living patterns develop through practice and we gradually become co-dependent. How we treat ourselves and other people is a result of the rules we learned to follow when we were growing up. However, we can learn and then choose new ways of being.

Here are some “rules” that prevent a co-dependent person from freely learning and choosing new ways:
- It’s not OK to discuss problems.
- Don’t openly express feelings.
- Communication is best if indirect with one person acting as the messenger between two others (triangulation).
- Have unrealistic expectations especially in perceived response to someone else.
- Don’t be selfish.
- Do as I say, not as I do.
- It’s not OK to play or to be playful.
- Don’t rock the boat.

3. If you look carefully at the “rules”, you will see that they all protect or isolate the person from other people by minimizing risks which might lead to more intimacy or closeness than desired.

Here are some growth enhancing rules or affirmations:
- I share my problems and get feedback about myself from other persons.
- I express persistent feelings with the appropriate person.
- I speak for myself.
- I gradually let go of the need for perfection, details, and for always being “right.”
- I enjoy caring about me. Doing things for myself is healthy.
- I follow through with actions rather than just words.
- I have fun. I can even be silly.
- I look at change as healthy, as fun, and as a challenge.
## COMPARING CO-DEPENDENT AND ABUSE AFFECTED BEHAVIORS*

<table>
<thead>
<tr>
<th>CO-DEPENDENT</th>
<th>ABUSE AFFECTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I assume responsibility for another’s feelings or behaviors.</td>
<td>• I am held responsible for the abuser’s feelings and behaviors.</td>
</tr>
<tr>
<td>• I feel especially responsible for another’s feelings or behaviors.</td>
<td>• For my safety, I must be aware of the abuser’s feelings or behaviors.</td>
</tr>
<tr>
<td>• I have difficulty expressing feelings.</td>
<td>• If I express my feelings, I jeopardize my safety.</td>
</tr>
<tr>
<td>• I have difficulty forming or maintaining close relationships.</td>
<td>• It is dangerous for me to form or maintain close relationships.</td>
</tr>
<tr>
<td>• I am afraid of being hurt or rejected.</td>
<td>• Having been hurt or rejected, I am afraid of it happening again.</td>
</tr>
<tr>
<td>• I judge myself with other people’s standards. Nothing is good enough.</td>
<td>• I am usually harshly judged by the abuser. Nothing I do is good enough.</td>
</tr>
<tr>
<td>• I question or ignore my own values to connect with significant others.</td>
<td>• The abuser ignores or devalues my opinions. For my safety, I value the abuser’s opinions more than my own.</td>
</tr>
<tr>
<td>Nothing is good enough.</td>
<td>• My self esteem is systematically destroyed by my abuser’s tactics.</td>
</tr>
<tr>
<td>• My self esteem is bolstered by outside influences.</td>
<td></td>
</tr>
</tbody>
</table>

*developed by P. Ford-McComb & T. Hubacher, Family Crisis Shelter, Portland, ME, 1991
### STAGES OF SUBSTANCE ABUSE IN THE HOME: EFFECTS ON CHILDREN

<table>
<thead>
<tr>
<th>SUBSTANCE ABUSE STAGE</th>
<th>PARENTAL EFFECTS</th>
</tr>
</thead>
</table>
| PROBLEM USER: episodic heavy use | inconsistent home life  
exposure to “using” behaviors  
exposure to “scary” behaviors  
frequent real or imagined illnesses  
frequent “parties”  
increased self-care, especially in the morning  
learned association that behaviors are OK |
| EARLY STAGE: increase in tolerance, and number of blackouts, increased guilt around using | behaviors listed above, plus...  
parent role models frequent drinking, smoking joints, or using syringes and needles  
increased preoccupation with using less time for emotional contact with children  
confusion or double messages; parent’s guilt-motivated behavior which compounds child’s confusion  
braken promises  
increased episodes of angry outbursts  
problems at school begin  
problems with peers begin  
problems with trust begin |
| MIDDLE STAGE: family and friends becoming concerned; increased emotional and social isolation; increasing problems with work, friends and relationships | same as above plus...  
as user struggles internally, children are more emotionally distanced  
children witness arguments and fights; sense there’s a problem  
children get involved with trying to control parent’s using  
children internalize problem and consider themselves the problem  
decreased functioning at school and with peers  
increasingly rebellious behavior puts child at risk of choosing rebellious peers  
increasing number of broken promises  
children lose trust  
increased fighting within the family  
increasing possibility of physical violence toward the children  
children are left to “raise” themselves and siblings  
poor finances increases risk of not meeting basic needs  
increased safety risks due to lack of supervision |
| LATE STAGE: lower tolerance; health problems; more binging; acute depression and increasing episodes of suicidal thoughts and actions | same as above plus...  
children who respond to crises but increase emotional distance from using parent  
increasing levels of children’s self-blame and self-contempt  
increase in destructive life choices  
increased suicidal thoughts/actions by child |
FACTS ABOUT THE CHILDREN OF ALCOHOLICS*

Children of alcoholic parents may have a variety of problems such as:

**Guilt.** The child may see him/herself as the main cause of the parents drinking.

**Anxiety.** The child may constantly worry about the situation at home. He/she worries about whether the alcoholic parent will become sick or injured. The child may also fear fights and violence between the parents.

**Embarrassment.** Parents may give the message that there is a terrible secret at home. The ashamed child does not invite friends home and is afraid to ask anyone for help.

**Inability to have close relationships.** Because the child has been disappointed so many times by the drinking parent, he/she often does not trust others.

**Confusion.** The alcoholic parent may suddenly change from loving to being angry regardless of the child’s behavior. A regular daily schedule which is important to a child, does not exist because bed times and meal times are constantly being changed.

**Anger.** The child is angry at the alcoholic parent for drinking, and may also be angry at the non-alcoholic parent for lack of support and protection.

**Depression.** The child feels lonely and helpless to change the situation.
ALCOHOLISM: FAMILY DYNAMICS

THE HERO: Always volunteers, feels responsible, and is driven to succeed. The child has a need for attention and approval. Often a class leader who assumes a parental or bossy approach with peers. Often acts older than his/her age, becoming disappointed when he/she loses or doesn’t get what he/she wants. Frequently leads to depression and self-criticism. Tends to act superior or condescending when winning and is frequently labeled as a “teacher’s pet” by other students.

How to Interact

**DO...**

1. give child attention at times the child is not achieving

2. validate the child’s intrinsic worth and try to separate the child’s behavior from his/her person—i.e., separate the child’s feelings of self-worth from the child’s achievements

3. let the child know that it’s OK to make a mistake; encourage and validate the child trying new things that he/she may not be good at

**DON’T...**

1. let the child monopolize conversations or always be the first to answer a question or volunteer

2. let the child validate his/her worth only by achieving

THE MASCOT: Uses humor or distracts for attention. Child likes to hide, make faces, and play practical jokes as part of his/her acting out behavior.

How to Interact

**DO...**

1. appropriately respond to the “class clown’s” behavior -e.g., reprimand without personalizing, ignore, negatively reinforce

2. try to give the child an assignment or job that has some importance and responsibility

3. hold the child accountable

4. encourage responsible behavior

5. encourage appropriate sense of humor

6. insist on eye contact

**DON’T...**

1. laugh with him/her or he/she won’t take you seriously in other interactions

2. laugh at silly behavior
ALCOHOLISM: FAMILY DYNAMICS

THE LOST CHILD: Teachers and other adults sometimes can’t remember child’s name because he/she is so quiet and is seldom a behavior problem. Has few friends. Likes to work alone and is often creative in non-verbal areas such as art and writing. Peers either leave them alone or tease them about not being involved.

How to Interact

<table>
<thead>
<tr>
<th>DO...</th>
<th>DON’T...</th>
</tr>
</thead>
</table>
| 1. inventory your children; if there are names you consistently can’t remember, you may have identified lonely, lost children  
2. try one to one contact; talk to him/her  
3. point out and encourage child’s strengths, talents, and creativity  
4. try to identify the child’s personal interests  
5. use touch sparingly at first  
6. help the child build a relationship  
7. encourage working in small groups to build confidence | 1. let child remain silent by not actively involving him/her or not calling on him/her  
2. allow other children to take care of him/her by talking and answering for him/her |

THE SCAPEGOAT: Tends to blame others, makes strong peer alliances, and is often disciplined for being disruptive and breaking rules. The child is usually considered “irritating,” stubbornly defiant, irresponsible, and verbally challenging. Adults are usually heard to say, “I don’t know what to do with that child!” or “I’ve tried everything and he still acts that way!”

How to Interact

<table>
<thead>
<tr>
<th>DO...</th>
<th>DON’T...</th>
</tr>
</thead>
</table>
| 1. let the child know immediately when behavior is inappropriate  
2. reinforce the child when he/she takes responsibility  
3. remember that the child is hurting inside which might reduce your anger  
4. set limits; give clear explanations of responsibilities and clear choices and consequences  
5. help child understand that he/she is accountable for behavior; use a key phrase whenever he/she acts out like “who’s in control now?”  
6. consistently follow through with consequences | 1. feel sorry for the child  
2. treat the child as special and give him more power  
3. agree with the child’s complaints about the other children or adults  
4. take the child’s behavior personally or as a sign of your own incompetence |
ALCOHOLISM: FAMILY DYNAMICS

SUMMARY

1. Understand child’s role as a survival mechanism. Your anger, frustration, judgmental behavior, and intolerance does not help them.

2. If you have personal experience with alcoholism in the home, you need to address it before you can successfully work with children facing the same problem.

3. The child’s behaviors have nothing to do with your skills or competencies.

4. You can’t always change the child. But you can continue to give the child feedback in an effort to help him/her initiate change - i.e., you can create the conditions and increase the potential for change.

5. Teachers, child care providers, nurses, and other practitioners are not fixers. You aren’t responsible for getting the family straightened out but you can be supportive and offer feedback and hope.

6. Don’t carry the pain.

7. Let the children know that they are not alone and that it’s not their fault that their mother or father has a problem.

8. Teach the child that parental alcoholism does have an effect on them and that it might increase the possibility that they might become addicted to alcohol or other substances.

9. Help them separate the parent from the alcohol or drug-induced behavior.
ALCOHOLISM AND THE FAMILY*

Important concluding points from this last section are:

• The addict, as s/he becomes a victim of his/her addiction, covers his/her decreasing self-worth with protective behaviors.

• The spouse covers his/her growing pain by developing protective behaviors.

• The children cover their growing pain by developing protective behaviors.

• All family members are out of touch with their ability to generate good feelings for themselves.

• All family members feel powerless to change the situation.

• Each family member carries his/her dysfunction with him/her as a part of his/her personality pattern.

• Family members’ dysfunction will tend to interfere with their outside life.

• Or, they develop two personalities, one for the family and one for the outside world.

• They play survival role, which is different from who they really are.

At this point each family member needs treatment, and can be helped whether or not:

1) the alcoholic is still drinking;
2) they have left the system; or
3) they are senior citizens.

Even if the alcoholic has left or drinks until death, other family members can get well.

TYPES OF TREATMENT SERVICES*

Detoxification

A “detox” is a residential program that provides assessment, diagnosis, and medical treatment to stabilize people who are experiencing withdrawal from alcohol or other drugs.

Residential Rehabilitation

Residential rehabilitation programs offer substance abuse treatment in a twenty-four hour residential setting for seven to twenty-one days. Treatment includes lectures, groups and individual counseling.

Extended Care

Clients with extensive substance abuse or coexisting disorders of substance abuse and mental illness may enter an extended care program, a residential treatment program that offers treatment stays in excess of 180 days.

Intensive Outpatient

Nonresidential rehabilitation programs provide intensive and structured substance abuse treatment, three to four days a week. The programs usually last three or four weeks and may be conducted during the daytime or in the evening.

Outpatient

This treatment model is non-residential. Outpatient programs offer individual, group and family sessions, usually for an hour or ninety minutes once a week.

Halfway House

Halfway houses are three to six-month residential programs that provide support for sobriety, and prepare clients to re-enter the work force and re-establish themselves in the community. The programs help clients develop socialization skills and vocational needs.

Shelter

Shelters provide food, clothing, and lodging for up to twelve hours a day. Shelter programs can also motivate people to seek and enter treatment.

Extended Shelter

An extended shelter offers structured residential treatment for people who are on waiting lists for residential treatment or have completed detoxification and need to develop a social support system to help them remain sober.

Methadone Detoxification

This is a program that provides opioid detoxification. The detoxification process involves the reduction of Methadone to a zero dosage upon discharge.

Methadone Maintenance

Under medical supervision, Methadone Maintenance clinics administer opioid agonists, monitor dosages, and provide counseling to people with a dependence on heroin or other morphine-like drugs.

*Information compiled from Maine Office of Substance Abuse Website: www.state.me.us/bds/osa/directory/definitions.htm 07/03
# HANDOUT
## Caring for the Abuse Affected Child and Family

### BARRIERS TO TREATMENT FOR WOMEN*

<table>
<thead>
<tr>
<th>Personal</th>
<th>Interpersonal</th>
<th>Societal</th>
<th>Treatment Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal denial</td>
<td>Child custody and access concerns</td>
<td>Values</td>
<td>Lack of women-centered components e.g. child care</td>
</tr>
<tr>
<td>Shame and Guilt</td>
<td>Lack of child care</td>
<td>Attitudes</td>
<td>Lack of diversity-sensitivity</td>
</tr>
<tr>
<td>Fear of losing love, support, &amp; security</td>
<td>Lack of partner/family support for their participation in treatment</td>
<td>Stigma - as a woman who is a user</td>
<td>Lack of information</td>
</tr>
<tr>
<td>Being overwhelmed by other things</td>
<td></td>
<td>Stigma - as a participant in treatment</td>
<td>Lack of flexibility (time, duration)</td>
</tr>
<tr>
<td>Fear of criminal prosecution</td>
<td></td>
<td></td>
<td>Costs - treatment, transportation, child care</td>
</tr>
</tbody>
</table>


January 2004

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Session 2, Handout 21
Alcoholics Anonymous

The original Twelve-Step recovery program began in 1935. It was founded by two alcoholics to provide mutual help and support for people who have a desire to stop drinking.

Times and places of meetings are usually listed in your local paper. A meeting can usually be found almost every day of the week. If you are unable to locate a meeting in your area, call 1-800-737-6237 for information and assistance.

Narcotics Anonymous

A Twelve-Step program for people addicted to drugs other than alcohol but can include alcohol.

Time and places of meetings are usually listed in your local paper. If you are unable to locate a meeting in your area, call 1-800-737-6237.

Al-Anon

A Twelve-Step recovery program for family members and friends of alcoholics, including Adult Children of Alcoholics (ACOA).

Time and places of meetings are usually listed in your local paper. A meeting can usually be found almost every day of the week. If you are unable to locate a meeting in your area, call 1-800-737-6237 for information and assistance.

Alateen

A Twelve-Step recovery program for adolescent children of alcoholics.

Time and places of meetings are usually listed in your local paper. These meetings are not as frequent and are more difficult to find. These meetings are listed in the local paper and you can also call the information number 1-800-737-6237.

Contact Information: 212-292-0220 or email- SRmail@aol.com
MAINE ALCOHOL AND OTHER DRUG ABUSE SERVICES

Information and Resource Center

Maine Office of Substance Abuse

159 State House Station
A.M.H.I. Complex, Marquardt Building
Augusta, Maine 04333-0159

Telephone: 1-800-287-8900

Web: http://www.state.me.us/bds/osa

Email: osa.ircosa@maine.gov
Quitting an addiction involves different phases. Interventions that work well at one stage may not be effective at another. Researchers have identified the stages of change in quitting an addiction (e.g., DiClemente and Prochaska, 1985). These stages of change can be applied to any lifestyle situation that we are engaged in that impacts our lives negatively, including alcohol, drugs, tobacco products, weight, poor work performance, etc.

1. **Precontemplation**: The person has not yet identified the behavior as a problem. They may believe: “I don’t think ________ is a problem for me.”

2. **Contemplation**: The person has become at least ambivalent, saying things like, “My ________ use is bothering me, but not so much that I have to quit.”

3. **Desire and Commitment**: This is the turning point at which the person decides to change or quit the behavior. They may say things like “____________ is not helping me anymore. I think I might quit but, what do I do?”

4. **Action**: The person starts to take specific steps to quit ________ use. They may say “I need help, I’m going to stop using today.”

5. **Maintenance**: A person is in this stage if he or she has not used for an extended period of time. This stage involves ongoing efforts to keep from going back to using. They may say: “I’ve quit using ________ and I am taking steps to keep myself relaxed, healthy, and away from situations that lead to using.”

6. **Relapse**: People often slip or give up on their efforts to change. Relapse is so common that it needs to be considered a stage in the process. Long-term success in quitting depends on how people respond to relapse, whether they renew their commitment to change, and how they go about getting back on track.
6 STAGES OF CHANGE

Pre Contemplation
Contemplation
Decision
Action
Maintenance
Relapse
Exit

PROCHASKA – DICLEMENTE
LEARNING TO LET GO*

• To let go doesn’t mean to stop caring. It means, I am caring. It means, I can’t do it for someone else.

• To let go is not to cut myself off; it’s the realization that I can’t control another.

• To let go is not to enable, but to allow learning from consequences.

• To let go is to admit powerlessness, which means the outcome is not in my hands.

• To let go is not to try to change or blame another. I can only change myself.

• To let go is not to care for, but to care about.

• To let go is not to fix, but to be supportive.

• To let go is not to judge, but to allow another to be a human being.

• To let go is not to be in the middle of arranging all the outcomes, but to allow others to effect their own outcomes.

• To let go is not to be protective; it is to permit another to face reality.

• To let go is not to deny but to accept.

• To let go is not to nag, scold or argue but to search out my own shortcomings and correct them.

• To let go is not to adjust everything to my desires, but to take each day as it comes and to cherish the moment.

• To let go is not to criticize and regulate anyone but to try and become what I dream I can be.

• To let go is not to regret the past but to grow and live for the future.

• To let go is to fear less and love more.

*Essay from “Spiritual Ministries”
Role Play A: Mother

1. Background: An inebriated parent, the mother, is arriving at the child care center to pick up her child. You must decide how you will handle this situation and recreate it in a role play.

2. Include the following roles:
   - the mother
   - a child care staff member
   - other roles, if you choose, such as a supervisor, the child, etc.; feel free to get volunteers from the rest of the group.

3. Create the situation you think would happen when the inebriated mother comes to pick up her child at the child care center.

4. You have 8 - 10 minutes to prepare for the Role Play and 5 - 8 minutes to enact it.
GROUP ROLE PLAY

Role Play B: Father

1. Background: An inebriated parent, the father, is arriving at the child care center to pick up his child. You must decide how you will handle this situation and recreate it in a role play.

2. Include the following roles:
   - the father
   - a child care staff member
   - other roles, if you choose, such as a supervisor, the child, etc.; feel free to get volunteers from the rest of the group

3. Create the situation you think would happen when the inebriated father comes to pick up his child at the child care center.

4. You have 8 - 10 minutes to prepare for the Role Play and 5 - 8 minutes to enact it.
Session Two:

Substance Abuse
Overview

• Units 1 & 2: Overview of Substance Abuse
• Units 3 & 4: Substance Abuse and the Family
• Unit 5: Substance Abuse Treatment Options
• Unit 6: Role Plays
Purpose

Identify basic knowledge and facts about substance abuse including its prevalence in Maine and its impact on the family system and the child’s development.
Objectives:

1. Understand the difference between substance use, abuse, dependence and addiction.

2. Recognize the potential impact of substance abuse on the entire family.
Objectives:

3. Understand the process that individuals go through when attempting to make changes in their lives.

4. Know how to contact local substance abuse treatment programs.
Substance Abuse

The term most commonly used to describe ‘problem-causing’ use of alcohol and other drugs.
FACILITATOR’S GUIDE

Session Three
Domestic Violence

Table of Contents

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• Unit 6: Domestic Violence Services 13
• Closure to Session 14
• Battered Women’s Risk Analysis Chart 15
• Effects of Domestic Violence on Children 19
• Participant Handouts
• Overheads
Trainer Preparation

For Introduction to Session:

- There are overheads available for the Session Overview, Purpose and Objectives. If you do not have an overhead projector available, prepare 3 sheets of flip chart paper with the following information.

  - **Overview:**
    Unit 1: Self Assessment
    Unit 2-4: Overview of Domestic Violence
    Unit 5: Domestic Violence and Children
    Unit 6: Domestic Violence Services

  - **Purpose:** Sensitize those who work with families and children to the realities of domestic violence - i.e., its causes, consequences, and remedies.

  - **Objectives:**
    1. Explore beliefs, feelings, and judgments about common myths and facts pertaining to domestic violence.
    2. Understand the prevalence of domestic abuse/violence
    3. Recognize abusive behavior
    4. Recognize a battered woman’s risk analysis
    5. Apply the ecological analysis of trauma to domestic violence/abuse
    6. Understand how children are affected by witnessing domestic violence/abuse in the home.
    7. Understand the services provided by domestic violence service agencies
    8. Understand how to make referrals.

For Unit 1:

- Prepare two signs and post them on either side of the training room. One sign should read “Agree” and the other “Disagree”.

- Read through Session 3, Handout 2: Personal Assessment: Domestic Violence. Prioritize which questions you would most like to cover in the exercise. Review Session 3, Handout 3: Myths and Facts about Domestic Violence.

For Unit 2:

- There is an overhead available, Definition of Domestic Violence. If you do not have an overhead projector available or would like to use the definition that your project uses, prepare a sheet of flip chart paper with the definition:

  **Definition of Domestic Violence:** Abuse and battering are systems of behaviors (physical, sexual, verbal, emotional, financial, spiritual, etc.) used by one person to control another’s actions and feelings. One way to think of these behaviors is as tactics, actions which are chosen and planned. An abuser is not “out of control” - the abuser is trying to control the victim.
For Unit 3:
• Bring 19 Person exercise cards.

• Ask one of your co facilitators to play the role of the batterer. You may want to set up a time to practice the exercise before the training.

• Ask another co facilitator to keep an eye on the participants during the activity. This exercise can bring up powerful feelings for some participants.

• If possible, arrange chairs in the training room to form a semicircle around a chair for the battered woman in the center of the circle.

For Unit 4:
• Read “Battered Women’s Risk Analysis Chart”, in Session 3 Facilitator’s Guide.

For Unit 5:
• Read “Effects of Domestic Violence on Children”, in Session 3 Facilitator’s Guide.

• Prepare a sheet of flip chart paper with the following questions:
  • What are the developmental behaviors of children in this age group?
  • What effects would you expect to see in a child of this age living in a home where there is domestic violence?

For Unit 6:
• Bring any project/coalition brochures and information to distribute to participants.

• There is an overhead available, Session 3, Overhead 15: Guiding Principles. If you do not have an overhead projector available, prepare a sheet of flip chart paper with the following:

  **Guiding Principles**
  • Regard the safety of victims and their children as a priority
  • Respect the integrity and authority of each battered woman over her own life choices
  • Hold perpetrators responsible for the abuse and for stopping it
  • Advocate on behalf of the victims of domestic violence and their children
  • Acknowledge the need to make changes in our faith communities to improve our response to domestic violence

For Closure to Session:
• Bring Session 3 evaluations for completion by participants (RDC Team Members).

• Bring plenty of your business cards (optional) to distribute to participants.
Purpose, Objectives, and Outline

**Purpose:**
Sensitize those who work with families and children to the realities of domestic violence - i.e., its causes, consequences, and remedies.

**Objectives:**
1. Explore beliefs, feelings, and judgments about common myths and facts pertaining to domestic violence.
2. Understand the prevalence of domestic abuse/violence.
3. Recognize abusive behavior.
4. Recognize a battered woman’s risk analysis.
5. Apply the ecological analysis of trauma to domestic violence/abuse.
6. Understand how children are affected by witnessing domestic violence/abuse in the home.
7. Understand the services provided by domestic violence service agencies.
8. Understand how to make referrals.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to Session</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Unit 1: Self Assessment</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Unit 2: Power and Control Wheel</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Unit 3: Interactive Exercise</td>
<td>45 minutes</td>
</tr>
<tr>
<td>Break</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Unit 4: Risk Analysis</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Unit 5: Domestic Violence and Children</td>
<td>35 minutes</td>
</tr>
<tr>
<td>Unit 6: Domestic Violence Services</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Closure to Session</td>
<td>5 minutes</td>
</tr>
<tr>
<td><strong>Total Session Time</strong></td>
<td><strong>3 Hours</strong></td>
</tr>
</tbody>
</table>
Introduction to Session (5 minutes)

Overheads for Introduction:
- Session 3, Overhead 1: Overview
- Session 3, Overhead 2: Purpose
- Session 3, Overhead 3 - 4: Objectives

Suggested Order of Activities:

1. Welcome the group back.

2. Briefly present Session Three Overview, Purpose, and Objectives in your own words. There are overheads for each of these if you would like to use them.

3. Remind the group of the sensitive nature of this topic and encourage self care.

4. Go over the ground rules if it would be helpful.

5. Remind participants to de-identify any personal examples.

Trainer Notes:
Unit 1: Self Assessment (30 minutes)

Purpose:
Explore beliefs, feelings, and judgments about common myths and facts pertaining to domestic violence and to understand the prevalence of domestic abuse/violence.

Handouts for Unit 1:
• Session 3, Handout 1: Domestic Violence Statistics
• Session 3, Handout 2: Personal Assessment: Domestic Violence
• Session 3, Handout 3: Myths and Facts about Domestic Violence
• Session 3, Handout 4: Alcohol Abuse and Domestic Violence

For suggestion on key statistics to present, see Session 3, Handout 1.
For myths and facts related to the self assessment, see Session 3, Handout 3: Myths and Facts about Domestic Violence

The purpose of this exercise is to allow the participants to explore their own beliefs, feelings, and judgements about common myths and facts pertaining to domestic violence. Many of the questions asked in the self assessment are not easy to answer, and we want to create a safe place for the group to discuss these issues. Encourage participants to take the time to think about where they fall on the continuum between agree and disagree.

There most likely will not be time to cover all of the questions on the self assessment. Much of this is determined by how interactive the group is. Before the training begins, look through the list and pick out the questions that you would most like to cover during the training. Keep an eye on time and ask more questions if time allows.

Suggested Order of Activities:

1. Introduce any key statistics to help frame the discussion of domestic violence.
2. Explain to participants that we are going to do an exercise designed to help us explore some of the common myths and facts related to the issue of domestic violence.
3. Divide the room in half and place an “agree” sign on one side and a “disagree” sign on the other side.
4. Read a question from the Self Assessment and ask participants to go to the side of the room that matches their response. If they are unsure of their answer they can place themselves anywhere along the continuum.
5. Ask the participants first on one end of the continuum and then the other why they chose to “agree” or “disagree”. Ask those in the middle why they chose to stand where they did.
6. As the facilitator of this exercise, use participants questions and comments to dispel myths or biases.
Unit 2: Power and Control Wheel (20 minutes)

Purpose:
Define domestic violence and acquaint participants with the Duluth Power and Control Wheel.

Handouts for Unit 2:
• Session 3, Handout 5: Power and Control Wheel
• Session 3, Handout 6: Equality Wheel
• Session 3, Handout 7: Culture Wheel
• Session 3, Handout 8: Signs of Abuse
• Session 3, Handout 9: Some Indicators of Abuse at Home
• Session 3, Handout 10: Methods of Coercion

Overheads for Unit 2:
• Session 3, Overhead 5: Definition of Domestic Violence
• Session 3, Overhead 6: Power and Control Wheel
• Session 3, Overhead 7: Equality Wheel
• Session 3, Overhead 8: Culture Wheel

Suggested Order of Activities:

1. Present either the definition of Domestic Violence provided in the curriculum or bring in a definition that your project uses in training. Read from either your prepared flip chart or the overhead.

   Definition of Domestic Violence: Abuse and battering are systems of behaviors (physical, sexual, verbal, emotional, financial, spiritual, etc.) used by one person to control another’s actions and feelings. One way to think of these behaviors is as tactics, actions which are chosen and planned. An abuser is not “out of control” - the abuser is trying to control the victim.

2. Review the Duluth Power and Control Wheel to illustrate the nature of domestic abuse/violence

To help illustrate the Power and Control Wheel, share professional experiences. Use personalized cases to emphasize a point or describe an abusive relationship using the Power and Control Wheel.

Trainer Notes:
Unit 3: Interactive Exercise* (45 minutes)

Purpose:
- Gain an appreciation for the process a battered woman goes through as she experiences abuse and as she seeks support and services from her community
- Recognize the difficult choices battered women face as they try to end abuse in their lives
- Understand the powerful messages used by batterers to maintain power and control
- Observe how batterers manipulate cultural messages to reinforce their control
- Observe how your potential personal and professional roles fit in the community’s response to domestic abuse
- Recognize that your words are heard within a framework or context that you cannot control
- Recognize that achieving safety is complex and can take many paths

Handouts for Unit 3:
- Session 3, Handout 11: The Impact of Domestic Violence on Women
- Session 3, Handout 12: Comparing Co-Dependent and Abuse Affected Behaviors

Suggested Order of Activities:
1. If you are working with a large group, ask for 19 volunteers to come forward to either stand or sit in a semicircle around the trainer portraying the battered woman. Pass out one card per person. In a smaller group you can distribute several cards to each of a few people. The people reading the cards may remain in their seats or line up behind the battered woman in the front of the room. Pass out the cards to training participants.

   These interactions do not happen in a linear fashion in women’s lives. The cards are numbered in an order that works well, but they can be used randomly, since she could be interacting with these people in pretty much any order. Seeking help and perspective is not a connect-the-dots sort of thing. Each person will follow a different route.

2. The person playing the battered woman sits in a chair or stands, facing the audience.

3. The person playing the batterer may stand in one place or move around the room throughout the skit.

4. Once everyone is in place, give the following introduction to the exercise:

   “In this exercise, the people with cards to read are some of the well-meaning people involved in the battered woman’s life — family, friends, and service providers. Each person is to read his or her card. Read both who you are – friend, minister, whatever – and the line written for you to say. After that, I [the trainer] will respond as a battered woman might be thinking or feeling in response to what you have just said – not what she would say. This is meant to reflect her inner process. After I speak as the battered woman, my assistant will provide the voice of the batterer – the voice in my head. It is important to remember that even if we are alone with a battered woman, the batterer is in the room as well, because she carries his voice in her head, his threats, promises, opinions, and attitude. He may not speak every time. Please stay in role throughout the exercise, which will take about 25 minutes. We will discuss your responses afterward.”
Unit 3: Interactive Exercise (Continued)

Note to Performers:
In order for the exercise to be most convincing and realistic, the trainers should draw from their personal and professional understanding of abuse. Take care not to portray the battered woman as entirely helpless, afraid, and overwhelmed. While these are some of her feelings, it is important to reflect a wide range of emotions, such as courage, anger, affection, sense of humor, and frustration. Similarly, the batterer must display both sweet words and threats. He may cut her off sometimes, since one of the points to illustrate is how the batterer’s presence in her mind interrupts the battered woman’s thought process and influences her feelings and choices. It is not necessary for the batterer to speak after every card. When he skips a couple of times, the audience anticipates his voice, engaged in their own little bit of hyper vigilance. The person playing the batterer should not call the person playing the battered woman by her name. It is out of character for a batterer and unsettling for the trainer playing the role. The intensity of the batterer’s presentation should not overwhelm the battered woman’s presence. The focus of the exercise is the battered woman, not the batterer.

5. Debrief the Exercise: When the last card is read, announce that the exercise is over and allow some silent time before moving on to the discussion. Initially, limit audience responses to their impressions of what the battered woman is feeling in response to the skit rather than comments and questions about the content. Then, respond to questions raised and talk about how audience members felt during the exercise.

   Resist the temptation to focus on the person playing the batterer. Sometimes the audience wants to reassure itself that the actor is not like the character portrayed in the skit, which can be used to illustrate the common misconception that batterers fit a certain profile or our notions of what a batterer would look like.


It is important not to characterize the community service providers, friends, and family members who were portrayed in the cards as having said or done “the wrong things”. These are well-intentioned people, usually saying the things that make sense in the context of their work or relationship to the battered woman. While each individual interaction is important, the goal of this exercise is to consider the whole experience, the impact of these combined interactions on her feelings, decisions, and safety.

*Developed by: Susan Bradford and Francine Stark, Spruce Run, Bangor, Maine.

**Trainer Notes:**
Unit 4: Battered Woman’s Risk Analysis* (15 minutes)

Purpose:
Challenge participants’ thinking around the risks women face if they stay with their partner in contrast to if they leave.

Handouts for Unit 4:
• Session 3, Handout 13: Safety Planning
• Session 3, Handout 14: Levels of Safety Planning to be taken into Account
• Session 3, Handout 15: Assessment of Lethality of Batterer
• Session 3, Handout 16: Assessment of Risk to Children
• Session 3, Handout 17: Things to Consider About Yourself in Your Interactions with a Battered Woman
• Session 3, Handout 18: Interventions to Avoid

Overheads for Unit 4:
• Session 3, Overhead 9: Safety Planning

This exercise is a dramatic illustration of the complex issues facing battered/abused women and their children. Participants may clamor for solutions but keep them focused on weighing the risks. You can let them know that a discussion of safety planning will follow the exercise.

There may be discussion during this exercise that battered/abused women are making conscious choices, weighing real issues. They may downplay the danger they face in order to survive the daily chore of self-protection when they have no reasonable alternatives. Encourage participants to read handout article, “The Impact of Domestic Abuse on Women.”

For additional information on issues to cover in this exercise, see Risk Analysis, Facilitator Guide, page 15.

Suggested Order of Activities:

1. On newsprint pad divide paper in half, one side entitled ‘STAY’, the other ‘LEAVE’.

2. Have participants brainstorm risks of staying. To help with the brainstorming suggest categories such as legal status, mental health, economic, family and friends, relationship, children, physical and psychological harm.

3. After making a substantial list, move to the ‘risk of leaving’ column. For each item ask participants to describe whether this risk would continue to be an issue. Draw an arrow from the staying to the leaving column. Observations that some risks may increase if she leaves may be noted with a + after the arrow.

4. Now circle the entire list and write the words “safety planning” in large print somewhere on the newsprint pad. We need to reframe the question of “why does she stay?” to “how can she be as safe as possible”

5. Conclude: As this illustrates, for some women leaving an abusive partner does not end the abuse/violence immediately. In fact, some dangers may increase. Therefore, abused women make careful plans (safety plans) to protect themselves and their children from the dangers they face. Sometimes their strategies are not the solutions we (family, friends, helpers) would prefer, but we are rarely aware of the risks women face both in and out of their relationships.

6. Point out and discuss Session 3, Handouts 13-16.

*Developed by Jill Davies, Esq. Greater Hartford Legal Assistance, 1994, used with permission.
Unit 5: Domestic Violence and Children (35 minutes)

Purpose:
Understand how children are affected by witnessing domestic violence/abuse in the home.

Handouts for Unit 5:
• Session 3, Handout 19: Effects of Domestic Violence on Children

Suggested Order of Activities:

1. Depending on number of participants you have, either divide the group into four smaller groups or facilitate the activity with the group as a whole.

2. Assign each group a developmental stage to focus on.
   • Group One: Womb to the end of 1st year
   • Group Two: Ages 2 to 4 years old
   • Group Three: Ages 5 to 12 years old
   • Group Four: Teenagers

   If time is a factor in doing this exercise have the group concentrate on the effects of domestic violence on the age group served by the participants.

3. Ask each group to work together to answer the following questions for children in their assigned age range:
   • What are the developmental behaviors of children in this age group?
   • What effects would you expect to see on a child of this age living in a home where there is domestic violence?

4. Give each group a sheet of flip chart paper and instruct them to choose a recorder who will be responsible for reporting their answers back to the larger group. The small groups have 10 minutes to do this piece of the exercise.

   This exercise works well when the whole training team is involved in the facilitation of it. Each facilitator can be assigned to a different small group to clarify questions, provide some examples to start things off and ensure that the group is on the right track. Use the “Effects of Domestic Violence on Children” handout found on pages 19-22 of the facilitators guide as a resource for this exercise.

5. Reconvene groups after 15 minutes to report their findings. Start with the Womb – age 1 group, and then proceed sequentially through the other three groups. Facilitators may need to supply answers that each group omits and elaborate on the key effects.

6. Once each group has had a chance to report, point out Session 3, Handout 19: “Effects of Domestic Violence on Children”. This handout should complement what they came up with on their own.

7. If time allows, ask participants to talk about other factors in addition to the age and sex of the child that might influence how a child is affected by abuse.
Unit 5: Domestic Violence and Children (Continued)

This exercise was designed to illustrate that while witnessing domestic violence can be traumatic for children, the effects may differ depending upon numerous variables and resiliency factors. Witnessing may interfere with some children reaching developmental goals though not all children are affected in the same way or to the same degree. Factors such as age, sex, adult supports, cultural differences, etc. will all impact how a child may be affected by witnessing domestic violence. In debriefing this exercise reflect back on the ecological view of trauma and how it relates to the effects of domestic violence on children.

Trainer Notes:
Unit 6: Domestic Violence Services (10 minutes)

Purpose:
Give participants an understanding of the services provided by domestic violence service agencies and how to make referrals.

Handouts for Unit 6:
• Session 3, Handout 20: Domestic Abuse Project Services
• Session 3, Handout 21: Coordinated Community Action Wheel

Overheads for Unit 6:
• Session 3, Overhead 10 – 14: Domestic Abuse Project Services
• Session 3, Overhead 15: Guiding Principles

Suggested Order of Activities

1. Discuss local Domestic Abuse Project Services using the overheads and handouts. Note the resources/informational brochures that you brought.

2. Point out the Coordinated Community Action Wheel and discuss the importance of a coordinated community response to domestic violence.

3. As closure to the session, review the Session 3, Overhead 15: Guiding Principles.

Trainer Notes:
Closure to Session (5 minutes)

1. Thank the group for their participation.

2. Conduct a brief check-in with group members and encourage them to use self-care strategies between this session and the next one. Remind participants that the information they received today was an overview, and it’s not the intention of the training to make them advocates.

3. Distribute your business cards (optional) and encourage participants to contact you or your office any time they have questions.

4. Distribute Session 3 Evaluations and encourage participants to be candid and thorough. Remind the group to keep voice tones low as they are leaving so that others may concentrate.

Trainer Notes:
Facilitator’s Guide

Battered Women’s Risk Analysis Chart

As battered women experience and respond to their partner’s behavior they will analyze a wide range of risks stemming from their partner’s violence. These can be described as “batterer-generated risks”.

The following chart: *Battered Women’s Risk Analysis: Batterer-Generated Risks* was developed to illustrate a number of points, including:

- Physical violence is just one of the batterer-generated risks faced by battered women. Battered women may not consider physical violence to be their greatest risk.
- Leaving a relationship does not guarantee the reduction or elimination of a risk. In some circumstances, leaving may increase risks for some women.
- Much domestic violence advocacy focuses exclusively on responding to the risk of physical violence. The primary strategy used is to get women to leave their relationships. This approach will not fit the reality of some battered women’s lives or safety plans. To enhance a woman’s safety plan, an advocate will ensure that women have relevant information about all their options and choices.
- Every battered woman must be approached as an individual with different risks, options, and resources. The chart lists the potential batterer-generated risks that women face and the effect that staying in the relationship or leaving the relationship has on those risks. Of course, not all the risks nor potential scenarios listed apply to every battered woman.

### Battered Women’s Analysis: Batterer-generated risks
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<table>
<thead>
<tr>
<th>Possible risks if she stays in the relationship</th>
<th>Possible risks if she leaves the relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Physical injury:</strong> he can continue to hit her and injure her</td>
<td><strong>Physical injury:</strong> he may continue to hit and injure her. Some studies have shown he may be more likely to hurt her after she has left.</td>
</tr>
<tr>
<td><strong>Death:</strong> he may kill her</td>
<td><strong>Death:</strong> threats can surface when a woman explores leaving or tries to leave, “If I can’t have you nobody will.” Leaving does not insure that he will not find her and may increase the chance she will be killed.</td>
</tr>
<tr>
<td><strong>HIV:</strong> through unsafe behavior with partner, she may have no choice regarding sex, including whether to practice safer sex, he may sexually assault her</td>
<td><strong>HIV:</strong> unsafe behavior with partner may continue, he may sexually assault her</td>
</tr>
</tbody>
</table>

Much advocacy ends at this point on this list of risks that women with violent partners face. The risks that follow are acknowledged, and advocates do try to respond to these concerns. However, the primary resources, options and services are designed to address physical risks.

| **Psychological**                              |                                             |
| **Psychological harm:** his use of violence to keep control will continue to affect her and he can continue to attack her verbally & emotionally | **Psychological harm:** he may continue to have access to her, particularly if they have children in common and there is ongoing contact due to court ordered visitation |
| **Substance abuse:** she may abuse drugs and/or alcohol to help her cope with the emotional and physical pain | **Substance abuse:** even if she leaves she will take an addiction with her, she may abuse drugs and/or alcohol to cope with her new life situation |
| **Long term effects:** she may experience long term psychological issues | **Long term effects:** she may experience long term psychological issues |
| **Suicide (victim, partner):** he could commit murder/suicide, she may commit suicide as a result of the psychological effects of his violence or her desire to take control of a death she may believe is inevitable | **Suicide (victim, partner):** he could commit murder/suicide, she may commit suicide as a result of the psychological effects of his violence or her desire to take control of a death she may believe is inevitable |
### Battered Women’s Analysis: Batterer-generated risks

©Greater Hartford Legal Assistance, Inc. 1994.

<table>
<thead>
<tr>
<th>Possible risks if she stays in the relationship</th>
<th>Possible risks if she leaves the relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td></td>
</tr>
<tr>
<td>Physical injury or psychological harm to children: children can witness violence, be the object of physical violence or psychological attack, can be hurt while trying to protect their mother</td>
<td>Physical injury or psychological harm to children: children can witness violence, be the object of physical violence or psychological attack, can be hurt while trying to protect their mother, may be at greater risk while on visitation without parent-victim present, no visitation may also harm the child</td>
</tr>
<tr>
<td>Loss of child/ren: child protective services could become involved if violence is disclosed, “failure to protect”-type arguments could be used to place children in foster care or proceed on termination of parental rights case</td>
<td>Loss of child/ren: he could legally gain custody or just take the children, child protective services could still be involved or become involved</td>
</tr>
<tr>
<td>Being alone, single parenting: he could be emotionally unavailable, he could do little to help her with the children</td>
<td>Being alone, single parenting: he is unavailable and she may not be able (or want) to “find someone new,” he may not visit or help raise the children, it may not be safe for the children or her to have him do so</td>
</tr>
<tr>
<td><strong>Financial</strong></td>
<td></td>
</tr>
<tr>
<td>Standard of living: he may control the money and give her little money to live on, he could lose or quit his job, he could make her lose or quit her job</td>
<td>Standard of living: she may now live solely on her income, she may have to move out of her home, neighborhood, she may have less money, he could make her lose her job</td>
</tr>
<tr>
<td>Loss of income/job: he could keep her from working, limit how much she works, he may sabotage her efforts to find a job, succeed at a job or pursue job training</td>
<td>Loss of income/job: she could lose his income, have to quit a job to relocate, have to quit if she has become a single parent, he could keep her from working by harassment, threats</td>
</tr>
<tr>
<td>Loss of housing: she could be evicted due to “disturbance” or damage he has done</td>
<td>Loss of housing: she may need to move out in order to leave relationship or go into hiding for safety, she could lose her residence as part of a divorce</td>
</tr>
<tr>
<td>Loss or damage to possessions: he may destroy things of importance or value to her to further his control</td>
<td>Loss or damage to possessions: he may destroy things of importance or value to her to further his control, she may have to leave things behind when she leaves, he may win the right to possessions in a divorce proceeding</td>
</tr>
<tr>
<td>Possible risks if she stays in the relationship</td>
<td>Possible risks if she leaves the relationship</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Family and Friends</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Threat or injury to family or friends:</strong> may be at risk, particularly if they try to intervene</td>
<td><strong>Threat or injury to family or friends:</strong> may be at risk, particularly if they try to intervene, protect the woman, provide her with housing; threat can be used to keep a woman from going into hiding—“If I don’t know where you are I’ll get your family.”</td>
</tr>
<tr>
<td><strong>Loss of family/friends’ support:</strong> they may want her to leave and stop supporting her if she stays, they may not like him or may be afraid of him, he may keep her isolated from them</td>
<td><strong>Loss of family/friends’ support:</strong> they may not want her to leave him, they may blame her for the end of the relationship</td>
</tr>
<tr>
<td><strong>Relationship</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Loss of partner or relationship:</strong> he could leave her or be unavailable emotionally</td>
<td><strong>Loss of partner or relationship:</strong> leaving means the loss of her partner and significant change to the relationship</td>
</tr>
<tr>
<td><strong>Loss of caretaker:</strong> if she is disabled and he is her caretaker he may not adequately care for her</td>
<td><strong>Loss of caretaker:</strong> if she is disabled and he is her caretaker he will no longer be there to help her</td>
</tr>
<tr>
<td><strong>Arrest, legal status</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Her arrest:</strong> he could threaten to turn her in or turn her in if she has participated in criminal activity, he may threaten this to keep her from leaving, he may force her to participate in criminal activity, she may defend herself against him and be charged with a crime. Arrest could lead to incarceration, loss of job, loss of children, public embarrassment, etc.</td>
<td><strong>Her arrest:</strong> he could threaten to turn her in or turn her in if she has participated in criminal activity, he may force her to be involved in criminal activity, she may defend herself against him and be charged with a crime. Arrest could lead to incarceration, loss of job, loss of children, public embarrassment, etc.</td>
</tr>
<tr>
<td><strong>Partner’s arrest:</strong> he might be arrested leading to his retaliation, the loss of his job, public embarrassment for her and her family</td>
<td><strong>Partner’s arrest:</strong> he might be arrested leading to his retaliation, the loss of his job, public embarrassment for her and her family</td>
</tr>
<tr>
<td><strong>Loss of residency status:</strong> ongoing threat, he could carry out that threat</td>
<td><strong>Loss of residency status:</strong> ongoing threat, he could carry out that threat</td>
</tr>
</tbody>
</table>
## Effects of Domestic Violence on Children

### AGE: Womb - End of 1st year

**Developmental Stage:** physical growth and development; trust and attachment

<table>
<thead>
<tr>
<th>Ways of being drawn in</th>
<th>Effects of Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>miscarriage</td>
<td>miscarriage</td>
</tr>
<tr>
<td>premature birth</td>
<td>premature birth</td>
</tr>
<tr>
<td>tension and stress</td>
<td>injury in utero</td>
</tr>
<tr>
<td>injury to mother</td>
<td>death</td>
</tr>
<tr>
<td>hearing it</td>
<td>failure to thrive</td>
</tr>
<tr>
<td>seeing it</td>
<td>depressed</td>
</tr>
<tr>
<td>being woken up from sleep</td>
<td>fright</td>
</tr>
<tr>
<td>being ripped out of mother’s arms by abuser</td>
<td>being traumatized</td>
</tr>
<tr>
<td>having toys broken</td>
<td>sleep disturbances</td>
</tr>
<tr>
<td>being colicky or sick</td>
<td>eating disturbances</td>
</tr>
<tr>
<td>hit or injured while in mother’s arms</td>
<td>being colicky or sick</td>
</tr>
<tr>
<td></td>
<td>hit or injured while in mother’s arms</td>
</tr>
<tr>
<td></td>
<td>being nervous, jumpy, crying a lot</td>
</tr>
<tr>
<td></td>
<td>insecurity from being cared for by a traumatized mother</td>
</tr>
<tr>
<td></td>
<td>not being responsive or cuddly</td>
</tr>
</tbody>
</table>
**Facilitator’s Guide**

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**Effects of Domestic Violence on Children**

**AGE: 2 - 4 years**

**Developmental Stage:** Growth of individuality; regulation of emotions and bodily functions.

<table>
<thead>
<tr>
<th>Ways of being drawn in</th>
<th>Effects of Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>seeing it</td>
<td>speech problems</td>
</tr>
<tr>
<td>hearing it</td>
<td>verbalizes witnessing abuse</td>
</tr>
<tr>
<td>hits parent</td>
<td>acting out violently, hitting mother</td>
</tr>
<tr>
<td>tries to stop altercation</td>
<td>may be injured withdrawn, insecure, depressed</td>
</tr>
<tr>
<td>becoming abused themselves - physical, sexual, emotional name calling</td>
<td>problems relating to other children</td>
</tr>
<tr>
<td>neglect</td>
<td>hits parent</td>
</tr>
<tr>
<td>yelling and intimidation</td>
<td>begins to take on behavior of abusive parent</td>
</tr>
<tr>
<td>shame</td>
<td>acting out violently with others</td>
</tr>
<tr>
<td>excessive punishment</td>
<td>delayed toileting</td>
</tr>
<tr>
<td>rigid sex role stereotypes</td>
<td>eating problems</td>
</tr>
<tr>
<td>abuser has unrealistic expectations for age of child</td>
<td>nervous, jumpy, hyper-vigilant</td>
</tr>
<tr>
<td>abuser threatens abandonment</td>
<td>sleep problems</td>
</tr>
<tr>
<td>threats to send them away</td>
<td>fearful</td>
</tr>
<tr>
<td></td>
<td>passive, shy, clingy</td>
</tr>
<tr>
<td></td>
<td>fear of being left; emotional abandonment</td>
</tr>
<tr>
<td></td>
<td>fear of abandonment</td>
</tr>
</tbody>
</table>
Facilitator’s Guide

Effects of Domestic Violence on Children

AGE: 5 - 12

Developmental Stage: peer relationships, empathy & controlling impulses, self concept, assessing strengths.

<table>
<thead>
<tr>
<th>Ways of being drawn in</th>
<th>Effects of Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>sees and hears it</td>
<td>insecurity, low self esteem</td>
</tr>
<tr>
<td>picks one parent to defend</td>
<td>depression, withdrawal</td>
</tr>
<tr>
<td>physically intervenes</td>
<td>running away</td>
</tr>
<tr>
<td>calls the police</td>
<td>angry, sad, lonely</td>
</tr>
<tr>
<td>physical, sexual, emotional abuse</td>
<td>early interest in drugs or alcohol</td>
</tr>
<tr>
<td>neglect</td>
<td>school problems or over achiever</td>
</tr>
<tr>
<td>intimidation</td>
<td>regressive behavior - fear of dark, bedwetting, temper tantrums</td>
</tr>
<tr>
<td>name calling, yelling</td>
<td>sexual activity</td>
</tr>
<tr>
<td>violence to pets &amp; property</td>
<td>becomes caretaker of adults</td>
</tr>
<tr>
<td>abuser uses children as confidants</td>
<td>becomes violence prone (vs. aggressor)</td>
</tr>
<tr>
<td>shaming</td>
<td>develops problems to divert parents from fighting</td>
</tr>
<tr>
<td>abuser threatens abandonment</td>
<td>begins to make choices around being a victim vs. an aggressor</td>
</tr>
<tr>
<td>abuser controls access to friends and family</td>
<td>loyalty conflicts</td>
</tr>
<tr>
<td>excessive punishment</td>
<td>embarrassed by his/her family</td>
</tr>
<tr>
<td>threats to send them away</td>
<td>reconciliation fantasies - denial of problem, rescue fantasies</td>
</tr>
<tr>
<td></td>
<td>don’t learn boundaries</td>
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Facilitator’s Guide

Effects of Domestic Violence on Children

AGE: Teen years

Developmental Stage: identity issues, separation from family, independence/dependence issues, sexual development and handling feelings, mourning loss of childhood.

<table>
<thead>
<tr>
<th>Ways teen boys are drawn in</th>
<th>Effects of abuse on both girls and boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>kills or tries to kill the perpetrator</td>
<td>school and or social problems</td>
</tr>
<tr>
<td>tries to otherwise intervene</td>
<td>shame and embarrassment about family</td>
</tr>
<tr>
<td></td>
<td>sexual activity</td>
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<td></td>
<td>tendency to get serious in relationships too early</td>
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<thead>
<tr>
<th>Ways teen girls are drawn in</th>
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<tbody>
<tr>
<td>becomes physically or sexually abused herself by the abuser or in teen dating relationship</td>
</tr>
<tr>
<td>may become pregnant in order to escape home truancy</td>
</tr>
<tr>
<td>poor school performance super achiever in school</td>
</tr>
<tr>
<td>depression, suicide, self mutilation eating disorders</td>
</tr>
<tr>
<td>alcohol and/or drug problems confusion about gender roles</td>
</tr>
<tr>
<td>learns that men/women are violent learns not to respect women/men</td>
</tr>
<tr>
<td>dating violence</td>
</tr>
<tr>
<td>attacks father or mother embarrassed about being female/male</td>
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</tbody>
</table>

all of the previous ways of being drawn in that affect 5 -12 year olds, also affect teens.
Domestic violence is virtually impossible to measure with absolute precision due to the numerous complications, including the societal stigma that inhibits victims from disclosing their abuse and the varying definitions of abuse used from study to study. Due to these and other complications, estimates of the number of domestic violence incidents differ greatly. The following fact sheet on domestic violence was prepared by the Family Violence Prevention Fund and includes citations for each statistic listed. The data here is supportable and can be used without reservation.

**Prevalence of Domestic Violence**

Estimates range from 960,000 incidents of violence against a current or former spouse, boyfriend, or girlfriend per year (U.S. Department of Justice, “Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends,” March 1998) to 3.9 million women who are physically abused by their husbands or live-in partners per year (The Commonwealth Fund, “First Comprehensive National Health Survey of American Women,” July 1993).

One out of every four American women (26 percent) report that they have been physically abused by a husband or boyfriend at some point in their lives. Thirty percent of Americans say they know a woman who has been physically abused by her husband or boyfriend in the past year (Lieberman Research Inc., “Domestic Violence Advertising Campaign Tracking Survey” (Wave IV) Conducted for The Advertising Council and the Family Violence Prevention Fund, July - October 1996).

While women are less likely than men to be victims of violent crimes overall, women are five to eight times more likely than men to be victimized by an intimate partner (U.S. Department of Justice, “Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends,” March 1998).


Women of all races and Hispanic and non-Hispanic women are about equally vulnerable to violence by an intimate (Bureau of Justice Statistics, “Violence Against Women: Estimates from the Redesigned Survey,” August 1995).

Male violence against women does much more damage than female violence against men; women are much more likely to be injured than men (Murray A. Straus and Richard J. Gelles, “Physical Violence in American Families,” 1990).
DOMESTIC VIOLENCE STATISTICS

Domestic Homicides
In 1996, approximately 1,800 murders were attributed to intimates; nearly three out of four of these had a female victim (U.S. Department of Justice, “Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends,” March 1998).

Among all female murder victims in 1995, 26 percent were known to have been slain by husbands or boyfriends. Only three percent of the male victims were known to have been slain by wives or girlfriends (Federal Bureau of Investigation, “Crime in the United States 1995: Uniform Crime Reports”).

Health Issues

Thirty-seven percent of women who sought treatment in emergency rooms for violence-related injuries in 1994 were injured by a current or former spouse, boyfriend or girlfriend (U.S. Department of Justice, “Violence Related Injuries Treated in Hospital Emergency Departments,” August 1997).

Domestic Violence and Youth
Eight percent of high school age girls said “yes” when asked if “a boyfriend or date has ever forced sex against your will” (“The Commonwealth Fund Survey of the Health of Adolescent Girls,” November 1997).

Forty percent of teenage girls age 14 to 17 report knowing someone their age who has been hit or beaten by a boyfriend (Children Now/Kaiser Permanente poll, December 1995).

During the 1996-1997 school year, there were an estimated 4,000 incidents of rape or other types of sexual assault in public schools across the country (U.S. Department of Education, “Violence and Discipline Problems in U.S. Public Schools: 1996-1997”).

Domestic Violence and Children
Slightly more than half of female victims of intimate violence live in households with children under age 12 (U.S. Department of Justice, “Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends,” March 1998).

Stalking
Eighty percent of women who are stalked by former husbands are physically assaulted by that partner and 30 percent are sexually assaulted by that partner (Center for Policy Research, “Stalking in America,” July 1997).
## PERSONAL ASSESSMENT: DOMESTIC VIOLENCE

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>AGREE</th>
<th>DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Most victims are non-white, young, poor and uneducated.</td>
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<tr>
<td>2. Battering is the single major cause of injury to women.</td>
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<td>3. Battered women are helpless and dependent.</td>
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<td>4. Batterers are “out of control” when violent or abusive.</td>
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<td>5. Anger or stress can trigger a violent episode.</td>
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<td>6. Drugs or alcohol are involved in nearly all battering episodes.</td>
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<tr>
<td>7. Successful substance abuse treatment does not solve the problem of</td>
<td></td>
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<tr>
<td>violence and abuse.</td>
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<tr>
<td>8. Batterers are easy to spot because they are mean and nasty.</td>
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<tr>
<td>9. Most batterers have a history of abuse in their own childhood.</td>
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<tr>
<td>10. Women with high self-esteem do not choose batterers as partners.</td>
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<tr>
<td>11. Violence is predictable.</td>
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<tr>
<td>12. A woman can change her partner’s behavior by changing her own.</td>
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<tr>
<td>14. Helping couples communicate better will end the abuse in the</td>
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<tr>
<td>relationship.</td>
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<tr>
<td>15. Couples counseling can help reduce or eliminate the abusive/violent</td>
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<tr>
<td>behavior.</td>
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<tr>
<td>16. Successful batterer intervention programs should focus on anger</td>
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<tr>
<td>management.</td>
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</tbody>
</table>
**MYTHS AND FACTS ABOUT DOMESTIC VIOLENCE**

1. **He’s out of control**  
   He’s actually in control. He decides who, when, where, parts of body, severity, and length of episode. It may go on for hours. He may remove jewelry. He also may tell he is “going to do something” and when.

2. **Poor control of anger**  
   Many batterers are not angry. They may create the anger and become angry if the victim does not respond the way he wants or expects. No behavior on her part will change his decision to hurt her.

3. **Stress**  
   He chooses to deal with stress violently. This is considered culturally approved behavior. He believes he has a right to control and get his way.

4. **Poor Communication Skills**  
   Batterers are excellent communicators. They demand that their needs be met before all others. For their safety, battered women learn to read even subtle, non-verbal communications well. This myth is grounded in the belief that the abuser wouldn’t abuse if his needs were met - a form of victim blaming. However even when she meets his needs, he continues to abuse her.

5. **He has low self-esteem**  
   Batterers do not differ from non-battering men in their level of self-esteem. The difference is in the batterer’s belief system about women and children. May have low self esteem around his relationship.

6. **Substance Abuse**  
   Getting him sober and “working a program” does not stop the abuse or violence. He may use “recovering addict or alcoholic” as a way not to take responsibility for his behavior. It is another way for him to not be accountable for his behavior. Why are his targets always women? Getting sober is a first step in dealing with the underlying issues of power and control; he cannot enter a batterer intervention program until sober.

7. **He has a history of abuse from his childhood**  
   True - many batterers were abused as children. Many men who were abused grow up and choose not to abuse. Men who batter are more likely to have witnessed father abusing the mother as opposed to having actually been physically abused themselves, though both are big risk factors.

8. **The battering is provoked or is enjoyed by victim**  
   Battering and other accompanying abuses are degrading and humiliating; no behavior on part of victim ever justifies battering; no behavior on victims part can change his decision to batter.

9. **Batterers need to learn non-violence**  
   Batterers know non-violence; the problem is not their inability to resolve conflict non-violently but their unwillingness to do so. There must be negative consequences for the abusive and/or violent behavior; all systems in society must take responsibility for holding the abuser accountable.
ALCOHOL ABUSE AND DOMESTIC VIOLENCE

Many studies show a high rate of alcohol abuse among men who batter their female partners. Yet is there really a link between alcohol abuse and domestic violence? No evidence supports a cause-and-effect relationship between the two problems. The relatively high incidence of alcohol abuse among men who batter must be viewed as the overlap of two widespread social problems.

Efforts to link alcohol abuse and domestic violence reflect society’s tendency to view battering as an individual deviant behavior. Moreover, there is a reluctance to believe that domestic violence is a pervasive social problem that happens among all kinds of American families. For these reasons, it is essential to emphasize what is known about the relationship between alcohol abuse and domestic violence.

- Battering is a socially learned behavior, and is not the result of substance abuse or mental illness. Men who batter frequently use alcohol abuse as an excuse for their violence. They attempt to rid themselves of responsibility for the problem by blaming it on the effects of alcohol.

- Many men who batter do not drink heavily and many alcoholics do not beat their wives. Some abusers with alcohol problems batter when drunk and others when they are sober. For example, Walker’s (1984) study of 400 battered women found that 67% of batterers frequently abused alcohol. However, only one-fifth had abused alcohol during all battering incidents on which data was collected. The study also revealed a high rate of alcohol abuse among non-batterers.

- In one batterers program, 80% of the men had abused alcohol at the time of the latest battering incident. The vast majority of men, however, also reportedly battered their partners when not under the influence of alcohol.

- Data on the concurrence of domestic violence and alcohol abuse vary widely, from as low as 25% to as high as 80% of cases.

- Alcoholism and battering do share some similar characteristics, including:
  - both may be passed from generation to generation
  - both involve denial or minimization of the problem
  - both involve isolation of the family

- A battering incident that is coupled with alcohol abuse may be more severe and result in greater injury.

Alcoholism treatment does not “cure” battering behavior. Both problems must be addressed separately. However, provisions for the woman’s safety must take precedence.

- A small percent (7%-14%) of battered women have alcohol abuse problems, which is no more than that found in the general female population. A woman’s substance abuse problems do not relate to the cause of her abuse, although some women may turn to alcohol and other drugs in response to the abuse. To become independent and live free from violence, women should receive assistance for substance abuse problems in addition to other supportive services.

- Men living with women who have alcohol abuse problems often try to justify their violence as a way to control them when they’re drunk. A woman’s failure to remain substance free is never an excuse for the abuser’s violence.


NATIONAL WOMEN ABUSE PREVENTION PROJECT
USING MALE PRIVILEGE
Treating her like a servant • making all the big decisions • acting like the “master of the castle” • being the one to define men’s and women’s roles

USING ECONOMIC ABUSE
Preventing her from getting or keeping a job • making her ask for money • giving her an allowance • taking her money • not letting her know about or have access to the family income.

USING CHILDREN
Making her feel guilty about the children • using the children to relay messages • using visitation to harass her • threatening to take the children away

USING COERCION AND THREATS
Making and/or carrying out threats to do something to hurt her • threatening to leave her, to commit suicide, to report her to welfare • making her drop charges • making her do illegal things

USING INTIMIDATION
Making her afraid by using looks, actions, gestures • smashing things • destroying her property • abusing pets • displaying weapons

USING EMOTIONAL ABUSE
Putting her down • making her feel bad about herself • calling her names • making her think she is crazy • play mind games • humiliating her • making her feel guilty

USING ISOLATION
Controlling what she does, who she sees and talks to, what she reads, where she goes • limiting her outside involvement • using jealousy to justify actions

USING ISOLATION
Controlling what she does, who she sees and talks to, what she reads, where she goes • limiting her outside involvement • using jealousy to justify actions

DOMESTIC ABUSE INTERVENTION PROJECT
202 East Superior Street
Duluth, MN 55802
(218)722-2781

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Session 3, Handout 5
EQUATITY WHEEL

NON VIOLENCE

NEGOTIATION AND FAIRNESS
Seeking mutually satisfying resolutions to conflict • accepting change • being willing to compromise

NON-THREATENING BEHAVIOR
Talking and acting so that she feels safe and comfortable expressing herself and doing things

ECONOMIC PARTNERSHIP
Making money decisions together • making sure both partners benefit from financial arrangements

RESPECT
Listening to her non-judgmentally • being emotionally affirming and understanding • valuing opinions

SHARED RESPONSIBILITY
Mutually agreeing on a fair distribution of work • making family decisions together

TRUST AND SUPPORT
Supporting her goals in life • respecting her right to her own feelings, friends, activities, and opinions

RESPONSIBLE PARENTING
Sharing parental responsibilities • being a positive non-violent role model for the children

HONESTY AND ACCOUNTABILITY
Accepting responsibility for self • acknowledging past use of violence • admitting being wrong • communicating openly and truthfully

DOMESTIC ABUSE INTERVENTION PROJECT
202 East Superior Street
Duluth, MN 55802
(218)722-2781
SIGNS OF ABUSE

- Do you see or hear about repeated bruises, broken bones, or other injuries, the result of “falls” or “accidents”?

- Does she seem frightened, withdrawn, isolated, unusually quiet, reluctant to speak?

- Do you feel uncomfortable when her partner is present? Does he criticize her in front of you, or make “joking” remarks that belittle her? Does he tell her what to do and not to do? Does she seem significantly different – perhaps unusually cheery or exceptionally quiet? Does he appear charming and solicitous while she is withdrawn, quiet, and tense?

- Are you afraid of her partner?

- Does she refer to his bad moods, anger, temper, or short fuse? Does she refer to obnoxious things he does when he drinks? Does she hint that there is trouble or conflict at home?

- Does he ignore the children or abuse them emotionally, physically, or sexually? Do they seem timid, frightened, or angelic in his presence? Do the children abuse her, verbally or physically?

- Have there been suicide or homicide attempts or threats in this family?

- Is he accusing her of having affairs with other men or women? Does he try to control her every move?

- Has there been a suspicious injury or death of a pet reported?

- Does she seem continually to try to keep things smooth, to avoid upsetting him?

- In warm weather, does she sometimes wear inappropriate clothes with long sleeves, turtlenecks, or neck scarves?

Adams, Carol, Violence Against Women and Children, page 40.
SOME INDICATORS OF ABUSE AT HOME

❖ Repeated bruises or injuries
❖ Seasonally inappropriate clothes – long sleeves, turtlenecks
❖ Pattern of cancelled appointments
❖ Signs of being frightened
❖ Unusually quiet – changed demeanor
❖ Rarely seen without partner present
❖ Sensitive about home life or hints that there are troubles at home
❖ Disruptive personal visits to the workplace
❖ Direct observations of her/his partner’s behavior
# METHODS OF COERCION

<table>
<thead>
<tr>
<th>Method</th>
<th>Examples</th>
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<tbody>
<tr>
<td><strong>Isolation</strong></td>
<td>He moved me away from my friends. He didn’t want me to go anywhere unless he was with me. He would eavesdrop.</td>
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<tr>
<td>Deprives victims of all social support or the ability to resist.</td>
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<tr>
<td>Develops an intense concern with self.</td>
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<td>Makes victim dependent upon interrogator.</td>
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<tr>
<td><strong>Monopolization of Perception</strong></td>
<td>I was always scared he’d blow up. I had to dress up for him. Give him sex whenever he wanted. I had to control the children so they wouldn’t bother him. It was like walking on eggshells.</td>
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<tr>
<td>Fixes attention upon immediate predicament; fosters introspection.</td>
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<td>Eliminates stimuli competing with those controlled by captor.</td>
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<td>Frustrates all actions not consistent with compliance.</td>
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<tr>
<td><strong>Induced Debility and Exhaustion</strong></td>
<td>He wouldn’t let me sleep. He started fights at night. He wouldn’t let me see a doctor.</td>
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<td>Weakens mental and physical ability to resist.</td>
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<tr>
<td><strong>Threats</strong></td>
<td>He threatened to kill the cat. He said he’d take the kids. He said he’d have me committed. He said he’d burn down the house. He said he’d find me if I left.</td>
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<tr>
<td>Cultivates anxiety and despair.</td>
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<tr>
<td><strong>Occasional Indulgences</strong></td>
<td>He took me on vacation. He bought me jewelry. He allowed me sex only when we “made up.” Once in awhile he really listened to me and seemed to care.</td>
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<tr>
<td>Provides positive motivation for compliance.</td>
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<td><strong>Demonstrating “Omnipotence”</strong></td>
<td>He beat me up. He had me followed. He called me deluded.</td>
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<td>Suggests futility of resistance.</td>
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<tr>
<td><strong>Degradation</strong></td>
<td>He told me I’m too fat. He’d call me names and touch me inappropriately in public. He put me down intellectually and sexually and said I was ugly.</td>
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<tr>
<td>Makes cost of resistance appear more damaging to self-esteem than capitulation.</td>
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<td>Reduces prisoner to ‘animal level’ concerns.</td>
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<tr>
<td><strong>Enforcing Trivial Demands</strong></td>
<td>The bacon had to be cooked to a particular doneness. I couldn’t leave a cup on the bathroom basin. The canned goods were to be arranged alphabetically.</td>
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<tr>
<td>Develops habit of compliance.</td>
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THE IMPACT OF DOMESTIC ABUSE ON WOMEN

Physical violence in the home is a crime. It may take many forms, including pushing, shoving, spitting, throwing things, choking, kicking, stabbing, and shooting. Some of the impact of physical abuse is obvious: bruises, broken bones, and black eyes. Physical violence reinforces and intensifies the impact of all other forms of abuse, but it is only one of the many tactics batterers use to exert and maintain control. Some abusers are never physically violent.

Some women respond to such tactics by breaking off the relationship quickly—though it may take years for the batterer to leave her alone. Other women may believe that their partner’s abusive behavior is the result of a bad childhood, stress, or some other issue which she may be able to help her partner overcome. She may think that a short-term compromise of her own choices is a reasonable sacrifice for the long term happiness she believes possible for herself and the partner she loves. Some believe the justifications the batterer gives for the abuse and lose their ability to accurately name their experience as abuse. People who are abusive blame their victims for their violence, saying such things as ‘it was because of the way she kept the house, the tone of her voice, the look on her face, the way she spent the money’.

An abused woman may respond initially by trying to prove herself to him, changing how she looks and acts, hoping that he will come to trust and appreciate her. She may hope that if she proves her love, he will be kind and loving in return. As the abuse intensifies, she responds by focusing all her time and energy on monitoring his moods, looks, demands, and slightest movement in a desperate attempt to avoid abuse.

For women, the experience or threat of physical violence becomes the context for future choices. Her emotional and physical survival depends on being in tune with him and complying with his wishes. He may be warm and loving one day, telling her she has no reason to be afraid, while being threatening, violent, or sullen the next. This serves to keep her off-balance and feeling crazy, one day hopeful about the relationship, the next terrified and seeking a way out. Her eating and sleeping patterns may be disrupted and injuries left untreated. Her overall health may deteriorate.

Once these patterns are in place, it becomes extremely difficult to break away.

At some point, intent upon ending the abuse in her life, a battered woman may leave, hoping that her leaving may inspire her abuser to recognize the impact of his behavior and change. She may or may not want to end the relationship. She does, however, want the abuse to end. The abuser usually responds by apologizing, promising to go to counseling, to support her goals for schooling or employment. He’ll say whatever it takes to win her back. She may go back, hoping his promises will come true. She may feel defeated by the challenges and loneliness she faces in establishing a separate life for herself and the children.

The real and perceived threat of physical violence does not immediately cease when a battered woman ‘leaves’ the person who is abusing her. Abusers often are the most dangerous when they realize that their partners are preparing to leave or have left—when it becomes clear that the tactics that have persuaded her to stay with him in the past are no longer effective. The batterer may continue to abuse her even if she leaves, using such tactics as telephone harassment, stalking, and manipulating visitation arrangements with children, as well as ongoing threats to her emotional and physical well-being.
One might reasonably ask, “what could be worse than staying in a relationship with someone who is abusive?” Here are some answers from battered women:

**Worse battering**
Unsuccessful attempts to get away may lead to escalated violence. Perhaps the abuser will carry out threats of suicide and/or homicide.

**Harm to the children**
Most battered women and some batterers try to protect their children from the worst of the violence. Few battered women are willing to leave their children unprotected in the care of a batterer, and some do not have sufficient resources to take their children with them when they leave. In addition, many batterers threaten that they will gain full legal custody of the children if their wives leave.

**Retaliation against parents, other close relatives, friends, or others**
Some batterers make a point of threatening to kill their in-laws if their partners ever leave them. Some threaten to harm anyone who helps her to leave.

**Starvation and homelessness**
Many batterers are careful to keep their partners economically powerless. Property and bank accounts are kept exclusively in the batterer’s name. With no money available to them, how can the women leave without starving? Where will they stay if their husbands have socially isolated them from friends and relatives? Those women who do have friends with whom they could stay often fear endangering their friends by hiding out at their homes. Many battered women do not understand their legal rights to household property or are afraid to take anything when they leave.

**Shame, failure, and public sin**
It is common for battered women to take responsibility for the continuation of even a violent marriage. The shame of admitting failure can be very great. In the case of women who are religious, staying in violent marriages and protecting the children as best they can are the only ways to avoid being defined as sinfully irresponsible. They may believe that their personal sacrifice is their duty to God.

**Loss of social identity, loneliness, and one’s entire way of life**
Violence has a way of creeping into an otherwise comfortable life, increasingly polluting it but never changing it too much all at once. Thus, battered women may maintain their social identities through most if not all of the abuse. Leaving the abuser often means losing all that is familiar in their lives. In cases where the couple is part of a small cultural or ethnic community, leaving could result in isolation from the woman’s heritage and from others who speak her language.
When battered women leave, they face numerous challenges in the community, for example:

- Lack of real alternatives for employment and financial assistance
- Lack of affordable legal assistance to obtain a divorce, custody order, or permanent protection from abuse order
- Limited availability of subsidized housing and lack of public transportation, particularly in rural communities
- The structure of family law, which approaches parental rights and responsibilities with the presumption that joint custody is best, and that spouse abuse is an exception that requires careful proof.
- Public disdain for single parents
- Lack of affordable childcare and health care

Every individual person who is abused has a unique story to tell, resources to muster, and fears to overcome. Amazingly, many women muster the strength from within and break free.

About half of the people who call Spruce Run for support have already separated physically from the abuser and are trying to establish abuse-free lives for themselves and their children. Others have plans to leave in the future if the batterer fails to follow through with promises to change.

The process of safely separating from an abuser can take a long time. Essential to their successes are the responses of the people and institutions in their lives.

Any of us may play a crucial role in helping people who have been abused to establish emotional and/or physical safety in their lives. For example, if the police aggressively enforce orders of protection and conditions of release, the abuser is more likely to get the message that they cannot continue to control this woman, that law enforcement supports her demand for safety. Health care providers who continually give the message that they are concerned for her well being and offer support may give a battered woman the encouragement she needs to make positive change. Clergy can be helpful as community change agents who work with others to alter the conditions listed above that become obstacles for many women as they seek safety for themselves and their children.

To be helpful, however, we must be open to receive the information she gives us, willing to ask questions, and recognize the limits of legal remedies and social services. Above all, we must consistently give the unequivocal message that everyone has the right to be treated with respect and that there are no justifications for abuse.

Developed by Sue Bradford and Francine Stark, Spruce Run, Bangor, Maine.
### COMPARING CO-DEPENDENT AND ABUSE AFFECTED BEHAVIORS*

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<thead>
<tr>
<th>CO-DEPENDENT</th>
<th>ABUSE AFFECTED</th>
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<tr>
<td>• I assume responsibility for another’s feelings or behaviors.</td>
<td>• I am held responsible for the abuser’s feelings and behaviors.</td>
</tr>
<tr>
<td>• I feel responsible for another’s feelings or behaviors.</td>
<td>• For my safety, I must be aware of the abuser’s feelings or behaviors.</td>
</tr>
<tr>
<td>• I have difficulty expressing my feelings.</td>
<td>• If I express my feelings, I jeopardize my safety.</td>
</tr>
<tr>
<td>• I have difficulty forming or maintaining close relationships.</td>
<td>• It is dangerous for me to form or maintain close relationships.</td>
</tr>
<tr>
<td>• I am afraid of being hurt or rejected.</td>
<td>• Having been hurt or rejected, I am afraid of this happening again.</td>
</tr>
<tr>
<td>• I judge myself with other people’s standards. Nothing is good enough.</td>
<td>• I am usually harshly judged by the abuser. Nothing I do is good enough.</td>
</tr>
<tr>
<td>• I question or ignore my own values to connect with significant others. I value other people’s opinions more than my own.</td>
<td>• The abuser ignores or devalues my opinions. For my safety, I value the abuser’s opinions more than my own.</td>
</tr>
<tr>
<td>• My self esteem is bolstered by outside influences.</td>
<td>• My self esteem is systematically destroyed by my abuser’s tactics.</td>
</tr>
</tbody>
</table>

*developed by P. Ford-McCombs & T. Hubacher, Family Crisis Shelter, Portland, ME, 1991*
Strategies to reduce a batterer’s ability to use power and control over the lives of his partner and children

Battered women, while unable to prevent their abuser’s violence, can make plans to increase their safety. Friends, family, and service providers may all be part of helping to develop and/or implement safety plans.

In order to contribute to her safety and not cause harm, it is important to appreciate and build on the strategies that a battered woman has already identified. As you talk with a woman about safety planning, know that this woman has thought many times and for many hours about how to make herself safe and free from abuse and has tried a number of strategies. If she is still being abused, those strategies have not worked completely. The fact that she is still able to lead a functional life means that they have worked to some degree.

Anyone offering assistance to battered women must remember two critical facts: only the batterer controls the abuse; the battered woman and children will live with the consequences of the strategies used in the attempt to decrease the batterer’s ability to abuse them.

What is safety?

Safety is not simply having a place to go where the batterer cannot find her, although that may be part of a larger safety plan. In reality, safety involves many things that most of us take for granted. These are a few examples:

- Having a place to live (long term)
- Having enough food
- Having enough money to maintain housing, healthcare, food, and transportation
- Being free of scrutiny (being watched in the course of daily life)
- Having the right to establish a routine – going to the same grocery store every week or taking a walk in the park every lunch hour
- Living without fear
- Sharing hopes, concerns, and pleasure with friends and family
- Sleeping soundly

What kinds of safety plans are there?

It takes time, experience, and a variety of strategies to create personal safety. Battered women may be seeking help in accomplishing any number of different safety goals.

- Immediate — How do I get away tonight? Should I call the police?
- Short term — How do I survive the next month?
- Longer range – How can I keep him away from me? Is there any realistic possibility he’ll change – How will I know? How do I live with the loneliness? What can I do about how hurt and angry I feel? How can I remain safe while exchanging the children for visitation? How will I support myself and the children?
How do battered women make safety plans?

Most of us have been in situations where we had to make difficult decisions. For example, even when we may recognize that we are unhappy with our job, few of us are able to simply walk away from that job immediately. There are many things to be taken into account: How will I pay my bills? What will future employers think? How long will I be unemployed? Am I qualified or worthy of a better job? What will my choices mean to my family? What will happen to the projects I have started? Will I lose the friendships I’ve made through this job? Until there are answers to at least several of these questions, leaving our job, however unsatisfying, is not a viable option. Sometimes the process of changing jobs takes years for people in such a situation.

For battered women, making plans to get free from abuse follow a similar path, but she is considering her options and developing plans under the constant scrutiny of her abuser, subject to his abusive tactics to keep her from making any changes. Battered women’s safety plans may include a wide variety of things. The following pages list some of the things she may consider. She recognizes the threats to her safety, thinks of ways to reduce them, tries out her plans, learns from what happens, and reassesses her situation, options, and plans for the future.

Helping battered women with safety plans

One thing that everyone can do is to be sure that their place of work, worship, or community gathering place (such the library) has easily accessible information about contacting the local domestic violence project.

Domestic violence advocates have been helping battered women with safety plans for many years and are uniquely able to provide accurate information in response to battered women’s questions. They have specialized training in active listening and crisis intervention skills. Hotlines allow women to remain anonymous and take as much time as they need to express their feelings, tell their experiences, and engage in problem solving. They are expert at supporting battered women in their safety planning process, without telling the woman what she should do. Hotline workers recognize that battered women are experts on their experience of abuse and know best what strategies may enhance their safety or increase their danger.

Because domestic violence advocates have heard many battered women describe their experiences and the threats they were able to overcome, domestic violence advocates are more likely to be able to explore the question ‘what will happen if …?’ and will be well informed of local services and other options.

It is difficult for most of us to avoid giving advice, particularly when we are afraid of what will happen to someone we are concerned about. However, the helper must recognize that, no matter what, only the battered woman and her children will live with the consequences of the choices she makes. Whatever strategy she chooses, only the batterer controls future abuse.
A battered woman may have many people involved in her life who can be helpful in a variety of ways:

**Family/friends** – a place to stay, childcare, transportation, money, people to talk to

**The criminal justice system (police officers, the district attorney, judges)** – arresting the batterer, following up on conditions of release, prosecution of charges, informing the battered woman about the criminal process

**Clergy** – offer information about local services, especially the domestic violence project, addressing her theological questions in ways that prioritize her safety, autonomy, and right to a violence-free life; offer assistance with shelter, childcare, transportation, money, and the support of a caring community.

**Employers** – involving workplace security in the enforcement of any court orders, screening phone calls for her, offering flexible hours and time off for things she need to do (court, house hunting, caring for children)

**Support groups** – a place to talk, gain perspective, make friends, and create a sense of community

**Domestic violence projects** – someone to talk to, validation, support, information, advocacy, shelter, problem solving, and safety planning

LEVELS OF SAFETY PLANNING TO BE TAKEN INTO ACCOUNT

• Safety during a violent incident
  Where can you go to be safe in your home? Whom can you call? Is there anyone who could call the police for you? If you have to leave your home, where could you get to quickly? Where could you hide a set of car keys? Do you know about the local domestic abuse hotline and shelter?

• Safety when preparing to leave: What kinds of things can you do ahead of time to ease the transition?
  Where can you store important items? Open a bank account? Apply for housing? Get a post office box? Attend a support group at Spruce Run? Get a prepaid phone card?

• Safety in separate residence: What things will make my new home as secure as possible?
  Quality locks and doors? Smoke detectors? Good outside lighting? Making a plan with neighbors to call police? Unlisted phone number? Getting a third party to help exchange the kids for visitation?

• Safety with a protection order and/or criminal restrictions: What legal remedies would help?
  Have you ever called the police before? What happened? Have you called Spruce Run to find out about protection orders? Does the local police department have a copy of your order? Do you keep a copy of your order with you at all times? Has the abuser been arrested or convicted? Are there bail conditions? Does he have a probation officer?

• Safety on the job and in public: What will help you feel safe to get on with your life?
  Telling your boss or coworkers? Talking with security about enforcing your protection order? Having someone screen your calls? Establishing a new bank, grocery store, or gas station than you used before? Getting a car phone? Making new friends? Carrying a loud whistle?

• Safety and drug or alcohol use: What is your use of alcohol, medications, or drugs like? What is the relationship between that and your safety?
  Do you attend Al-anon or other 12 step groups?

• Safety and one’s emotional health: How can you take care of yourself through the very challenging and emotionally draining process of creating a new life for yourself [and your children]?
  Do you know about the local domestic abuse hotline and support groups? Do you have an answering machine to screen your calls? What are your hobbies? What kinds of things do you like to do when you are alone? If you could make things be anyway that you wanted, how would that be? Do you keep a journal? What things make you feel better during times you’ve been sad or overwhelmed? Would it be helpful to make a list of things to do when you feel like giving up?

• Items to keep safe and available: What are the things that you need to take care of yourself and your children? What are the things you would have to go back and get if you left them behind?
  Identification, money, credit cards, keys to house/car/office, medications, green card, divorce papers, protection order, address book, children’s special toys . . .

Maine’s domestic violence projects provide safety planning assistance through their 24-hour hotlines, support groups, and shelters. Encouraging people to use free local resources helps break their isolation, establish new contacts, and gain a greater sense of personal power and hope. At the very least, be sure to give them the hotline number, and, if possible, offer them access to a private phone to make the call.
ASSESSMENT OF LETHALITY OF BATTERER

No one can predict when or if a batterer will kill or escalate the violence to a life threatening level. However, there are indicators that can serve as warnings that a batterer may be reaching that level.

- The acts of abuse/violence are no longer hidden but done in public.
- Threats of suicide or homicide.
- Sexual abuse against woman &/or children.
- Use of or threat to use weapon (other than fists or feet).
- Substance abuse.
- Stalking the woman &/or children.
- Escalation of violence; extreme jealousy.
- He perceives loss of control over family through separation, divorce, victim fleeing.
- Specific, lethal threats; may have verbalized a plan.
- History of mental health problems.
ASSESSMENT OF RISK TO CHILDREN*

• Has your partner ever threatened to hurt or kill your child?

• Has your partner ever removed or threatened to remove your child from your care? What happened?

• Has your child ever witnessed your partner hit you or abuse you in other ways?

• Has your partner hit your child with belts, straps, or other objects which have left marks, bruises, welts, or other injuries?

• Has your partner touched your child in a way that made either you or your child uncomfortable?

• Has your child ever been unintentionally harmed when objects were thrown or weapons used in the home?

• Does your child’s behavior remind you of your partner’s behavior? If yes, describe.

• Has your child ever assaulted you?

• Does your child ever try to hurt him/herself, pets, or destroy possessions?

• Is your child anxious or fearful of leaving you?

• Does the teacher/baby-sitter/daycare provider complain about your child’s behavior (fighting, destroying property, not paying attention, withdrawn?)

• Has your partner ever assaulted you while you were holding your child?

*Massachusetts Department of Social Services
THINGS TO CONSIDER ABOUT YOURSELF IN YOUR INTERACTION WITH A BATTERED WOMAN

Things to Consider About Yourself In Your Interaction with a Battered Woman

- What is she hoping you can do?
- What may she fear you will do?
- What is your role? What are your limitations?
- What is your potential impact?
- Do you have the time and/or skill?
- Who else is involved?
- What do you do when you don’t like her choices?
- Don’t make assumptions:
  - regarding her experience
  - regarding her options
  - about how she’s been treated
  - about what she’s got to lose
- Do ask….if you have time to listen.

A Few Helpful Things to Say

- I am afraid for your safety.
- I am afraid for the safety of your children.
- You don’t deserve to be treated this way.
- What can I do to help?
- I am so sorry that this has happened to you.
- I’m here to listen, if you want to talk.
- No one has the right to be abusive - no matter what.
- The local domestic abuse project might be able to give you some ideas and support.
INTERVENTIONS TO AVOID*

- Options for protection for mother that in her estimation increase the level of danger.
- Couples or family therapy;
- Court mediation;
- Anger management groups and traditional treatment modalities that don’t require batterers to end their abusive behaviors;
- Visitation arrangements that allow batterers ongoing contact with mothers;
- Joint service plans that disclose mother’s safety plan and/or tasks to the batterer.

*Massachusetts Department of Social Services
EFFECTS OF DOMESTIC VIOLENCE ON CHILDREN

AGE: Womb - End of 1st year

Developmental Stage: physical growth and development; trust and attachment

<table>
<thead>
<tr>
<th>Ways of being drawn in</th>
<th>Effects of Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>miscarriage</td>
<td>miscarriage</td>
</tr>
<tr>
<td>premature birth</td>
<td>premature birth</td>
</tr>
<tr>
<td>tension and stress</td>
<td>injury in utero</td>
</tr>
<tr>
<td>injury to mother</td>
<td>death</td>
</tr>
<tr>
<td>hearing it</td>
<td>failure to thrive</td>
</tr>
<tr>
<td>seeing it</td>
<td>depressed</td>
</tr>
<tr>
<td>being woken up from sleep</td>
<td>fright</td>
</tr>
<tr>
<td>being ripped out of mother’s arms by abuser</td>
<td>being traumatized</td>
</tr>
<tr>
<td>having toys broken</td>
<td>sleep disturbances</td>
</tr>
<tr>
<td>being colicky or sick</td>
<td>eating disturbances</td>
</tr>
<tr>
<td>hit or injured while in mother’s arms</td>
<td>being colicky or sick</td>
</tr>
<tr>
<td></td>
<td>hit or injured while in mother’s arms</td>
</tr>
<tr>
<td></td>
<td>being nervous, jumpy, crying a lot</td>
</tr>
<tr>
<td></td>
<td>insecurity from being cared for by a traumatized mother</td>
</tr>
<tr>
<td></td>
<td>not being responsive or cuddly</td>
</tr>
</tbody>
</table>
## EFFECTS OF DOMESTIC VIOLENCE ON CHILDREN (Continued)

**AGE: 2 - 4 years**

**Developmental Stage:** Growth of individuality; regulation of emotions and bodily functions.

<table>
<thead>
<tr>
<th>Ways of being drawn in</th>
<th>Effects of Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>seeing it</td>
<td>speech problems</td>
</tr>
<tr>
<td>hearing it</td>
<td>verbalizes witnessing abuse</td>
</tr>
<tr>
<td>hits parent</td>
<td>acting out violently, hitting mother</td>
</tr>
<tr>
<td>tries to stop altercation</td>
<td>may be injured withdrawn, insecure, depressed</td>
</tr>
<tr>
<td>becoming abused themselves - physical, sexual, emotional</td>
<td>problems relating to other children</td>
</tr>
<tr>
<td>name calling</td>
<td>hits parent</td>
</tr>
<tr>
<td>neglect</td>
<td>begins to take on behavior of abusive parent</td>
</tr>
<tr>
<td>yelling and intimidation</td>
<td>acting out violently with others</td>
</tr>
<tr>
<td>shame</td>
<td>delayed toileting</td>
</tr>
<tr>
<td>excessive punishment</td>
<td>eating problems</td>
</tr>
<tr>
<td>rigid sex role stereotypes</td>
<td>nervous, jumpy, hyper-vigilant</td>
</tr>
<tr>
<td>abuser has unrealistic expectations for age of child</td>
<td>sleep problems</td>
</tr>
<tr>
<td>abuser threatens abandonment</td>
<td>fearful</td>
</tr>
<tr>
<td>threats to send them away</td>
<td>passive, shy, clingy</td>
</tr>
<tr>
<td></td>
<td>fear of being left; emotional abandonment</td>
</tr>
<tr>
<td></td>
<td>fear of abandonment</td>
</tr>
</tbody>
</table>
EFFECTS OF DOMESTIC VIOLENCE ON CHILDREN (Continued)

AGE: 5 - 12

Developmental Stage: peer relationships, empathy & controlling impulses, self concept, assessing strengths.

<table>
<thead>
<tr>
<th>Ways of being drawn in</th>
<th>Effects of Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>sees and hears it</td>
<td>insecurity, low self esteem</td>
</tr>
<tr>
<td>picks one parent to defend</td>
<td>depression, withdrawal</td>
</tr>
<tr>
<td>physically intervenes</td>
<td>running away</td>
</tr>
<tr>
<td>calls the police</td>
<td>angry, sad, lonely</td>
</tr>
<tr>
<td>physical, sexual, emotional abuse</td>
<td>early interest in drugs or alcohol</td>
</tr>
<tr>
<td>neglect</td>
<td>school problems or over achiever</td>
</tr>
<tr>
<td>intimidation</td>
<td>regressive behavior - fear of dark, bedwetting, temper tantrums</td>
</tr>
<tr>
<td>name calling, yelling</td>
<td>sexual activity</td>
</tr>
<tr>
<td>violence to pets &amp; property</td>
<td>becomes caretaker of adults</td>
</tr>
<tr>
<td>abuser uses children as confidants</td>
<td>becomes violence prone (vs. aggressor)</td>
</tr>
<tr>
<td>shaming</td>
<td>develops problems to divert parents from fighting</td>
</tr>
<tr>
<td>abuser threatens abandonment</td>
<td>begins to make choices around being a victim vs. an aggressor</td>
</tr>
<tr>
<td>abuser controls access to friends and family</td>
<td>loyalty conflicts</td>
</tr>
<tr>
<td>excessive punishment</td>
<td>embarrassed by his/her family</td>
</tr>
<tr>
<td>threats to send them away</td>
<td>reconciliation fantasies - denial of problem, rescue fantasies</td>
</tr>
<tr>
<td></td>
<td>don’t learn boundaries</td>
</tr>
</tbody>
</table>

Maine Child Welfare Training Institute
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Session 3, Handout 19c
AGE: Teen years

Development stage: identity issues, separation from family, independence/dependence issues, sexual development and handling feelings, mourning loss of childhood.

Ways teen boys are drawn in
- Kills or tries to kill the perpetrator
- Tries to otherwise intervene

Ways teen girls are drawn in
- Becomes physically or sexually abused herself by the abuser or in teen dating relationship

All of the previous ways of being drawn in that affect 5-12 year olds, also affect teens.

Effects of abuse on both girls and boys
- School and or social problems
- Shame and embarrassment about family
- Sexual activity
- Tendency to get serious in relationships too early
- May become pregnant in order to escape home
- Truancy
- Poor school performance
- Super achiever in school
- Depression, suicide, self mutilation
- Eating disorders
- Alcohol and/or drug problems
- Confusion about gender roles
- Learns that men/women are violent
- Learns not to respect women/men
- Dating violence
- Attacks father or mother
- Embarrassed about being female/male
DOMESTIC ABUSE PROJECT SERVICES

Maine’s domestic violence projects are nonprofit organizations whose purpose is to decrease domestic violence by providing services for people affected by abuse and to foster a coordinated community response to abuse.

24 Hour Hotlines

These hotlines are available for anyone affected by domestic abuse. We offer support, feedback, and information about options. We use a self-help approach, based on the belief that callers both have the ability and right to make their own decisions and act on their own behalf. At Spruce Run, the hotline is the primary service, receiving between 200 and 300 calls each month. Most people we serve never use our shelter. In the course of hotline calls, we are able to:

- validate the callers’ feelings
- provide opportunities for them to describe what is happening in their life
- offer support, a new perspective, and information about domestic violence
- engage in safety planning and problem solving
- explain the process for obtaining protection from abuse orders
- provide information about how to obtain public assistance, housing, and other social services
- explain the divorce process
- help callers learn how to advocate for themselves
- listen

Hotline services are free, confidential, and can be made anonymously.

During the day, the hotline is answered directly, while after hours calls are relayed through an answering service. Face to face meetings are also available in the project’s offices or in outreach locations.

Family members, friends, co-workers, or other service providers are welcome to call the hotline for support and information about how to be helpful to someone they care about.

Support and Education Groups

Nearly all domestic violence projects provide ongoing peer support groups for abused women, most with simultaneous groups for the children of women participating in groups. Participants help each other by sharing experiences and offering encouragement and understanding to one another. The facilitators are trained domestic abuse workers, not therapists.

Some domestic violence projects offer groups that follow a structured curriculum or are intended for special populations. People interested in participating in a group can call the hotline for more information.
Shelter & Safe Homes

We provide assistance to people who are not safe in their home by helping them consider their options, one of which may be staying in a shelter or safe home for abused women and their children. Each domestic violence project has either a shelter or a network of safe homes available. When one is full, there is likely space in another. Most shelters can house approximately five families in a confidential location. Each shelter has several bedrooms and bathrooms, kitchens, play areas both inside and out, and is accessible to people with limited mobility.

Most domestic abuse shelters do not have 24-hour staffing. Residents have access to workers through the hotline and workers go to the shelter during scheduled hours. Therefore, anyone living in shelter must be able to take care of themselves and their children, while living safely and cooperatively with others.

Some individual services agencies in Maine do not have a shelter. Rather, trained volunteers offer their homes as “safe homes” for women and their children. The stay in a safe home is usually a few days, until a more permanent plan is arranged.

Most of the people served by domestic violence projects never seek emergency shelter or safe home. Sometimes, people are able to remain in their homes, the abuser being ordered to stay away through a protection from abuse order or bail conditions. Frequently, people have friends or family with whom they feel more comfortable and supported than staying in a shelter among strangers. We discuss these and other options with hotline callers.

Community Response and Public Education

In order to end violence against women and children, we must acknowledge, understand, and change the practices in our communities which allow battering to continue and hinder it’s victims’ efforts to achieve lives free from fear. There is no single, simple solution to this problem. No shelter, hotline, law, class, or treatment program alone will “fix” a problem that has been an integral part of our culture for centuries and affects at least a quarter of the population. We all must work together.

Fostering a coordinated community response involves providing information about domestic violence and facilitating changes within our community that will decrease battering and increase safety and support for battered women and their children. We work toward these goals in three ways: intensive training programs, systems advocacy, and public education. Several communities have a task force or council on domestic violence, supporting the efforts of the local domestic violence project.

Through the community response program, projects are able to assist local institutions and agencies in policy development as well as provide customized training and consultation.
DOMESTIC ABUSE PROJECT SERVICES

24-Hour Hotline

Support and Education Groups

Shelter

Children/Teen Programs

Specialized Training for Professionals

Public Awareness and Education

Fostering a Coordinated Community Response to Abuse
DOMESTIC ABUSE PROJECT SERVICES (Continued)

24-hour Hotline for People Affected by Domestic Abuse

➤ Confidential
➤ Anonymous
➤ No appointment or referral required
➤ No income or similar eligibility screening
➤ Available statewide
➤ Free

Maine’s Domestic Violence Projects serve more than 12,000 individuals each year.

Approximately 15% of those individuals use a shelter. Most receive assistance by calling a 24-hour hotline and never see a worker face to face.
24-hour Hotline for People Affected by Domestic Abuse Provides:

- Validation
- Non-judgment
- Safety planning
- Problem solving
- Legal information
- Information about public assistance for housing, finances, and other social services
- Advocacy
- Consultation and support for friends, family members, and service providers
Shelter

• Capacity: varies project to project
• Length of stay: usually up to 30 days; varies from project to project
• Communal living space
• Private bedrooms
• Special rooms for children to play in
• Fenced in yard with playground equipment
• Food provided
• Telephones available
• No “live-in” staff

Safe Homes

• Capacity: varies home to home; some homes do not accommodate children
• Length of stay: varies, through usually less than 3 days
• Private bedrooms; children stay in rooms with mother or have own room
• Food provided by safe home
• Telephone available; no collect calls; call blocking
This Model demonstrates, in abbreviated form, ways communities can accountably act to support battered women and children, and hold batterers accountable for their behavior. It is not a definitive representation. This Model identifies heterosexual males as perpetrators, as they comprise 95% of the batterers in this country. This Model was developed by Mike Jackson and David Garvin with the feedback of over 115 reviewers. We are grateful for their input, and acknowledge the Domestic Abuse Intervention Project for the wheel format. Permission to reproduce is given if there are no changes and credit is given. To obtain an 18 x 24 poster of this Model, or to ask questions about the model, contact: DVIM at 313-769-6334.

Domestic Violence Institute of Michigan
P.O. Box 130107
Ann Arbor, MY
48113-0107
(313) 769-6334
Session Three:

Domestic Violence
Overview:

Unit 1: Self Assessment

Unit 2-4: Overview of Domestic Violence

Unit 5: Domestic Violence and Children

Unit 6: Domestic Violence Services
Purpose

Sensitize those who work with families and children to the realities of domestic violence—i.e., its causes, consequences and remedies
Objectives:

Explore beliefs, feelings and judgments about common myths and facts pertaining to domestic violence.

Understand the prevalence of domestic abuse/violence.
Objectives:

3. Recognize abusive behavior.

4. Recognize a battered woman’s risk analysis.

5. Apply the ecological analysis of trauma to domestic violence/abuse.
Objectives:

6. Understand how children are affected by witnessing domestic violence/abuse in the home.

7. Understand the services provided by domestic violence service agencies.

8. Understand how to make referrals.
Definition of Domestic Violence:

Abuse and battering are systems of behaviors (physical, sexual, verbal, emotional, financial, spiritual, etc.) used by one person to control another’s actions and feelings. One way to think of these behaviors is as tactics, actions which are chosen and planned. An abuser is not “out of control”- the abuser is trying to control the victim.
USING INTIMIDATION
Making her afraid by using looks, actions, gestures • smashing things • destroying her property • abusing pets • displaying weapons

USING EMOTIONAL ABUSE
Putting her down • making her feel bad about herself • calling her names • making her think she is crazy • playing mind games • humiliating her • making her feel guilty

USING ISOLATION
Controlling what she does, who she sees and talks to, what she reads, where she goes • limiting her outside involvement • using jealousy to justify actions

USING CHILDREN
Making her feel guilty about the children • using the children to relay messages • using visitation to harass her • threatening to take the children away

MINIMIZING, DENYING, & BLAMING
Making light of the abuse • not taking her concerns about it seriously • saying the abuse didn’t happen • shifting responsibility for abusive behavior • saying she caused it

USING MALE PRIVILEGE
Treating her like a servant • making all the big decisions • acting like the “master of the castle” • being the one to define men’s and women’s roles

USING ECONOMIC ABUSE
Preventing her from getting or keeping a job • making her ask for money • giving her an allowance • taking her money • not letting her know about or have access to the family income

USING COERCION AND THREATS
Making and/or carrying out threats to do something to hurt her • threatening to leave her • committing suicide • reporting her to welfare • making her drop charges • making her do illegal things

USING CHILDREN
Making her feel guilty about the children • using the children to relay messages • using visitation to harass her • threatening to take the children away

POWER AND CONTROL

PHYSICAL VIOLENCE

SEXUAL VIOLENCE
Caring for the Abuse Affected Child and Family

**EQUALITY**

**NON-THREATENING BEHAVIOR**
- Seeking mutually satisfying resolutions to conflict • accepting change • being willing to compromise
- Talking and acting so that she feels safe and comfortable expressing herself and doing things

**RESPECT**
- Listening to her non-judgmentally • being emotionally affirming and understanding • valuing opinions

**TRUST AND SUPPORT**
- Supporting her goals in life • respecting her right to her own feelings, friends, activities, and opinions

**ECONOMIC PARTNERSHIP**
- Making money decisions together • making sure both partners benefit from financial arrangements

**SHARED RESPONSIBILITY**
- Mutually agreeing on a fair distribution of work • making family decisions together

**RESPONSIBLE PARENTING**
- Sharing parental responsibilities • being a positive non-violent role model for the children

**HONESTY AND ACCOUNTABILITY**
- Accepting responsibility for self • acknowledging past use of violence • admitting being wrong • communicating openly and truthfully

**NON VIOLENCE**
- Negotiation and Fairness
- Economic Partnership
- Shared Responsibility
- Responsible Parenting
- Honesty and Accountability
Caring for the Abuse Affected Child and Family

July 2004
Safety Planning

- Understand the importance of safety planning for battered women
- Understand the services available from domestic violence projects
- Encourage referrals to domestic violence project
- Recognize that we all do different work as part of any given battered woman’s safety plan
- Consider giving accurate information and good referral as helping with safety planning
- Appreciate the fact that we cannot make plans for a battered woman
- Remember only the batterer controls the abuse
Domestic Abuse Project Services

24-Hour Hotline
Support and Education Groups
Shelter
Children/Teen Programs
Specialized Training for Professionals
Public Awareness and Education
Fostering a Coordinated Community
Response to Abuse
24-hour Hotline for People Affected by Domestic Abuse

- Confidential
- Anonymous
- No appointment or referral required
- No income or similar eligibility screening
- Available statewide
- Free
Maine’s Domestic Violence Projects serve more than 12,000 individuals each year. Approximately 15% of those individuals use a shelter. Most receive assistance by calling a 24-hour hotline and never see a worker face to face.
24-hour Hotline for people affected by Domestic Abuse Provides:

- Validation
- Non-judgment
- Safety planning
- Problem solving
- Legal information
- Information about public assistance for housing, finances, and other social services
- Advocacy
- Consultation and support for friends, family members, and service providers
Shelter

- Capacity: varies project to project
- Length of stay: usually up to 30 days; varies from project to project
- Communal living space
- Private bedrooms
- Special rooms for children to play in
- Fenced in yard with playground equipment
- Food provided
- Telephones available
- No “live-in” staff
Safe Homes

- Capacity: varies home to home; some homes do not accommodate children
- Length of stay: varies, though usually less than 3 days
- Private bedrooms; children stay in rooms with mother or have own room
- Food provided by safe home
- Telephone available; no collect calls; call blocking
Guiding Principals

- Regard the safety of victims and their children as a priority.
- Respect the integrity and authority of each battered woman over her own life choices.
- Hold perpetrators responsible for the abuse and for stopping it.
- Advocate on behalf of the victims of domestic violence and their children.
- Acknowledge the need to make changes in our faith communities to improve our response to domestic violence.
FACILITATOR’S GUIDE

Session Four
Child Abuse/Neglect and Reporting Requirements

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- Unit 5: Child Abuse/Neglect Case Studies 15
- Closure to Session 17
- Participant Handouts
- Overheads
For Introduction to Session:
There are overheads available for the Session Overview, Purpose, and Objectives. If you do not have an overhead projector available, prepare 3 sheets of flip chart paper with the following information:

- Overview:
  Unit 1: Definitions of Child Abuse and Neglect
  Unit 2: Abuse Continuum
  Unit 3: Child Abuse Indicators
  Unit 4: Reporting Abuse/Working with DHHS
  Unit 5: Child Abuse/Neglect Case Studies

- Purpose:
  1. Sensitize participants to the types of child abuse and indicators of child abuse/neglect.
  2. Describe reporting requirements and DHHS beliefs and practices to help participants recognize possible child abuse/neglect and respond appropriately.

- Objectives:
  1. Know the primary types of abuse as identified by the Maine Statute.
  2. Recognize the possible behavioral indicators of child abuse.
  3. Understand the legal mandates for child abuse reporters and know how to make a report.
  4. Develop increased understanding of the complexity of child abuse and DHHS.

For Unit 1:
Overhead 6 has the definition from the Maine Statute. An alternative is to prepare a flip chart with the following:

‘Abuse or Neglect’ means a threat to a child’s health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these, by a person responsible for the child.

Overheads 7-10 have the four child abuse/neglect definitions. If you do not have an overhead projector available, prepare 4 sheets of flip chart paper with the following information:

Physical Abuse: Physical injuries inflicted by a parent/caretaker; also called non-accidental trauma. These could be rated as mild, moderate, or severe.

Neglect: Non-accidental failure or failure of a caretaker to provide a child physical, medical, or emotional necessities for normal life, growth, and development.
Emotional Abuse: Using words or behaviors that threaten, harshly criticize, ridicule, or harass the child; withholding affection; holding unrealistic expectations; associated with all forms of child abuse.

Sexual Abuse: Child abuse which results in any act of a sexual nature upon or with a child; any sexual involvement of a parent or caretaker with a child as a sexual act. Sexual exploitation is involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to, and that violate social taboos of family roles.

For Unit 2:
Make sure participants have enough space to work in four small groups, as each group needs space to spread out and work with their cards.

Bring Continuum Exercise cards, sorted into categories, each category shuffled. Have enough blank flip chart paper for each small group to have 2-3 sheets, dark colored markers, and tape.

For Unit 3:
Write on a sheet of flip chart paper:
Child Indicators
Indicators from Parent/Child Interaction

For Unit 4:
There are overheads available for the Mandatory Reporting presentation (Overheads 12 – 20). If you do not have an overhead projector available, you can ask participants to follow along in their participant handbook as a reference. You can make flip chart posters of some of the material in the Handouts section, to add variety and visual appeal.

For Unit 5:
Write on a sheet of flip chart paper:
1) Assign for Assessment
2) Refer to Community Intervention Program
3) Close Case

For Closure to Session:
- Bring Session 4 Evaluations for completion by participants (RDC Team Member).
- Bring your business cards (optional) to distribute to participants.
- Bring pamphlet “Maine Cares About Children and their Families” to distribute
- Bring Child Welfare Services Ombudsman pamphlet to distribute
PURPOSE, OBJECTIVES AND OUTLINE

**Purpose:**
Sensitize participants to the types and indicators of child abuse/neglect, reporting requirements and DHHS beliefs and practices. To help participants recognize possible child abuse/neglect and respond appropriately.

**Objectives:**
1. Know the different types of abuse as identified by Maine Statute
2. Recognize the possible behavioral indicators of child abuse
3. Understand the legal mandates for child abuse reporters and know how to make a report
4. Develop increased understanding of the complexity of child abuse and neglect and how DHHS responds to it.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to Session</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Unit 1: Definitions of Child Abuse and Neglect</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Unit 2: Child Abuse Continuum</td>
<td>45 minutes</td>
</tr>
<tr>
<td>Break</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Unit 3: Child Abuse Indicators</td>
<td>40 minutes</td>
</tr>
<tr>
<td>Unit 4: Reporting Abuse/Working with Child Protection</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Unit 5: Child Abuse and Neglect Case Studies</td>
<td>25 minutes</td>
</tr>
<tr>
<td>Closure to Session</td>
<td>5 minutes</td>
</tr>
</tbody>
</table>

**Total Session Time**
3 hours
Introduction to session (5 minutes)

Overheads for Introduction:
Session 4, Overhead 2: Overview
Session 4, Overhead 3: Purpose
Session 4, Overheads 4 & 5: Objectives

Suggested Order of Activities:

1. Welcome the group back.
2. Briefly go over the Session 4 Overview, Purpose and Objectives (overheads 2-5) in your own words.
3. Remind the group of the impactful nature of this topic and encourage self-care.
4. If it would be helpful, review the ground rules.
5. Explain that you are bound by confidentiality and may not discuss any specific cases in the session.
6. Remind participants to de-identify personal examples.

Trainer Notes:
Unit 1: Definitions of Child Abuse and Neglect (15 minutes)

Purpose:
Describe the four primary types of child abuse as defined by Maine Statute and encourage participants to consider how legal definitions may differ from one’s personal definition of abuse.

Handouts for Unit 1:
   Session 4, Handout 1: Child Abuse and Neglect Definitions

Overheads for Unit 1:
   Session 4, Overhead 6: Definition from Maine Statute
   Session 4, Overheads 7-10: Child Abuse and Neglect Definitions

Suggested Order of Activities:

1. Present the definition of child abuse/neglect from the Maine Statute, using the overhead or your prepared flip chart. Describe the significance of each part of the definition to help participants begin to understand the legal definition. Trainer can also ask participants if they think anything is missing from this definition. If they don’t mention it you can add sibling abuse, stranger assault, educational and medical neglect.

2. Use the overheads (7-10) or refer them to Handout 1 to present each of the four primary abuse types. State that for each type of abuse DHHS must assess the degree of impact or threatened impact of the abuse, the degree of risk the person poses to all children and how likely it is that abuse or neglect will occur in the very near future.

3. Encourage participants to begin thinking about how their own definitions of abuse may differ from the legal definitions. Tell them that this exercise will challenge them to look more closely at abuse perspectives and those factors that can affect the impact abuse has on children.

   This is also a terrific time to talk about how each legal definition impacts your work.
Title 22 is the backbone of public child welfare services in Maine and drives the process of all civil child protection matters.

The child welfare caseworker must work within a strict legislative mandate in terms of assessing, identifying, and responding to child abuse. The caseworker must also be looking for and identifying family strengths. They must recognize the impact of abuse on the child(ren) in the home.

Other community members and professional providers may see and respond to this issue through the particular lens in which they view and work with the family and according to agency policy. What is common to each of us is that we bring our own conceptual framework, our feelings and our values to our work. We each understand the individual or family within the context of the services we provide and according to what the family brings. We bring both a personal and a professional understanding of the issue of abuse.

“Child Protective Services or law enforcement agencies in a community are the only bodies’ authorized to assess allegations of abuse, provide physical protection for a child, and restrain the behavior of an adult who is abusive.”


Trainer Notes:
Unit 2: Abuse Continuum (45 minutes)

Purpose:
Illustrate the behaviors that constitute abuse across the four primary abuse types and sensitize participants to the various factors that may impact the severity of the abuse.

Handouts for Unit 2:
Session 4, Handout 2: Sexual Abuse, Why Children Tell and Don’t Tell

Suggested Order of Activities:
1. Inform the group that the following exercise provides an opportunity to consider behaviors that constitute abuse across the four primary types of abuse – physical, neglect, emotional, and sexual. Participants will be asked to work in small groups to arrive at a consensus in putting in order cards with examples of abuse, from most to least severe. Groups will be asked to take into consideration several different factors, such as age or vulnerability of a child who may experience the maltreatment. Groups will have an opportunity to see one another’s work, but each group will work with only one of the categories.

2. Divide participants into four groups. Give each group a set of cards for one of the abuse types, and ask them to lay the cards out where all group members can see them. Give the groups time to familiarize themselves with the cards first and to make sure everyone is clear about what each card says.

3. Tell groups they are to order the cards as if a six-month old infant were experiencing the abuse. Some of the cards may not seem realistic for an infant; ask participants to set those cards aside for the moment. Remind them that they must reach consensus and that no two cards may occupy the same space.

4. After the groups finish, tell them to arrange all of the cards as if a five year-old girl were experiencing the abuse.

5. When they finish, ask participants to walk around and observe the work done by other groups. Tell them they may not change the order of the cards, but encourage them to think about anything they might have done differently.

6. Have participants return to their original group. Ask them if they were still working with a five year old, would they change the order of the cards if the primary caretaker is a heroin addict? If so, ask them to make those changes now.

7. Tell the group their next task is to order the cards as though the child experiencing the abuse is a thirteen year old boy. When completed, ask the group how (or if) the order might be different if the child is a girl.
8. The small group work of the exercise is now completed. Ask participants to remain in their small groups for a whole-group process and debrief.

**Large Group Discussion- Ask participants:**

- What was it like for you to first read and then work with the examples of abuse?
- What happened for you when the age of the child changed? What did you find yourself considering or discussing?
- What was challenging in trying to reach consensus in your small groups?
- What will you take away from this exercise?

The large group debrief is the most important part of this exercise, as it can be quite illuminating for participants to discover that we all have different perspectives on abuse and its impact. Try to hear from as many people as possible. It’s also a terrific time to talk very briefly about severity and imminence, because this exercise clarifies those factors well. Be sure not to shift into direct instruction, however, as the purpose of this time is for the whole group to process and reflect.

Trainer can also refer participants to Handout 6 and talk briefly about why children do and don’t tell.

**Trainer Notes:**
Unit 3: CHILD ABUSE INDICATORS (40 minutes)

Purpose:
Raise participant’s awareness of possible behavioral indicators – or red flags – of abuse in children, and possible behavioral indicators of abuse in parent (or caregiver) and child interactions

Handouts for Unit 3:
Session 4, Handout 3: How Do I Recognize Child Abuse?
Session 4, Handout 4: How Do I Recognize an Abusive Parent or Caregiver?
Session 4, Handout 5: Boundary Breakdown: Adult to Child Interaction
Session 4, Handout 6: Children’s Range of Sexual Behavior

Overheads for Unit 3:
Session 4, Overhead 11: Brainstorm in Small Groups

Suggested Order of Activities:
1. Participants will remain in the same groups as for the Continuum Exercise.
2. Tell the whole group that this exercise builds upon the previous Continuum Exercise.
3. Encourage the small groups to think about the examples in the continuum exercise to generate thoughts about possible behavioral indicators in children of different ages (age 2, 5, 10, 15) and in various circumstances. Participants are encouraged to draw upon their own professional knowledge and experience – what have they seen that has concerned them?

With the continuum, the groups were considering various behaviors that constitute abuse across the primary abuse types. This was to consider how different factors impact the possible severity of abuse/neglect to children. In this exercise the goal will be to concentrate more on possible behavioral indicators presented by children who have experienced abuse and in the interaction between the adult and child. In other words, what might we expect to see in a child who has experienced physical abuse or neglect? An example might be a child dressed inappropriately for the season. What behavioral indicators may be present in the interaction between an emotionally abusive parent and his/her child? An example might be seeing the parent using harsh language or put downs with the child. We might see lack of eye contact between a neglectful parent and his/her child.

4. You may elect to have each group work with the same abuse type they had before, or assign them a new one.
5. Give each group two sheets of newsprint and markers. Ask groups to identify a recorder and reporter as they will be sharing their lists with the large group at the end of the exercise. Tell them to come up a list of behaviors they might see in an abused child and behaviors they might observe in the interaction between a parent and his/her child.

For the group’s reference display Overhead #11 or write on a flip chart page with the headings:

- Child Behavioral Indicators
- Indicators in Parent/Child Interaction.

6. Give groups fifteen to twenty minutes to generate their lists. Once time has been called, ask each group to report out on the behaviors they would see in the type of abuse (i.e. one group reports on emotional, one on neglect, one on sexual, one on physical) they were exploring. Ask groups to comment on any relevant discussions that occurred during the exercise. If time allows, ask the large group if they would like to add anything to any of the lists, or if there are questions about any of the lists.

You will want to look each list over carefully while groups are working to clear up any myths or misconceptions generated in the small group work. Remind the group that the behaviors may also be present with or without abuse.

7. Ask the group how child abuse relates to our initial discussion on trauma – and the ecological model presented. What do we know about trauma response and what might happen with a child depending on their support system, their history and their environment?

Trainer Notes:
Unit 4: Reporting Abuse and Working With DHHS (30 minutes)

Purpose:
Increase participants’ knowledge of the legal mandates for child abuse reporters, including how to make a report to child protective intake and the basic processes, services, and roles of the Office of Child and Family Services.

Handouts for Unit 4:
- Session 4, Handout 7: DHHS Abbreviations
- Session 4, Handout 8: Mandatory Reporting: Frequently Asked Questions
- Session 4 Handout 9: Mandatory Reporting: Thinking About Our Obligations
- Session 4, Handouts 10a-10c: Child and Family Services and Child Protection Act
- Session 4, Handout 11: Child Protection Findings
- Session 4, Handout 12: DHHS Timeframe
- Session 4, Handouts 13a-13b: DHHS Practice Model

Overheads for Unit 4:
- Session 4, Overheads 12 & 13: DHHS Abbreviations
- Session 4, Overheads 14-17: Child Protection Findings and Report types
- Session 4, Overheads 18 & 19: DHHS Timeframe
- Session 4, Overhead 20: DHHS Practice Model

Suggested Order of Activities:
1. Tell participants that this part of the training will focus on mandatory reporting and other important guidelines for Maine child care providers, and on the roles, functions and services of the Office of Child and Family Services. Tell the group that due to confidentiality and ethical considerations, you will not be able to discuss specific cases or situations. The discussion will be more of a general nature.

2. State that childcare providers are mandated reporters for child abuse and neglect. Describe the law, including reporter immunity from liability. Remind people that they are only mandated in their role at work - not when they are at home or in the supermarket.

This discussion may prompt participants to bring up situations that were frustrating or were a source of conflict for them in dealing with the Department regarding a child protection report, investigation, or case outcome. It is helpful to acknowledge the challenges providers face and to remind the group that issues of child abuse and neglect are often extremely complex. In order to maintain the rights of families to privacy and confidentiality, the Department will never discuss particular details of an ongoing investigation or case. This can leave service providers feeling ‘out of the loop’. The rest of the training team will want to be prepared to support their colleague if the discussion becomes overly critical or challenging for the lead trainer.
3. Let participants know that Handouts #8-9 give examples of Frequently Asked Questions and Thinking about our Obligations as Mandated Reporters. Invite them to read it over during the break and bring any questions they may have back to the group.

4. Describe the roles and mandates of the Department in responding to child abuse. Primarily, the law authorizes the Department to act to protect children who are reported to be abused or neglected and to provide services that support and reinforce parental care of children. To explain how the Department process works and some of the frequently used abbreviations show Overheads #12 and 13.

5. Then explain that for any report coming into the Department there are three possible outcomes. Use Overhead #14 to define these outcomes and then Overheads #15 - #17 to explain what the Department does depending on the outcome of the report.

6. Show Overheads #18 and 19 to review the timeframe of the reporting process. Explain that the emphasis of both the state and federal child welfare systems’ is on permanency planning within a very short time period. Child safety is always paramount. The Department is committed, however, to simultaneously working to create a permanency plan. Give examples from your own practice to emphasize the process.

Also mention that when a report is made regarding possible institutional abuse it is assigned to the Institutional Abuse Unit for assessment. This includes alleged abuse in a child care setting. Remind participants of the importance of reporting and how if a report is not made a child care setting could lose their license and have charges brought against them.

7. Show Overhead #20 that explains DHHS’ newly revised Practice Model, developed from Belief Statements reflecting the changes in the emphasis on the importance of family and permanency planning. Talk about how it might have changed your own personal practice in the Department (if it has) and how it has influenced and changed the practice of social workers in general.

8. Emphasize the importance of aligning their child care provider documentation system with the changes that have occurred in the Department.

If time allows, ask the group to talk about why it is important to document child and family status and significant episodes that occur in the child care setting. What do they document in their centers or agencies? What methods, forms, or approaches do they use to document?

This is a great opportunity for participants to share their knowledge and practices with each other.

9. Tell participants about community resources or Community Intervention Programs (CIP’s) available for child care providers in their region.
10. Talk about other recent system changes or terminology that may be helpful to mention including: Aggravating Factors, Permanency Planning, Concurrent Planning, Kinship Care, and Rights to Other Parties.

11. Share information concerning particular initiatives in your region that providers may hear about or that may inform their work, such as reform activities, collaborations, family team meetings, reunification, kinship adoption or family court.

**Trainer Notes:**
Unit 5: Child Abuse and Neglect Case Studies (25 minutes)

Purpose:
Increase participant understanding of the range and complexities of cases Child Protective Services deal with on a daily basis.

Handouts for Unit 5:
Session 4, Handouts 14a-14c: Child Abuse and Neglect Case Studies

Overheads for Unit 5:
Session 4, Overhead 21: Case Studies

Suggested Order of Activities:

1. Tell participants that for the following activity they will be working with five cases reported to DHHS. Share the following points with the group:
   - These cases all come from one week of reports in one region. There were more in addition to these.
   - The job of the Child Protective Supervisor is to review the reported cases and then decide which to assign for assessment, which to refer to a Community Intervention Program, and which will be closed.

   Emphasize to the group that even though they may want to open or assign every case - it is not possible for the Department to do this. Supervisors need to make some hard decisions about whether there is a clear indication that a child is in danger now or will be in the very near future and whether there is a clear allegation of abuse or neglect in the case. Tell participants that they will be asked to do the same with these cases.

2. Divide the participants into small groups (or have them work at table groups) and instruct each group to read all five case scenarios.

3. For the group’s reference display Overhead #21 or write on a flip chart page:
   - Refer the case to a Community Intervention Program (CIP) to work with the family, or
   - Assign the case to a case worker for assessment, or
   - Close the case.

   Explain that for this exercise they will take the perspective of the Regional Supervisor and decide what to do with the cases they received from Central Intake this week. As a group they must come to consensus on what action to take.

4. Give groups ten minutes to review the cases and make their decisions.
5. Ask the groups to report on what they decided to do with each case (perhaps have each table report out on one case and then have others talk about differences and similarities) and what caused them to come to that determination.

One member of the training team should record the case number and reasons on a flipchart while you facilitate the discussion.

6. The group should also understand that the job of Child Protection is to ‘facilitate safety’ not ‘ensure safety’. Ask if this makes their thinking about the cases any different. After all groups have reported out have a discussion with the whole group about what it was like to make those decisions? Ask them to reflect on whether there is any other information that might have been helpful to them in making their decisions.

Optional: You may want to offer what you think might happen to each of the cases presented, and what factors would influence that decision. Explain that unfortunately the decision can be influenced by the number of difficult cases reported that week- but in the end the criteria of whether there is clear indication that a child is in danger now or in the future and whether there a clear allegation of abuse or neglect in the case determines the decision made.

Also, remind participants that reports naturally focus on the problems within a family. It is the Department’s goal, however, to identify and build upon strengths within families as well.

**Trainer Notes:**
Closure to Session (5 minutes)

Suggested Order of Activities:

1. Thank the group for their participation in this session.

2. Conduct a brief check-in with group members, encouraging them to use self-care strategies between now and the next session. Remind participants that the information they received today was an overview and it is **not** the intention of the training to make them into child abuse investigators and/or assessors.


3. Distribute your business cards (optional) and encourage participants to contact you or your office at any time at they have questions.

4. Distribute Session 4 evaluations and encourage participant to be candid and thorough. Remind the group to keep voice tones low as they are leaving so others may concentrate.

**Trainer Notes:**
Child Abuse and Neglect Definitions

Child Abuse and Neglect
“Abuse and neglect means a threat to a child’s health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these, by a person responsible for the child.”

Title 22 MRSA, §4002

Physical Abuse
Physical injuries inflicted by a parent/caretaker; also called non-accidental trauma. These could be rated as mild, moderate, or severe.


Neglect
Non-accidental failure or failure of a caretaker to provide a child physical, medical, or emotional necessities for normal life, growth, and development.


Emotional Abuse
Using words or behaviors that threaten, harshly criticize, ridicule, or harass the child; withholding affection; holding unrealistic expectations; associated with all forms of child abuse.

Caring for the Abuse Affected Child and Family USM, Muskie School of Public Service (2003)

Sexual Abuse
Child abuse which results in any act of a sexual nature upon or with a child; any sexual involvement of a parent or caretaker with a child as a sexual act. Sexual exploitation is involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to, and that violate social taboos of family roles.

Sexual Abuse: Why Children Tell and Why They Don’t Tell

**Barriers to Disclosure: Why children Don’t Tell**
1. They feel responsible (as partners), not as victims.
2. They fear that adults won’t believe them.
3. They believe the abuser’s threats.
4. They avoid disappointing adults who they think may be repulsed by the information.
5. They don’t like to talk about “nasty” things.
6. They don’t know how to describe what’s happened to them.
7. They are taught not to “tattle” or “squeal”.
8. They are taught to respect adults, so they are afraid of getting an adult in trouble or disobeying an adult who has sworn them to secrecy.

**Breaking Barriers: Why Children Tell**
1. They meet somebody who already seems to “know.”
2. They meet a person who appears confident, non-judgmental, non-critical, and non-threatening.
3. They believe that continuation of the abuse is unbearable.
4. They get physically injured.
5. They get information about sexual abuse and sexual abuse prevention.
6. They want to protect another child.
7. They are potentially pregnant.
8. They meet someone who’s willing to protect them.
### How Do I Recognize Child Abuse?

<table>
<thead>
<tr>
<th>Abuse</th>
<th>Physical Indicators</th>
<th>Behavioral Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Abuse</strong></td>
<td>unexplained bruises in various stages of healing, welts, human bite marks, bald spots</td>
<td>self-destructive</td>
</tr>
<tr>
<td></td>
<td>unexplained burns, especially cigarette burns or immersion burns</td>
<td>withdrawn and aggressive: behavioral extremes</td>
</tr>
<tr>
<td></td>
<td>unexplained fractures, lacerations, or abrasions</td>
<td>uncomfortable with physical contact</td>
</tr>
<tr>
<td></td>
<td></td>
<td>arrives at school early and stays late as if afraid to go home</td>
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<tr>
<td></td>
<td></td>
<td>chronically runs away (adolescent)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>complains of soreness or moves uncomfortably</td>
</tr>
<tr>
<td></td>
<td></td>
<td>wears clothing inappropriate to weather to cover up</td>
</tr>
<tr>
<td><strong>Neglect</strong></td>
<td>abandonment</td>
<td>regularly displays fatigue or listlessness, falls asleep during activities</td>
</tr>
<tr>
<td></td>
<td>unattended medical needs</td>
<td>steals food, begs from peers</td>
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<tr>
<td></td>
<td>consistent lack of supervision</td>
<td>reports that no caretaker is at home</td>
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<td></td>
<td>consistent hunger, inappropriate dress, poor hygiene</td>
<td>frequently absent or tardy</td>
</tr>
<tr>
<td></td>
<td>lice, distended stomach, emaciation</td>
<td>self destructive</td>
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<tr>
<td></td>
<td></td>
<td>dropout (adolescence)</td>
</tr>
<tr>
<td><strong>Sexual Abuse</strong></td>
<td>torn, stained, or bloody underclothing</td>
<td>withdrawal, chronic depression</td>
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<td></td>
<td>pain or itching in genital area</td>
<td>excessive seductiveness</td>
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<td></td>
<td>difficulty walking or sitting</td>
<td>role reversal, overly concerned for siblings</td>
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<td></td>
<td>bruises or bleeding in external genitalia</td>
<td>poor self-esteem, self-devaluation, lack of confidence</td>
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<td></td>
<td>sexually transmitted infection</td>
<td>peer problems, lack of involvement</td>
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<td></td>
<td>frequent urinary tract or yeast infections</td>
<td>massive weight change</td>
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<td></td>
<td>often, there are no physical indicators</td>
<td>eating disorders</td>
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<tr>
<td></td>
<td></td>
<td>suicide attempts (especially adolescents)</td>
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<td></td>
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<td>hysteria, lack of emotional control</td>
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<td></td>
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<td>sudden difficulties in school</td>
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<td></td>
<td></td>
<td>chronically runs away</td>
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<td></td>
<td></td>
<td>inappropriate sex play or premature understanding of sex</td>
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<td></td>
<td></td>
<td>threatened by physical contact, closeness</td>
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<tr>
<td><strong>Emotional Maltreatment</strong></td>
<td>speech disorders</td>
<td>habit disorders (sucking, rocking)</td>
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<td></td>
<td>delayed physical development</td>
<td>antisocial, destructive</td>
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<td></td>
<td>substance abuse</td>
<td>neurotic traits (sleep disorders, inhibition of play)</td>
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<td></td>
<td>ulcers, asthma, severe allergies</td>
<td>passive and aggressive: behavioral extremes</td>
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<td></td>
<td></td>
<td>delinquent behavior (especially adolescents)</td>
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<td></td>
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<td>developmentally delayed</td>
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Adapted from the American Association for Protecting Children, “Guidelines for Schools.” American Humane Association, Denver, CO, (no date)
How Do I Recognize an Abusive Parent or Caregiver?
Possible Behavioral Indicators

Physical Abuse

- Shows little concern for child
- Rarely responds to requests for information about the child
- Asks other supervising adults to use harsh punishment if child misbehaves
- Describes child as evil, bad, or worthless
- Gives conflicting, unconvincing, or no explanation for child’s injury
- Uses harsh physical discipline
- Has a history of abuse as a child

Neglect

- Appears indifferent towards the child
- Appears apathetic or depressed
- Behaves irrationally
- Is abusing alcohol or other drugs

Emotional Abuse

- Constantly blames, belittles, or berates the child
- Doesn’t seem concerned about the child
- Openly rejects the child

Sexual Abuse

- Unduly protective
- Severely limits social contact
- Secretive and isolated
  Note: The sexual abuser may have started perpetrating in his adolescent years
**Boundary Breakdown: Adult to Child Interaction**

### Psychological

<table>
<thead>
<tr>
<th>1. Covert Psychological</th>
<th>2. Overt Psychological</th>
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<tbody>
<tr>
<td>• Boundary ambiguity - role reversal</td>
<td>• Unnecessary “medical” exams</td>
</tr>
<tr>
<td>• Shaming interactional system</td>
<td>• Adults’ pre-occupation with child’s body and bodily functions</td>
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<tr>
<td>• Unmet dependency needs</td>
<td>• Disrespect of emotional privacy needs - e.g., reading a child’s diary</td>
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<tr>
<td>• Emotional enmeshment/disengagement</td>
<td>• Use of objectifying sexualizing language and concepts</td>
</tr>
<tr>
<td>• Blurring of generational lines - e.g., father talks to daughter about problems between him and mother</td>
<td>• Blurring of generational lines - e.g., father talks to daughter about problems between he and her mother</td>
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<tr>
<td></td>
<td>• Sexual jokes told by adults to children</td>
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</tbody>
</table>

### Physical

<table>
<thead>
<tr>
<th>3. Covert Physical</th>
<th>4. Overt Physical</th>
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<tbody>
<tr>
<td>• Touch deprivation</td>
<td>• French kissing</td>
</tr>
<tr>
<td>• Inappropriate sleeping arrangements</td>
<td>• Oral-genital contact</td>
</tr>
<tr>
<td>• Disrespect of child’s privacy</td>
<td>• Fondling</td>
</tr>
<tr>
<td>• Wrestling with genital touching</td>
<td>• Sex games</td>
</tr>
<tr>
<td>• Invasive hygienic practices</td>
<td>• Sodomy</td>
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<tr>
<td>• Excessive enemas</td>
<td>• Intercourse</td>
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<tr>
<td>• Sexual hugs</td>
<td></td>
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<tr>
<td>• Voyeurism/exhibitionism</td>
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From Neilsen, L. *Sexual Abuse and Chemical Dependency: Assessing the Risk for Women Alcoholics and Adult Children*, “Focus on the Family”, 1984
Children’s Range of Sexual Behavior

Normal
- genital or reproduction conversations with peers or siblings close to the same age
- the “show me yours/I’ll show you mine” game with peers
- playing doctor
- occasional masturbation without penetration
- imitation seduction - e.g., kissing, flirting
- dirty words or jokes within cultural or peer group norm

Yellow Flags
- preoccupation with sexual themes (especially sexually aggressive)
- attempt to expose other’s genitals - e.g., pulling pants down or lifting skirts up
- sexually explicit conversations with peers
- sexual graffiti (chronic and specifically directed to an individual)
- sexual innuendo, teasing, embarrassing others
- precocious sexual knowledge
- single occurrences of peeping, exposing, obscenities, pornographic interest, frottage
- preoccupation with masturbation
- mutual masturbation/group masturbation
- simulating foreplay with dolls or peers with clothing on - e.g., petting, deep kissing

Red Flags
- sexually explicit conversations with persons from a significantly different age group
- touching the genitals of others
- degradation, humiliation, of self or others with sexual themes
- forced exposure of another’s genitals*
- inducing fear or threats of force
- sexually explicit proposals, threats (including written notes)
- repeated or chronic peeping, exposing, obscenities, pornographic interests, frottage
- compulsive masturbation; interrupts tasks to masturbate
- female masturbation including vaginal penetration
- simulating intercourse with dolls, peers, animals - e.g., “humping”

No Questions
- oral, vaginal, anal penetration of dolls, children, animals
- forced touching of genitals
- simulating intercourse with peers with clothing off
- any genital injury or bleeding not explained by accidental causes

*Although ‘force’ is usually a factor in the ‘No Questions’ range, restraining an individual to pull down pants or expose breasts does occur in the context of ‘hazing’ among peers.
### DHHS Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CA/N</td>
<td>Child Abuse and Neglect</td>
</tr>
<tr>
<td>CI</td>
<td>Central Intake; all incoming calls to report child abuse are taken by Central Intake</td>
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<tr>
<td>CIP</td>
<td>Community Intervention Program</td>
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<tr>
<td>FTM</td>
<td>Family Team Meeting</td>
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<tr>
<td>GAL</td>
<td>Guardian Ad Litem; a judge-appointed person who ensures the child’s welfare is represented</td>
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<tr>
<td>OCFS</td>
<td>Office of Child and Family Services</td>
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<tr>
<td>PPO</td>
<td>Preliminary Protective Order; an order from a judge to protect a child from harm</td>
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<tr>
<td>S/A</td>
<td>Safety assessment; done by Child Protective Social Workers to ensure safety of child</td>
</tr>
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</table>
Mandatory Reporting: Frequently Asked Questions

1. **What am I required to report?**
   Knowledge of or suspicion that a child has been or is likely to be abused or neglected.

2. **What is the process for reporting?**
   Call Central Intake at DHHS at 1-800-452-1999.

3. **Is truancy a form of neglect that should be reported to DHHS?**
   No, truancy is not identified as a form of neglect under Maine statutes of abuse (as it is in some other states).

4. **Is it considered abuse to leave a child under twelve years old without adult supervision?**
   No, in Maine there is no standard of when a child may be left alone based solely on age.

5. **Can DHHS caseworkers enter a home and decide on the spot to remove the child/ren if they believe there has been serious abuse/neglect?**
   No. DHHS has to seek court action to remove the child/ren or call law enforcement to have the children placed in interim care for up to 6 hours.

6. **Must a mandated reporter give his/her name when calling in a report of suspected abuse/neglect?**
   Yes. Mandated reporters may request confidentiality, but not anonymity. With the exception of court action, mandated reporters may request that their name not be shared with the family, but as mandated reporters they must give their names to CI when making a report.

7. **Does DHHS actively explore relative or kinship placements when children come into state custody?**
   Yes, DHHS places a high priority on placing children with relative or kinsfolk when possible and appropriate, and this option is often explored prior to child/ren coming into custody.

8. **Is spanking against the law in the State of Maine?**
   No, physical discipline that causes only transient injury is allowable under Maine law.

9. **Must all abuse cases be reported to DHHS?**
   DHHS is involved only when the suspected abuser is a parent or caretaker of the victim. All other abuse should be reported to the DA’s office.

10. **Can children reach out directly to DHHS for help without obtaining parental permission?**
    Yes, DHHS can interview a child who calls without parental consent, but parents must be notified. (DHHS is legally obligated to do so.).

11. **Is a mandated reporter entitled to know what happened to their report?**
    Mandated reporters are not entitled to that information. Under its optional disclosure policy, DHHS decides whether or not to share information based on its impact on a child or family’s safety.

From DHHS Mandated Reporter Training for Suspected Child Abuse and Neglect
Mandatory Reporting: Thinking About Our Obligations

1. What if I learned about the abuse during a confidential interaction?

Nearly all professionals struggle with this dilemma. When we offer our assistance to someone with the understanding that his or her words will be held in confidence, it can feel like a betrayal to then report information from that interaction to someone else. We are faced with the ethical question: does my obligation to confidentiality outweigh my obligation to prevent harm to others?

Confidentiality means to hold information in trust and to share it with others only in the interest of the person involved or in order to protect others from harm by them. It is not intended to protect abusers from being held accountable for their actions or to keep them from getting the help that they need.¹

It is important to consider the potential impact of failing to report. Failing to report could contribute to the continuation of abuse.

2. How can I report the abuse without destroying the helping relationship I have developed with the person who told me?

Service providers rarely learn about child abuse from the perpetrator. Professionals will most often hear about abuse from the abused child, a protective parent, or another significant adult in the child’s life. The child’s dilemma is far greater than that of the professional, since they will live with the consequences of whatever action follows their disclosure. The children involved have been made to fear the consequences of revealing this behavior and feel responsible for what happens as a result. A protective parent may fear for their life should the perpetrator find out that the abuse has been disclosed.

One approach to reporting that can strengthen the helping relationship is to tell the person that a report must be made. Having opened that issue for discussion, time can be spent discussing the hopes and fears the person has regarding what may happen next. The helping professional may be able to provide support for the child and protective adult through the process of investigation and later action.

Title 22 M.R.S.A.
Chapter 1071: Child And Family Services and Child Protection Act
Subchapter 2: Reporting of Abuse or Neglect: §4011-A. Reporting of suspected abuse or neglect

1. **Required report to department.** The following adult persons shall immediately report or cause a report to be made to the department when the person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected.

   (1) An allopathic or osteopathic physician, resident or intern;
   (2) An emergency medical services person;
   (3) A medical examiner;
   (4) A physician's assistant;
   (5) A dentist;
   (6) A dental hygienist;
   (7) A dental assistant;
   (8) A chiropractor;
   (9) A podiatrist;
   (10) A registered or licensed practical nurse;
   (11) A teacher;
   (12) A guidance counselor;
   (13) A school official;
   (14) A children's summer camp administrator or counselor;
   (15) A social worker;
   (16) A court-appointed special advocate or guardian ad litem for the child;
   (17) A homemaker;
   (18) A home health aide;
   (19) A medical or social service worker;
   (20) A psychologist;
   (21) Child care personnel;
   (22) A mental health professional;
   (23) A law enforcement official;
   (24) A state or municipal fire inspector;
   (25) A municipal code enforcement official;
   (26) A commercial film and photographic print processor;
   (27) A clergy member acquiring the information as a result of clerical professional work except for information received during confidential communications;
   (28) A chair of a professional licensing board that has jurisdiction over mandated reporters;
   (29) A humane agent employed by the Department of Agriculture, Food and Rural Resources;
B. Any person who has assumed full, intermittent or occasional responsibility for the care or custody of the child, regardless of whether the person receives compensation. [2003, c. 210, §3 (amd)]

C. Any person affiliated with a church or religious institution who serves in an administrative capacity or has otherwise assumed a position of trust or responsibility to the members of that church or religious institution, while acting in that capacity, regardless of whether the person receives compensation. [2003, c. 210, §4 (new)].

Whenever a person is required to report in a capacity as a member of the staff of a medical or public or private institution, agency or facility, that person immediately shall notify either the person in charge of the institution, agency or facility or a designated agent who then shall cause a report to be made. The staff may also make a report directly to the department. (2003, c. 599, §8 (amd): §§, 14(aff)

2. **Required report to district attorney.** When, while acting in a professional capacity, any person required to report under this section knows or has reasonable cause to suspect that a child has been abused or neglected by a person not responsible for the child, the person immediately shall report or cause a report to be made to the appropriate district attorney’s office. [2001, c. 345, §5 (new)].

3. **Optional report.** Any person may make a report if that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected. [2001, c. 345, §5 (new)].

4. **Mental health treatment.** When a licensed mental health professional is required to report under subsection 1 and the knowledge or reasonable cause to suspect that a child has been or is likely to be abused or neglected comes from treatment of a person responsible for the abuse or neglect, the licensed mental health professional shall report to the department in accordance with subsection 1 and under the following conditions.

   A. The department shall consult with the licensed mental health professional who has made the report and shall attempt to reach agreement with the mental health professional as to how the report is to be pursued. If agreement is not reached, the licensed mental health professional may request a meeting under paragraph B. [2001, c. 345, §5 (new)].

   B. Upon the request of the licensed mental health professional who has made the report, after the department has completed its investigation of the report under section 4021 or has received a preliminary protection order under section 4034 and when the department plans to initiate or has initiated a jeopardy order under section 4035 or plans to refer or has referred the report to law enforcement officials, the department shall convene at least one meeting of the licensed mental health professional who made the report, at least one representative from the department, a licensed mental health professional with expertise in child abuse or neglect and a representative of the district attorney’s office having jurisdiction over the report, unless that office indicates that prosecution is unlikely. [2001, c. 345, §5 (new)].
C. The persons meeting under paragraph B shall make recommendations regarding treatment and prosecution of the person responsible for the abuse or neglect. The persons making the recommendations shall take into account the nature, extent and severity of abuse or neglect, the safety of the child and the community and needs of the child and other family members for treatment of the effects of the abuse or neglect and the willingness of the person responsible for the abuse or neglect to engage in treatment. The persons making the recommendations may review or revise these recommendations at their discretion. [2001, c. 345, §5 (new).]

The intent of this subsection is to encourage offenders to seek and effectively utilize treatment and, at the same time, provide any necessary protection and treatment for the child and other family members.

5. Photographs of visible trauma. Whenever a person is required to report as a staff member of a law enforcement agency or a hospital, that person shall make reasonable efforts to take, or cause to be taken, color photographs of any areas of trauma visible on a child.

A. The taking of photographs must be done with minimal trauma to the child and in a manner consistent with professional standards. The parent’s or custodian’s consent to the taking of photographs is not required. [2001, c. 345, §5 (new).]

B. Photographs must be made available to the department as soon as possible. The department shall pay the reasonable costs of the photographs from funds appropriated for child welfare services. [2001, c. 345, §5 (new).]

C. The person shall notify the department as soon as possible if that person is unable to take, or cause to be taken, these photographs. [2001, c. 345, §5 (new).]

D. Designated agents of the department may take photographs of any subject matter when necessary and relevant to an investigation of a report of suspected abuse or neglect or to subsequent child protection proceedings. [2001, c. 345, §5 (new).]
Child Protection Definitions: Types of Findings

Substantiated Finding: by a preponderance of the evidence, a parent(s)/caregiver(s) has caused and/or is likely to cause high severity child abuse and neglect. This person is considered a danger to children.

Indicated Finding: by a preponderance of the evidence a parent(s)/caregiver(s) has caused and/or is likely to cause low/moderate severity child abuse and neglect. Signs of risk may also be present.

Unsubstantiated Finding: by a preponderance of the evidence, a parent(s)/caregiver(s) did not abuse or neglect a child. Signs or risk, however, may be present.
OCFS Timeframe: What Happens After a Report is Made?

- Central Intake receives call (1-800-452-1999)
- **Within 24 hours:** Central Intake sends all appropriate reports to district supervisor.
- **Within 120 hours from report:** first contact is made with critical case members and a home visit occurs to determine Preliminary Safety decision.
- **Within 12 days from report:** DHHS determines whether there is information to support a finding of abuse/neglect and then DHHS decides whether to:

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<th>B</th>
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<td></td>
<td>Open Case (Serve Family) Needs to have a finding of abuse/neglect.</td>
<td>Send to Community Intervention Program. Can be sent to CIP with or without a finding of abuse/neglect.</td>
<td>Close Case</td>
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<td><strong>Part 1 Assessment completed within 19 days</strong></td>
<td>Referral made within 19 days</td>
<td>All documentation completed within 19 days</td>
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<td></td>
<td><strong>Part 2 Assessment completed within 35 days:</strong></td>
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<tr>
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<td>All documentation</td>
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<td></td>
<td>Family Team Meeting</td>
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<td>Family Team Plan</td>
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<td>Supervisor Approval</td>
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CHILD AND FAMILY SERVICES PRACTICE MODEL

- Child and Family Services joins with families and the community to promote long-term safety, well-being, and permanent families for children. This practice model guides our work with children and their families.

CHILD SAFETY, FIRST AND FOREMOST

- Making children and families safe is a collaborative effort. We create a team for each family, consisting of family, staff, and community members to find safe solutions for children.
- In our response to child safety concerns, we reach factually supported conclusions in a timely and thorough manner. Input from parents, children, extended family, and community stakeholders is a necessary component in assuring safety.
- We engage families with honesty and open minds. By exploring and listening, we help families use their strengths to meet safety needs of children.
- We value family perspectives, goals, and plans as critical to creating and maintaining child safety.
- We separate dangerous caregivers from children in need of protection. When court action is necessary to make a child safe, we will use our authority with sensitivity and respect.
- When children are placed in foster care, we ensure ongoing safety through frequent, meaningful contact with children and their caregivers. We welcome foster parents as a vital part of the family team.
- In our work to place children in adoption, safety is the first priority.

PARENTS HAVE THE RIGHT AND RESPONSIBILITY TO RAISE THEIR OWN CHILDREN

- We recognize that family members know the most about their own families. It is our responsibility to understand children and families within the context of their own family rules, traditions, history, and culture.
- Parents’ voices are valued and considered in decisions regarding the safety, permanency, and well-being of their children and family.
- We believe that people can change. Their past does not necessarily define their potential.
- Family teams develop and implement creative, individualized solutions that build on the strengths of families to meet their needs.
CHILDREN ARE ENTITLED TO LIVE IN A SAFE AND NURTURING FAMILY

- As family team leaders, we share responsibility with the family and community to help families protect and nurture their children.
- We support caregivers in protecting children in their own homes whenever possible.
- When children cannot live safely with their families, the first consideration for placement will be with kinship connections capable of providing a safe and nurturing home.
- We believe that children’s needs are best served in a family that is committed to the child. We support placements that promote family, sibling and community connections, and encourage healthy social development.
- We listen to children. Their voices are heard, valued, and considered in decisions regarding their safety, well-being, and permanence.

ALL CHILDREN DESERVE A PERMANENT FAMILY

- Permanency planning for children begins at first contact with Child and Family Services. We proceed with a sense of urgency until permanency is achieved.
- All planning for children focuses on the goal of preserving their family, reunifying their family, or achieving permanent placement in another family.
- Permanency is best achieved through a legal relationship such as parental custody, guardianship, or adoption. ‘Stability’ is not permanency.
- Life-long family connections are critical for children. It is our responsibility to promote and preserve kinship, sibling, and community connections for each child. We value past, present, and future relationships that consider the child’s hopes and wishes.

HOW WE DO OUR WORK IS AS IMPORTANT AS THE WORK WE DO

- Our organization is focused on providing high quality, timely, efficient, and effective services.
- As with families, we look for strengths in our organization. We are responsible for creating and maintaining a supportive working and learning environment and for open communication and accountability at all levels.
- As we work with children, families, and their teams, we clearly share our purpose, role, concerns, decisions, and responsibility.
- Relationships and communication among staff, children, families, foster parents, and community providers are conducted with genuineness, empathy, and respect.
- Our staff is our most important asset. Children and families deserve trained, skillful staff to engage and assist families.
Report #1
An anonymous referent called to report a mom that just brought her 18-week-old infant home from being detoxed off methadone. The child has been home 2-3 weeks. The referent feels the child is in danger. Mom is not watching over the child properly since she is drugged up all the time on benzodiazepine and alcohol. Mom goes to a methadone clinic and just had a urine test which came up dirty. When asked, she claimed she had a prescription of pills, but forgot to bring the bottle with her. She was asked to do so. The referent states that mom bought the pills off the street. Mom was drinking and doing pills when she was pregnant. The referent states she also placed a call while mom and child were still in the hospital.

Mom takes a bottle of bleach into the clinic when she goes in to give a urine sample, and pours bleach on her fingers as she is urinating. This way the test does not pick up the benzodiazepine.

Father called referent and stated he couldn’t get near the baby as mom would get mad. When things weren’t getting done, he’d comment on it and mom would get angry.

The thirteen year old acts like the baby is a play item. Father stated that she puts the cat in the crib with the baby and wakes the infant up to show to her friends. Today, father told mom he was leaving. Mom threw the baby on the couch and lunged at him, trying to choke him. Father is now staying at referent’s home.

Notes:

Report #2
The referent is a school guidance counselor. She called Child Protective Services to report physical abuse to a five year old by his father.

Today, the child reported to his school teacher that his father ‘punched’ him in the stomach. The child was sent to the guidance counselor and explained to her that over the weekend he was playing outside and was hitting his dog with a stick. The father shouted, “How would you like it if I hit you?” The child continued and the father went outside and ‘punched’ him in the stomach. It is not known if the child was injured.

Earlier this school year the child was required to write an essay after scratching a classmate. He wrote that when he becomes violent at home, his father hits him. The referent has no details about this.

Notes:
Report #3
The hospital social worker called Child Protective Services regarding a patient who is 6 months pregnant. During the patient’s pre-natal appointments she tested positive each of the three times she was tested for cocaine and marijuana. This mother has a history of substance abuse and has lost custody of her other two children to DHHS. She lost custody due to her substance abuse issues and also for domestic violence in her relationship. Reunification efforts with Mom and Dad were not successful and their parental rights have been terminated. DHHS is working to have these children adopted.

The father to the baby is also the father to the two other children. He was recently incarcerated for drug related offenses.

Notes:

Report #4
Referent called concerned about a family. The husband is very introverted and subservient to his wife. She is the polar opposite. The referent states that the mother is extremely verbally aggressive and sometimes yells at inanimate objects. The referent states that she is often angry and irrational and she is known to the local police department. The referent questions the husband’s ability to protect the child from the mother as he shows little to no reaction to her verbal attacks. The referent has no knowledge of any physical altercations involving the couple.

The referent reports that the home is very dirty. Some time ago, the couple had been complaining about mice in the apartment. The referent had to tell the couple to remove piles of clothing, empty boxes etc from the living area of the home. There were filthy dishes all over the kitchen piled on all available surfaces, and old food in the sink. The couple also had a couch positioned in front of the door to the apartment. The referent states that garbage removal has been a significant issue in this apartment as well.

The referent states that numerous tenants have told the referent that the couple screams incessantly, however the tenants don’t want to become involved. One tenant reported that the wife yelled at the baby to “shut the fuck up!” This occurred at approximately 2:00 AM. The referent states that another tenant reported that recently, during a cold spell, she was observed walking back and forth on the porch outside with the baby, who was wearing only a diaper. The tenant reported that the temperature was approximately 40 degrees.

Notes:
Report 5
Referent is a child care provider. Referent reports that this morning a four year old arrived at the child care center with bruising on her right arm. Referent stated that the bruising was above, below and on the center of the child’s elbow. Referent said she thought the bruise looked like finger marks.

Referent stated that when she asked the child what happened, she responded, “My mother spanked me for making bad choices.” Referent said she did not know what those bad choices were all about.

Referent mentioned that she can’t confirm whether the mother has a substance abuse problem; however, child care staff has on a few occasions detected an odor of an intoxicating substance on the mother’s breath as she spoke.

Notes:
Session Four: Child Abuse/Neglect
Overview

Unit 1: Definitions of Child Abuse
Unit 2: Child Abuse Continuum
Unit 3: Child Abuse Indicators
Unit 4: Reporting Abuse
Unit 5: Case Studies
Purpose

- Sensitize participants to types and indicators of abuse/neglect, reporting requirements and DHHS beliefs and practices.

- To help participants recognize possible child abuse/neglect and respond appropriately.
Objectives

1. Know primary types of abuse as identified by Maine Statute.

2. Recognize possible behavioral indicators of child abuse.
Objectives

3. Understand the legal mandates for child abuse reporters and how to make a report.

4. Increase understanding of the complexity of child abuse and how DHHS responds to it.
Abuse or Neglect

“A threat to a child’s health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection of these, by a person responsible for the child.”

(Title 22, MRSA Ch. 1071, child and Family Services and Child Protection Act, Subchapter 1 General Provisions, Art. 4002, Definitions)
Physical Abuse

Physical injuries inflicted by a parent/ caretaker; also called non-accidental trauma. These could be rated as mild, moderate, or severe.

Neglect

Non-accidental failure of a caretaker to provide a child physical, medical, or emotional necessities for normal life, growth, and development.

Emotional Abuse

Using words or behaviors that threaten, harshly criticize, ridicule, or harass the child; withholding affection; holding unrealistic expectations; associated with all forms of child abuse.

Caring for the Abuse Affected Child and Family USM, Muskie School of Public Service (2003)
Sexual Abuse

Any act of a sexual nature upon or with a child; any sexual involvement of a parent or caretaker with a child as a sexual act. Sexual exploitation is involvement of dependent, developmentally immature children and adolescents in sexual activities they do not fully comprehend, are unable to give informed consent to, and that violate social taboos of family roles.

Brainstorm in small groups

- Child behavioral Indicators
- Indicators in interaction between child and caregiver
DHHS Abbreviations

- **CA/N** = Child Abuse and Neglect
- **CI** = Central Intake
- **CIP** = Community Intervention Program
- **FTM** = Family Team Meeting
DHHS Abbreviations (cont.)

- **GAL** = Guardian Ad Litem
- **OCFS** = Office of Child and Family Services
- **PPO** = Preliminary Protective Order
- **S/A** = Safety Assessment
Child Protection Findings

- **Substantiated Finding**: it is more likely than not that high severity abuse or neglect happened. Parent(s)/caregiver(s) is considered a danger to children.

- **Indicated Finding**: it is more likely than not that low/moderate severity abuse or neglect did happen. Signs of risk may be present.

- **Unsubstantiated Finding**: It is more likely than not that no abuse or neglect happened. Signs of risk, however, may be present.
Unsubstantiated Report

- Letter sent
- Report kept 18 months.
- After 18 months- unsubstantiated report destroyed
Indicated Report

- Caregiver informed of report
- Caregiver informed of rights
- Ongoing Plan with caregivers occurs
Substantiated Report

- Caregiver informed of report
- Caregiver informed of rights
- Safety Plan created
- Ongoing Plan created
- Potential court action
OCFS Timeframe

Central Intake receives call (1- 800-452-1999)

Within 24 hours: Central Intake sends all appropriate reports to district supervisor.

Within 120 hours from report: first contact is made with critical case members and a home visit occurs to determine Preliminary Safety decision.

Within 12 days from report: DHHS determines whether there is information to support a finding of abuse/neglect and then DHHS decides whether to:
### OCFS Timeframe (continued)

<table>
<thead>
<tr>
<th>A</th>
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<th>C</th>
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<tbody>
<tr>
<td><strong>Open Case</strong>  (Serve Family) needs to have a finding of abuse/neglect</td>
<td><strong>Send to Community Intervention Program.</strong> Can be sent to CIP with or without a finding of abuse.</td>
<td><strong>Close Case</strong></td>
</tr>
<tr>
<td><strong>Part 1 Assessment</strong> completed <strong>within 19 days</strong></td>
<td><strong>Referral made within 19 days</strong></td>
<td><strong>All documentation completed within 19 days</strong></td>
</tr>
<tr>
<td><strong>Part 2 Assessment</strong> completed <strong>within 35 days</strong>:</td>
<td></td>
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<tr>
<td>All documentation</td>
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<tr>
<td>Family Team Meeting</td>
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<tr>
<td>Family Team Plan</td>
<td></td>
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<tr>
<td>Supervisor Approval</td>
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DHHS Practice Model

- Child Safety is Paramount
- Parents Have the Right and Responsibility to Raise Their Own Children
- Children Deserve to Live in a Safe and Nurturing Family
- All Children Deserve a Permanent Family
- **How** work is done is as important as what work is done
Case Studies

- Refer to a Community Intervention Program
- Assign the case
- Close the case
Session Five
Mental Health, Family Systems, and Differences

Table of Contents

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• Participant Handouts
• Overheads
For Introduction to Session:

- There are overheads available for the session Overview, Purpose, and Objectives. If you do not have an overhead projector available, prepare flip chart paper with the following information:
  - **Overview**
    - Unit 1: Mental Health
    - Unit 2: Family Systems
    - Unit 3: Case Study
  
  - **Purpose**
    - **Mental Health/Mental Illness Unit:**
      Consider the ways in which beliefs and attitudes affect perception of mental illness. Increase awareness of the issues of mental health and mental illness as they relate to children and families. Increase understanding of how families experiencing substance abuse, domestic violence, or child abuse and neglect may be affected also by issues related to mental health and mental illness.
    
    - **Family Systems Unit:**
      Increase awareness of the roles and function of the family system.
    
    - **Case Study Unit:**
      Experience the similarities, differences, and interactions of domestic violence, substance abuse, and child abuse and neglect as they affect the behaviors of both the child and family.
  
  - **Objectives**
    
    - **Mental Health/Mental Illness:**
      1. Identify and explore knowledge and feelings about mental health and mental illness, and beliefs about people who live with mental health problems.
      2. Explore the impact of receiving and living with a mental health diagnosis.
      3. Look at some of the connections between issues of abuse and issues related to mental health and mental illness.
    
    - **Family Systems:**
      1. Describe and demonstrate the elements and dynamics of a family system.
      2. Illustrate how the behavior of individual family members affects the family as a whole.
    
    - **Case Study:**
      1. Analyze and discuss abuse from the perspective of a family case study.

For Unit 1

1.1 Why Talk About Mental Health and Mental Illness?

- Prepare a sheet of flip chart paper with the heading ‘Why do you think mental health and mental illness is included in this training?’
Trainer Preparation (Continued)

1.2 Brainstorm Exercise and Discussion
• Bring along small Post-It Pads. Separate the pads so that each person has their own small pad.

• Read Historical Timeline at the end of the facilitator guide for Session 5.

1.3 ‘What is Normal?’ Exercise and Discussion
• There is an overhead available for Definition of Stigma. If you do not have an overhead projector available, prepare a sheet of flip chart paper with the following information:

  Stigma
  Stigma is the use of negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma, and the resulting discrimination, discourages individuals and their families from getting the help they need. (U.S. Surgeon General’s Report, 1999)

1.4 Impact on Individuals and Families
• If the exercise is to be done in two small groups, prepare two sheets of flip chart paper as follows:

  Group One: Think of an adult that you know who has received a mental health diagnosis. What are the possible positive and negative effects of being diagnosed and of living with the diagnosis and the mental health problem? Brainstorm a list of everything you can think of.

  Group Two: Think of a child that you know who has received a mental health diagnosis. What are the possible positive and negative effects of being diagnosed and of living with the diagnosis and the mental health problem? Brainstorm a list of everything you can think of.

• There is an overhead available for Resist Stereotyping. If you do not have an overhead projector available prepare a sheet of flip chart paper with the following statement:

  Resist Stereotyping
  The label is not the person.
  The diagnosis is not the illness

1.5 Connections, Resources and Barriers
• Ask each member of the training team to come prepared to discuss some of the barriers to services their clients have faced.

• Bring pamphlets and information about local community mental health resources for children and adults.

For Unit 2:

• Consider the size and configuration of the room in which family system exercises will take place. A large empty space is necessary, with ample room for the entire group to stand in a circle holding hands, at a comfortable distance from one another.
• Bring a 20-foot length of smooth rope (clothesline works well). This will be used to demonstrate a type of boundary in a family.

There are overheads available for Family Systems and Abuse. If you do not have an overhead projector available, prepare three sheets of flip chart paper with the following information:

**Family Systems and Abuse**

Family members lose options for choice in presence of abuse…
1. when one person centralizes power
2. where choices aren’t available
3. when exerting power may put a family member in danger

Changes in the behavior of one family member can result in a negative response by the abusive family member…
1. when a sexually abused child says “no”
2. when a battered woman says, “I’m leaving.”
3. when a husband tries to stop his wife from drinking

Family systems theory can be used to…
1. explain some of the inter-generational sources of abuse and trauma
2. show the effects of abuse, trauma, or any event on family members
3. demonstrate how abusive behaviors and abuse affected behaviors are interdependent and interactive

**For Unit 3:**
• No advance preparation is necessary.

**For Closure to Session:**
• Bring Session 5 Evaluations for completion by participants (RDC Team Member).

• Prepare a sheet of flip chart paper by writing the word Helper at the top of the page, left, and Rescuer on the right at the top of the page. You may draw a line down the middle of the page if you wish.
Purpose, Objectives, and Outline

Purpose

• Mental Health/Mental Illness:
  Consider the ways in which beliefs and attitudes affect perception of mental illness. Increase awareness of the issues of mental health and mental illness as they relate to children and families. Increase understanding of how families experiencing substance abuse, domestic violence, or child abuse and neglect may be affected also by issues related to mental health and mental illness.

• Family Systems:
  Increase awareness of the roles and function of the family system.

• Case Study:
  To experience the similarities, differences, and interactions of domestic violence, substance abuse, and child abuse and neglect as they affect the behaviors of both the child and family.

Objectives

• Mental Health/Mental Illness:
  1. Identify and explore knowledge and feelings about mental health and mental illness, and beliefs about people who live with mental health problems.
  2. Explore the impact of receiving and living with a mental health diagnosis.
  3. Look at some of the connections between issues of abuse and issues related to mental health and mental illness.

• Family Systems:
  1. Describe and demonstrate the elements and dynamics of a family system.
  2. Illustrate how the behavior of individual family members affects the family as a whole.

• Case Study:
  1. Analyze and discuss abuse from the perspective of a family case study.

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<th>Topic</th>
<th>Estimated Time</th>
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<tr>
<td>Introduction to Session</td>
<td>5 minutes</td>
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<tr>
<td>Unit 1: Mental Health/Mental Illness</td>
<td></td>
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<tr>
<td>Unit 1.1: Introduction-Why Talk About Mental Illness?</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Unit 1.2: Brainstorm</td>
<td>15 minutes</td>
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<tr>
<td>Unit 1.3: ‘What is Normal?’</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Unit 1.4: Impact on Individuals and Families</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Unit 1.5: Connections, Resources, and Barriers</td>
<td>10 minutes</td>
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<tr>
<td>Break</td>
<td>15 minutes</td>
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<tr>
<td>Unit 2: Family Systems</td>
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<tr>
<td>Unit 2.1: Family Systems Overview</td>
<td>10 minutes</td>
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<tr>
<td>Unit 2.2: Family Systems exercises and discussion</td>
<td>30 minutes</td>
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<td>Unit 3: Case Study</td>
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<tr>
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<td><strong>Total Session Time</strong></td>
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January 2004
Introduction to Session (5 minutes)

Overheads for Introduction:
• Session 5, Overhead 1: Overview
• Session 5, Overhead 2 & 3: Purpose
• Session 5, Overhead 4 & 5: Objectives

Suggested Order of Activities:
1. Welcome the group back.

2. Briefly present Session Five Overview, Purpose, and Objectives in your own words. There are overheads for each of these if you would like to use them.

3. Go over the ground rules if it would be helpful.

4. Remind participants to de-identify any personal examples.

Trainer Notes:
Unit 1: Mental Health/Mental Illness

Purpose:
Consider the ways in which beliefs and attitudes affect perception of mental illness. Increase awareness of the issues of mental health and mental illness as they relate to children and families. Increase understanding of how families experiencing substance abuse, domestic violence, or child abuse and neglect may be affected also by issues related to mental health and mental illness.

Handouts for Unit 1:
• Session 5, Handout 1: Why Talk About Mental Health and Mental Illness?
• Session 5, Handout 2: Historical Timeline
• Session 5, Handout 3: Definition of Stigma/Resist Stereotyping
• Session 5, Handout 4: Mental Health Resources

Overheads for Unit 1:
• Session 5, Overhead 6: Stigma
• Session 5, Overhead 7: Resist Stereotyping

Suggested Order of Activities:

Unit 1.1: Introduction – Why Talk About Mental Health and Mental Illness?(15 minutes)

1. Ask the group: Why do you think mental health is included in this training?

2. One trainer will write down responses from the audience, while the trainer leading this session facilitates the discussion. Be sure to include the following points if the participants do not raise them:

   • The issues are often co-occurring (or may seem to be co-occurring) in families experiencing abuse. People who are experiencing depression may abuse substances as a way to feel better. Some people may (falsely) believe that a perpetrator of domestic violence is abusive because he is mentally ill. The trauma of experiencing abuse in childhood or as an adult may lead to short or long-term mental health problems. Mental illness is not abuse, but people who live with a mental illness can be abused or can be abusive.

   • Our own issues, past experiences, bias, and lack of understanding can negatively affect how we respond to people, and can make us expect less than individuals are capable of achieving. We may think, “He has ADHD, he can’t really help himself” or, “She is bipolar, she can’t possibly be there for her child in a functional way.” We may experience fear when we see or perceive someone is different than ourselves, because of the things we have learned – many myths – about mental illness.

   • We hear about mental illness everywhere, even in the mass media. Because of our exposure to it, we may inappropriately use terms, try to make diagnoses, and place people and behaviors in categories. The process of labeling an individual with any diagnosis is supposed to involve a careful, clinical observation of behavior and condition over time. Very few of us possess these qualifications. It really matters very little about the diagnosis or the symptoms – the person is a human being and needs to be reacted to in a direct and present way.

   • More and more children are being given adult diagnoses and treated with medications, often not even tested for that age group. When children operate outside a narrow range of normalcy, they can be seen as needing treatment.
Unit 1.1: Introduction-Why Talk About Mental Health and Mental Illness (Continued)

- We need to look at issues affecting families from as many perspectives as possible, and acknowledge to ourselves and to the families we serve that there is more than one right answer to the issues families face. We can’t just treat someone’s mental health problems; we serve people who have complex lives (just as ours are) and a range of strengths and challenges. We need to look from a multi-disciplinary perspective.
- Mental health problems and illnesses can be invisible, and we may make unfair or inaccurate judgments against people because of it. For example, “Why can’t you just pull yourself up by the bootstraps and take control of your life?”

3. Post participant responses where everyone can see, refer, and add to them throughout the presentation. Refer participants to Session 5, Handout 1.

Trainer Notes:
Unit 1.2: Brainstorm Exercise and Discussion (15 minutes)

1. Explain that this next exercise is about looking at our attitudes and beliefs about mental illness and about our own responses to it. For this exercise it is important to leave behind your ‘politically correct’ or ‘professional’ hat. This should come from the gut – what have you learned about mental illness and people with mental illness? What are words or phrases that describe attitudes or beliefs you have heard? This is about what you have learned through family, personal experiences, and media images, as opposed to how you think you ‘should’ respond. If you have grown more enlightened over the years write about attitudes you were surrounded by growing up. Think of both positive and negative characteristics you have learned or heard. EXAMPLES: scary, unpredictable, charmed, creative, vulnerable, give them a wide berth on the street, not in my neighborhood.

2. Instruct participants to write single words or short phrases on their sticky pads, use multiple pieces of paper. They can put these at the edge of their table and trainers will pick them up.

3. Trainers will stick the post-its on one or two sheets of newsprint at the front of the room.

4. Tell the participants that they will have an opportunity to look at all the responses a bit later.

5. Ask for group input: What were some of the thoughts, words, or phrases that came up for you in this exercise? Did some of you picture an individual in your mind? How or where do we learn about people with mental illness?

Discussion Points:

• The truth is that most of us have more misinformation and fear concerning this issue than real understanding.

• Often we are able to recall individuals who were perceived as being mentally ill in the communities in which we grew up. What were the messages we were given about these folks and about how we should interact with them?

• Most of us have been taught to fear and avoid people or situations that seem very different than us. Unfortunately, this often means that we see an illness, rather than seeing a person, or we see a behavior we do not understand, make a judgment, and either avoid the individual or try to tell them what to do to correct it.

• Today, we are bombarded with media images and with pharmaceutical companies marketing drugs for depression and anxiety. This too affects how we see others. It also makes it far too easy for us to throw around words and diagnoses that we really do not know about.

• Much of what we have learned is based upon how our society and our western culture has defined and treated mental illness.

Trainer should be prepared to speak briefly about some of the historical perspectives on mental illness that has shaped the way we view and treat people. The Historical Timeline is a guide for the trainer and is also provided as a handout to participants: Session 5, Handout 1.
**Unit 1.2: Brainstorm Exercise and Discussion** (Continued)

- Currently the emphasis, and the money, is targeted toward symptom correction and behavioral adjustment. So, we see lots of diagnoses and medications, and we see and hear about problem behaviors.

- Current trends also encourage us to focus on what needs to be fixed, right now, rather than to focus on the person and their individual strengths and challenges and what they need and want. In our work with children and families, we may be quick to make a judgment about what we see as an evident problem, before we have a clear understanding about all that is going on in their lives.

6. Inform the group that the next exercise helps us to look at what we consider to be ‘normal’ or acceptable, and the impact of this on each of us as individuals and on all of us together.

---

**Trainer Notes:**
Unit 1.3: ‘What is Normal?’ Exercise and Discussion (15 minutes)

1. Ask for five volunteers from the participant group to come to the front of the room and stand in a line next to one another and to arrange themselves by height.

2. Stand by the person in the middle and state that this individual represents the norm, at least in terms of outward appearances. If we were to increase the numbers of volunteers standing in the line, chances are that this person would still be at or very close to the middle. In whatever ways we might determine ‘normal’ in a given example, everything (or everyone) else is judged against it. Therefore, for this particular group, the person in the middle is normal and the two people on the ends represent those who fall outside the normal range.

3. Speak to the two people directly beside the middle person. Ask them to take two big steps forward. Say: Both of you fall within the range of normal.

4. Speak to the two people standing at either end. Ask them to take two steps out to the side and four big steps forward.

5. At this point, attach a value to these assignments. Let’s say that the middle position is the most desirable position, and that virtually all resources, privileges, and social/cultural expectations are directed toward encouraging and maintaining this norm. Everyone is heavily socialized to aspire to it. You hear messages and see images that reflect this norm. It’s obvious how some people do not fit within the norm and that they do not receive the same rights, recognitions or privileges. Sometimes they are scorned or not taken seriously.

6. First ask the person standing in the middle: How is it for you to be in this position? What are you thinking or feeling?

7. Ask the two people directly on either side of the middle position: How is it for you to be in this position? What are you thinking or feeling? What happened for you when I asked you to move forward?

8. Ask the two people standing at the ends of the line: How is it for you to be in this position? What are you thinking or feeling? What happened for you when I asked you to move out and forward?

9. Ask the participant observers: What are you seeing in this exercise? What thoughts and feelings does this bring up for you? What does this have to do with mental health or mental illness?

10. Draw attention to the pyramid shape that was formed by the line moving. Note that the most value (resources, privileges, recognitions) is attached to the position with the fewest numbers. And that those with less value are asked to stand out in front and at a distance from the norm. It is almost as though they are forced into positions of high visibility but not in a way that values them. Their value and contribution is often invisible, yet they are highly visible when it comes to society’s expectations of them to conform.

11. Thank the volunteers for their participation – they can be seated now.

12. Say: When it comes to our perceptions and beliefs about mental illness, being considered different or ‘not normal’ can have a serious and damaging effect on people’s lives.
Unit 1.3: ‘What is Normal?’ Exercise and Discussion (Continued)

13. Display Overhead 6: Stigma (or prepared flip chart sheet), and refer participants to Session 5, Handout 3: Definition of Stigma/Resist Stereotyping. Say: Laws have been enacted to attempt to protect people from discrimination resulting from stigma.

Discussion Points:

- It is interesting to consider visibility vs. invisibility when we think about what we consider to be ‘normal’ appearance, behavior, or states of being. The issue of mental health and mental illness is a largely invisible one (the invisibility of the disability); yet mental illness is one of the most stigmatized disabilities. This stigma can become internalized, creating incredible pressure for the individual or family.

- Some people may try to alter their appearance (or behavior) so as to seem closer to what is considered normal, especially because this may increase their access to resources and privileges. Their contributions within their personal, social, and work communities will be valued in accordance with how they are valued. Others may rebel against the decided norm, to speak out about the injustice of this arbitrary assignment of normal. Still others may feel an overwhelming pressure to ‘fit’ into an extremely narrow reality.

- The most important part of our conversation today is how we can actively support and assist people, with respect and dignity, and with the goal of reducing the stigma that surrounds mental illness. Just receiving a mental health diagnosis can be traumatic for some people or families.

- In the first session, we talked about trauma. It is important for us to realize that what looks like mental illness, at any point in a person’s life, may be a result of or connected to trauma or early victimization. An example of this is that many children are now being diagnosed and treated for cognitive and/or behavioral disorders. For many, their outward behaviors and/or symptoms may be the result of experiencing abuse or other traumatic events. We are quick to treat the immediate presenting behaviors with a medication or other intervention, often neglecting what is underlying the behaviors. The treatments alone can create additional problems and stigma for the child, adult, or family.

Trainer Notes:
Unit 1.4: Impact on Individuals and Families (20 minutes)

1. Explain that this exercise will give participants a chance to consider and discuss what it might be like to receive and live with a mental health diagnosis.

2. Divide participants into two working groups. Each group should identify a recorder and a reporter. Give each group their prepared newsprint sheet with instructions as follows:

- On one sheet of flip chart paper:
  Group One: Think of an adult that you know who has received a mental health diagnosis. What are the possible positive and negative effects of being diagnosed and of living with the diagnosis and the mental health problem? Brainstorm a list of everything you can think of.

- On the second sheet of flip chart paper:
  Group Two: Think of a child that you know who has received a mental health diagnosis. What are the possible positive and negative effects of being diagnosed and of living with the diagnosis and the mental health problem? Brainstorm a list of everything you can think of.

3. Give the groups about five minutes to come up with this list. Next, ask them to add to the list the possible positive and negative impacts for others in that adult or child’s life - family or close friends.

4. Ask the reporter for each group to share their responses with the large group. The trainer should supplement with additional thoughts about positive and negative impacts of receiving and living with mental health diagnoses.

5. Ask the large group: What is it that childcare providers can do to best assist and support the individuals and families with whom they work, when the family is managing mental health issues?

6. Ask individuals to think of a person in their life who at some point has struggled with a mental illness or mental health problem. On post-it sheets, write down two or three positive characteristics of that person. Ask the group: Was it difficult to think of strengths this person brings? (Most people will probably say “no”). Ask: Was it difficult to think of strengths when you were writing your responses during the brainstorm exercise earlier in this session? (Probably it was more difficult then).

7. Refer to the post-its and flip chart page(s) from the earlier exercise in Unit 1.2. Ask participants to get up and read these earlier responses and add the new ‘strengths’ to the lists, by placing the post-its they just completed on the flip chart page(s).

8. Display Session 5, Overhead 7: Resist Stereotyping (or prepared flip chart sheet). Refer participants to Session 5, Handout 3. Explain and ask for input.

Discussion Points:

- Personal experiences, social conditioning, media influences, political views, fears, and ideas affect how individuals understand and manage mental health and mental illness. These factors can perpetuate isolation and stigma or can help to foster empathy and increased understanding.

- For the person who has been diagnosed, the stigma is carried within and becomes something that independently can alter behavior, self-perception, and relationships with others.
Unit 1.4: Impact on Individuals and Families (Continued)

- When the person experiencing a mental illness or mental health problem is someone we know and care about, we are more likely to see the person, rather than to look first at the behaviors or the diagnoses. As providers of services, and in our work with children and adults, it is most important to recognize that the label is not the person and that the diagnosis is not the illness.

Trainer Notes:
Unit 1.5: Connections, Resources, and Barriers (10 minutes)

All team members will be prepared to discuss at least one specific example from their professional work to illustrate the following:

a) Specific issues related to mental/illness within your client population. (Please see Discussion Points below)

b) Mental health resources you access most often, on behalf of or in partnership with your service recipients.

The goals of this discussion are to help dispel myths, to demonstrate the ongoing struggle of individual service providers and service systems to create stronger systems of support for people affected by mental illness, and to highlight a few of the local community mental health resources.

1. Inform the participants that the training team will briefly share some successes, challenges, and opportunities for growth in responding to the issue of mental health and mental illness experienced by their service recipients.

2. Refer participants to Session 5, Handout 4: Mental Health Resources.

Discussion Points:

• **Domestic Violence:** An adult victim may be diagnosed and medicated for a mental disorder when the ‘symptoms’ are, in fact, related to abuse by an intimate partner; some victims experience PTSD as a result of the trauma of abuse; Most domestic abuse perpetrators are not mentally ill – abuse is a learned behavior and involves choice and intention; some children who witness domestic abuse may be at increased risk for trauma related conditions.

• **Child Abuse and Neglect:** Mental illness is not a cause of abuse, but it may be considered a contributing factor; children who have been abused may undergo mental health evaluations and treatments, according to the child’s age, developmental stage, and need for therapeutic intervention; therapeutic foster homes are required for some children who come into the temporary custody of the State of Maine; when an allegation of child abuse/neglect has been substantiated, parents may be offered parenting assessments including evaluating mental health, and treatments may be offered when indicated. Many parents with mental illness are able to function and provide adequate care of their children.

• **Substance Abuse:** Many people with mental health disorders also struggle with addictions. This may be called ‘co-occurring disorders’ or ‘dual-diagnosis’. (Describe briefly.) Treatment is varied and may wrap around all presenting issues or may be separate, focused on one issue or the other. There are few resources for intensive, residential treatment for parents with dependent children.

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_Trainer Notes:_
Unit 2: Family Systems (40 minutes)

Purpose:
Increase awareness of the roles and function of the family system.

Handouts for Unit 2:
• Session 5, Handout 5: Family Systems Theory, Discussion, and Summary
• Session 5, Handout 6: Family Systems and Abuse

Overheads for Unit 2:
• Session 5, Overhead 8-10: Family Systems and Abuse

Suggested Order of Activities:

Unit 2.1: Family Systems Overview (10 minutes)

1. Inform participants that this next part of the training is really about looking at how the family functions as its own unique system, and all the members of the family affect and are affected by the whole system. Abuse or other serious issues (such as mental illness) have an immediate effect upon how the family – as a whole and the individual members - functions internally and how it responds to outside influences.

2. Refer participants to Session 5, Handout 5: Family Systems Theory, Discussion, and Summary. Describe the basic tenets of any system:
   A system is comprised of a set of interacting parts that has the following characteristics:
   a) organization,
   b) interaction,
   c) interdependency, and
   d) integration.

3. Ask: What are some common examples of different types of systems or things that operate with systems?
   • Communities
   • Schools
   • Businesses
   • Automobiles
   • Engines
   • Governments

4. Say: Whether we are talking about complex machinery, organized governments, or families all systems depend upon organization (structure), interaction (relationships), interdependency (shared and individual needs), and integration (shared purpose) in order to function. The very nature of systems allows for some degree of compensation or adjustment when the balance is disturbed, but even the most secure systems become vulnerable under severe and unrelenting stress. Let’s see if we can demonstrate some of these characteristics in our group here – because we have developed our own unique system over the past several sessions!
Unit 2.2: Family Systems Exercises and Discussion (30 minutes)

Exercise 1:
1. Invite participants to join the trainers in a large open space in the room. Everyone is asked to stand in a circle and to hold hands.

Although it is ideal for all participants to participate in this exercise, physical touch in a close proximity may be very difficult for some. Encourage participation at all levels – if one or two folks opt out of the experiential activities, ask them to observe the exercises and share what they saw happening during the large group discussion.

The following exercises require the participation and input of all trainers on the team. One trainer is usually identified to begin the discussion, and to lead the exercise activities, but all trainers will offer thoughts about how families and individuals in families may respond when abuse is present.

2. First ask the group to turn inside out while still holding hands. They must find a way to end up in a circle, holding hands in the exact same way (arms swinging loosely at the sides), except that the circle will be facing out. They may not let go of hands as they are deciding how to accomplish the task.
   • Ask: What happened? What went on among us? Did any one or more people emerge as leaders? Were there any folks who thought that the task was not possible?

Discussion Points:

• Much energy was expended.
• Members needed to cooperate, communicate, collaborate, and to trust and rely on others.
• Each individual in the group experienced the exercise differently. People participated in different ways.
• In families, individuals bring various strengths and challenges when the family is struggling to work through a difficult issue or task.
• Communication may occur in smaller sub-groups of the family – according to relationships, physical proximity, affinity, etc. The four sub-systems in families are (1) marital or spousal; (2) parental; (3) sibling; (4) grandparental.

3. Next, without disclosing her intentions, the lead facilitator will let go of the hand of one of the people standing beside her, now forming a single line rather than a closed circle. The leader moves across the room taking the group with her. Eventually the facilitator will lead the group back to the starting position, again in the circle formation, and taking the hand of the person next to her.

Some facilitators have even taken their group outside the room, into hallways or out of doors. You are the best judge of your group – if it feels safe and do-able with them, by all means challenge their comfort zones in this exercise. It is an excellent way to demonstrate group behavior when one person is perceived as clearly ‘in charge’!
Unit 2.2: Family Systems Exercises and Discussion (Exercise 1, Continued)

- Ask: How did you all feel about this? What was I demonstrating? What was happening in the group as we were moving around the room?

Discussion Points:

- Most people in the group will go along with the exercise, even if they feel uncertain or annoyed. This may be because people feel they can trust your intentions as the leader, they do not want to step aside and appear to be resistant or uncooperative, or they may feel compelled to comply because of your status as the authority. Some group members may enjoy the activity, relishing the movement and unpredictability, wishing to extend and expand upon it! Parallels can be drawn between the behavior of participants in this exercise and the behaviors seen in families when one person in the family is ‘in control’. This can be a strengthening factor for the family with healthy dynamics, or it can be frightening for individual members when safety issues are present:
  - What if the person in control is an active substance abuser?
  - What if the person in control is a perpetrator of domestic abuse?
  - What if the person in control is abusive to one or more of the children in the household?

  Trainers should offer insight as to some of the possible dynamics involved when abuse is a factor. How might the family system respond? What about individual members? Speak about communication, vulnerability, safety, accountability, and control.

- This is not a simple equation. The person in control almost always possesses many strong and positive characteristics in the family system, even if they sometimes exert control over the family in an abusive or chaotic manner. This person may be the primary wage earner, may be the sole caretaker of the children, and may show love, concern, and remorse for their behaviors during non-abusive times. Individual members may feel fear, rebellion, or hopelessness in times of struggle, and may feel hope, gratitude, and fulfillment in good times. Members may stay safe in whatever ways that work for them. Any decision to separate the family is extremely difficult, given the inherent strengths of an intact unit, and the real and perceived stressors of compensating for the loss of a vital member.

4. At this point, the facilitator should step outside of the circle altogether, first joining the hands of the two people who were standing on either side of the facilitator.

5. Say: Now I want you to imagine that I am a family member who has been asked to leave the family because I have been abusive to one or more family members. It would not be safe for me to be allowed back into the home at this time.

6. Walk away from the group for a couple moments, then turn around and attempt to get back in. Beg, cajole, threaten, and make promises. Go around to different participants, asking them by name to let you back in. Try to get in using a bit of physical prying or light pushing (Keep it safe – this is a demonstration.)

7. At this point, the group often closes in, leaving no spaces between people. What was a large, open circle connected flexibly and loosely, becomes a small, tight, closed unit. This visual effect provides a dramatic demonstration of boundary adjustment in families experiencing crisis.

8. Pause only for a moment, and inform the group that they may open up again for discussion, but remain in the circle. Join the circle for discussion.
Unit 2.2: Family Systems Exercises and Discussion (Exercise 1, Continued)

Ask: What happened here? What was it like for you to keep me out of the circle? Who wanted to let me in? Who was determined to keep me out? (If there were participant observers to this exercise, ask for their observations.)

9. Thank participants for their participation. They may be seated.

10. Display Session 5, Overheads 8-10: Family Systems and Abuse (or prepared flip chart sheets). Refer participants to Session 5, Handout 6 Family Systems and Abuse.

Discussion Points:

- Each of the trainers should offer insights in this discussion, about what happens in families where abuse has occurred, and how the family organization and dynamic is changed because of it. For example: a parent who is in long-term residential treatment or who is serving jail time for a drunk driving conviction; or a victim of domestic abuse and her children who have to flee the home in order to increase safety; or a family in which a parent or caretaker has abused a child and is asked to leave the home.

- Family members have varied relationships with one another. For one person, keeping a family member out of the home may be their primary focus and commitment; for another, the need to allow that family member back in (physically, emotionally, financially…) is overwhelmingly strong.

- All family members influence and are influenced by each other.

- Every family has a boundary. It acts to determine where the system or sub-system begins and ends, especially in relation to the environment. In healthy families, the boundary allows flexibility so that its members can interact freely and safely with the environment outside the family and can enjoy a sense of safety, belonging and autonomy within the family. In a closed system, the rigid boundary is impermeable. This means that individuals within the system are bound to the behaviors, values, and beliefs of the internal environment of the family. Members are neither free nor safe to interact with the outside environment. In such a system, abuse may be perpetuated in isolation and silence.

- A natural response to crisis or threats is to tighten the external boundary around the family. When abuse has occurred and is discovered to the outside environment, it is highly likely that forces in the external environment may attempt to permeate the boundary of the family. This is especially the case when physical safety is at risk, i.e. law enforcement, child protection, medical or educational interventions. It should be no surprise that many families initially experience these ‘interventions’ as ‘intrusions’ - as yet one more potential threat.

- Systems resist change and seek stabilization. Both family and environment need to be included when considering change strategies with the family.

If time permits, the following exercise further demonstrates different boundaries and roles of members within families.
Unit 2.2: Family Systems Exercises and Discussion (Continued)

Exercise 2:

A second trainer may wish to take the lead in facilitating this exercise, with input from all of the training team in discussing and debriefing.

1. Ask for volunteers. Form up to four separate ‘family’ groups, each with four family members – two adults (most effective to demonstrate a mother and father, but alternative family groups are welcome too!) and two children each. Instruct the family groups to decide which roles they will take on.

2. Give all directions to the families so that the entire audience can hear them. It is important that the audience is part of the set up.
   - Family #1 – they must not touch. Maintain separation but stand in a circle.
   - Family #2 – holds hands in a circle.
   - Family #3 – loosely wraps the rope around them as they stand together in a circle. Have them hold the rope in their hands. Do not tie them up!
   - Family #4 – they turn around so that their backs are facing one another, in a circle facing outward. Have them link elbows.

3. Directions to Family Groups: For all groups, when the exercise begins, each member will take on a role. There are three parts of this exercise and only the father’s role changes in each part.
   - Mothers: • During each part, each ‘mom’ continually goes up and down, bending at the knee (Demonstrate this briefly).
   - Child #1: • Stand motionless.
   - Child #2: • Be hyperactive.
   - Fathers: • During 1st part – Father acts disinterested. Have family go into their roles for about 30-45 seconds. Stop the activity and ask questions, as outlined below.
     • During 2nd part – father stands in the middle of circle with hands over ears and eyes closed. Again, have families go into their roles for 30-45 seconds. Stop the activity and ask questions.
     • During 3rd part – father stands outside circle trying to get into the family circle. The family is instructed to not let him in. 30 – 45 seconds. Ask questions.

Questions: Ask questions after each part of this exercise. Feel free to let the conversation take its own direction. However, this exercise can bring up strong feelings in some folks so be sensitive to participants having a difficult time.
   - Ask members in each of the families what the exercise was like for them, in their roles? What did they want and/or need for themselves and from the other members of the family?

Trainers and other participant observers are encouraged to share what they saw happening in each of the family groups. Provide feedback on responses.
**Unit 3: Case Study** (30 minutes)

**Purpose:**
To experience the similarities, differences, and interactions of domestic violence, substance abuse, and child abuse and neglect as they affect the behaviors of both the child and family.

**Handouts for Unit 3:**
- Session 5, Handout 7: Case Study: Child Abuse and Neglect
- Session 5, Handout 8: Case Study: Domestic Violence
- Session 5, Handout 8: Case Study: Substance Abuse
- Session 5, Handout 10: Advocacy Is…

**Suggested Order of Activities:**

1. Explain to the group that the next exercise gives them a chance to analyze and discuss a case study, looking for possible indicators of abuse.

2. Divide into three working groups.

   Do not announce to participants that the three groups will be analyzing the same case study. This will become evident and a part of the discussion following the small group analysis.

3. Instruct Group One to work with Session 5, Handout 7: Case Study: Child Abuse and Neglect, Group Two with Session 5, Handout 8: Case Study: Domestic Violence, and Group Three will work with Session 5, Handout 9: Case Study: Substance Abuse. Groups are to read the case study and then answer the questions at the bottom. Ask the groups to appoint a recorder and a reporter, as they will share their responses out to the large group.

4. Give small groups about ten minutes to read and discuss the case study.

5. Each group then reports out their responses to the questions at the end of the case study. If it has not become evident, inform the participants that all three groups had the same case study, but each group was asked to look at the family from a different perspective.

**Discussion Points:**

- Did each of the groups pick out some of the same individual or family behaviors, though they were looking for the possibility of different abuse issues? What does this tell us?

- Do you know for a fact that there is substance abuse, child abuse, or domestic violence going on in the family?

- Do you see any signs of trauma? Do you see any possible indications of mental health concerns?

- What is your role as a child care provider?
Closure to Session (15 minutes)

1. In closing this session, invite participants to join you in a brief visualization and discussion about what is and is not helpful during times of struggle or crisis.

2. Ask participants to think about a time in their own lives where they felt they needed help or support. Examples: death of a loved one, personal crisis, ending of a relationship, etc. Now think about what support systems you called upon. Take a moment to jot down who or where you went to for help.

3. Ask participants to share their responses. It may be helpful to ask one trainer to write these responses on newsprint.

4. Note that most people probably did not say that they went to therapists, hotlines or crisis centers. Most people reach out to their families, friends, and trusted community affiliates (such as faith community) first.

5. Now ask everyone to think again about the same situation and imagine the qualities of the person who was most helpful to them. Write these responses on the prepared flip chart page Helper/Rescuer, under the Helper column.

6. And ask everyone to think about times when people may have been trying to be helpful, but it just didn’t seem very helpful to you. List these responses under the Rescuer column.

7. Refer participants to Session 5, Handout 9: Advocacy Is…
   Examples:
   Helper: guides, advocates, listens well, asks questions, knows resources, patient, long term, focuses on strengths
   Rescuer: takes control, more directive, gives answers, short term, offers advice

Discussion Points:

• There is a time and place for both helping and rescuing. If a child is going to run out into the road, they need a rescuer. But in the case of working with survivors of abuse/trauma, the role of many service providers is one of helper, advocate, and change agent.

• When a person reaches out to a helping system, there is already much they have done to help themselves, though initially they may not be able to identify the steps they have taken. You have a specific role, but they may also have other resources to draw on.

• There is also a history for that individual or family. Whether that involves some kind of internal, hidden, or silent struggle or a series of interactions with people and systems, this history has a profound effect upon the person receiving services.

• Our own histories, as providers of services and as humans navigating our own lives have a profound impact upon the way in which we perceive and connect with those with whom we work.

8. Thank the group for their participation during this intense session.

9. Encourage participants to use self-care strategies between this session and the next one.
Closure to Session (Continued)

10. Discuss with participants any details concerning celebration and closure during the next and final session of training.

11. Distribute Session 5 Evaluations and encourage participants to be candid and thorough. Remind the group to keep voices low as they are leaving so that others may concentrate.

Trainer Notes:
15th Century: “Madmen” were given to mariners to be taken away – Ships of Fools, according to Foucault.

Fear of madness replaced fear of death. Madness came to be seen as a threat coming from within the person, seen as a combination of natural and supernatural forces.

17th Century: General Hospital of Paris opened to confine the mad. Confinement viewed as a police matter, not a matter of medical care.


In America, families usually cared for their “lunatics”, though it was the responsibility of towns to provide for those who were “distracted”.

By late 17th century, madness seen as a confirmation of sin by Cotton Mather, Puritan clergyman, influential during Salem witch trials.

18th Century: Interpretation of madness as evidence of sin was evolving into an understanding that it involved moral excesses and physical illnesses.

In England, 1729, Samuel Tuke opened a retreat, in which patients were treated with warm baths and human kindness, involving isolation, rest, and reflection.

In America, first asylums appeared early in the century and by mid-century the first hospitals.

The first hospital exclusively for the insane established in Virginia, 1773, and provided care rather than medical treatment.

Deplorable treatment and conditions suffered by those who were viewed as demon-possessed or characterized as senseless animals. Physical and mental abuse was common and included use of straight jackets, heavy restraints, and ‘bleeding’.

Pinel developed concept of “moral treatment” of madness, founded on gaining the patient’s confidence and instilling hope. He saw insanity as curable and believed that environmental changes could alter an individual’s psychology and subsequent behavior. This approach relied on breaking patients’ wills through causing terror and forcing submission.
19th Century: Psychiatry was developing as the profession that cared for the mad. Psychiatrists administered moral treatment, and madness seen as a combination of inherited constitution and unfortunate life events or poor hygiene.

Perception shifted to seeing madness as a problem inside society, and increasing importance placed on monitoring and regulating those who were mad.

By late 19th century, psychiatric profession began to focus on observation and classification of mental conditions, which continues to this day.

20th Century: Mental health reform movement began in 1908 with Clifford Beers’ publication A Mind That Found Itself. The Connecticut Society for Mental Hygiene began that year and expanded the next year to form the National Committee for Mental Hygiene which existed to: improve attitudes toward mental illness and the mentally ill, improve services for the mentally ill, and work for the prevention of mental illness and promote mental health. Successful reforms initiated in several states.

First International Congress for Mental Hygiene in 1930 to promote constructive dialogue about fulfilling the mission of the Mental Health Movement.

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FAMILY SYSTEMS THEORY

Definitions

- **System**: a group of components with the following characteristics:
  * Organization
  * Interaction
  * Interdependency
  * Integration

- **Boundary**: determines where systems and sub-systems start and stop especially in relation to the environment. Boundaries can be rigid or permeable – i.e., the boundary can surround a closed system or act as an exchange with the environment as in an open system.

- **Tension, Stress, Strain, Conflict**: results from imbalance among the components (or members) of the (family) system.

- **Equilibrium**: results from maintenance activities for keeping the system in balance within and with the environment and adaptive activities which enable the system to adjust to variations; leads to stationary equilibrium where system has one point to which it returns after a disturbance and dynamic equilibrium where a new state of balance is achieved after a disturbance.

- **Output**: how the system affects the environment.

- **Feedback**: information the system gets to find out how it’s doing.

- **Open versus Closed System**: represents the degree to which the boundaries are permeable (see Boundary).

A family is a small social system made up of individuals related to each other by reason of strong reciprocal affections and loyalties, comprising a permanent household (or cluster of households) that persists over years and decades. Members enter through birth, adoption, or marriage and leave only by death.

For our purposes, family also refers to any subdivision of this kind of social unit, which itself possesses these same attributes of affection, loyalty, and durability of membership.

FAMILY SYSTEMS DISCUSSION

The concept of family systems is tricky when it comes to abuse. Family systems often look at the power of all in the family and shows how all members, including children, use their power and control with much emphasis on choice. In families where abuse occurs, power is divided up very clearly. The abuser has the most, and the victims (often including the spouse/partner and children) have little or none. The notion of choice does not apply in the same way when abuse is present.

Family systems also often implies an optimistic domino theory of change whereby a change in the behavior of one person can lead to a change in the behavior of another. This is true in many cases but can lead to victim-blaming in a system where abuse occurs by suggesting that if a child behaved in a different way or just said “no,” the father would not sexually abuse him/her. Or it could imply that a spouse could stop the other spouse’s drinking if s/he acted less dependently. And maybe if a battered woman stood up to her batterer, the battering would stop. We now know that battered women can be killed if they stand up to their batterers, children who say “no” to sex abuse often get abused anyway and one person can’t make another person stop drinking.
We believe that family systems is a useful concept if cautiously applied to explain how values, behavior, and traumas are passed from generation to generation and to show how the family as a whole gets caught in the trap of abuse. It illustrates how no members are left unaffected.

A family systems approach is also consistent with the notion of the 24 dimensions of abuse wherein the dimensions are interdependent and interactional, forming a whole which is greater than the sum of its parts. Again, no member of the family escapes the cumulative effect of these dimensions once they are set in motion.

Finally, the uniqueness of this curriculum is reflected in its attempts to show the similarities between perspectives that have been traditionally seen as different, if not competing. This is our first of many examples of finding a synthesis that takes the best of each discipline and creates a new whole.

**FAMILY SYSTEMS SUMMARY**

- All family members influence each other and are influenced by each other (reciprocity).

- A system is a set of interacting parts.

- Systems sometimes contain sub-systems. There are four of these sub-systems in families:
  1. marital or spousal;
  2. parental;
  3. sibling;
  4. grandparental.

  You are a sub-system of your family of origin.

- Boundaries separate one system from another. They may be diffuse or rigid. Clear boundaries allow information to flow between systems (permeability).

- Any change in one part of the system affects the entire system.

- Systems resist change and seek stabilization (homeostasis).

- Healthy systems encourage change. People live in a larger, complex system interacting with many types of other systems.

- Both family and environment need to be included when considering change strategy.
WHY TALK ABOUT MENTAL HEALTH AND MENTAL ILLNESS?

• The issues are often co-occurring (or may seem to be co-occurring) in families experiencing abuse.

• Our own issues, past experiences, bias, and lack of understanding can negatively affect how we respond to people, and can make us expect less than individuals are capable of achieving.

• We hear about mental illness everywhere, even in the mass media. Because of our exposure to it, we may inappropriately use terms, try to make diagnoses, and place people and behaviors in categories.

• More and more children are being given adult diagnoses and treated with medications, often not even tested for that age group.

• We need to look at issues affecting families from as many perspectives as possible, and acknowledge to ourselves and to the families we serve that there is more than one right answer to the issues families face.
HISTORICAL TIMELINE

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Definition of Stigma

Stigma is the use of negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma, and the resulting discrimination, discourages individuals and their families from getting the help they need.

(U.S. Surgeon General’s Report, 1999)

Resist Stereotyping

The label is not the person.

The diagnosis is not the illness.
MENTAL HEALTH RESOURCES

Maine Resources

State of Maine, Behavioral and Developmental Services http://www.state.me.us/bds/
Mailing Address: 40 State House Station, Augusta, ME 04333-0040
Location: Marquardt Building 2nd Floor, Hospital Street, Augusta, ME 04333-0040
Phone/Fax Numbers
Crisis: 1-888-568-1112
Voice: 207-287-4200
TTY: 207-287-2000
Fax: 207-287-4268

Maine Chapter, National Alliance for the Mentally Ill http://me.nami.org
Address: 1 Bangor Street, Augusta, ME 04330
Phone/Fax Numbers
Toll Free: 1-800-464-5767
Voice: 207-622-5767
Fax: 207-621-8430

National Resources

Center for Psychiatric Rehabilitation http://www.bu.edu/cpr/

http://www.surgeongeneral.gov/library/mentalhealth/home.html

National Alliance for the Mentally Ill http://www.nami.org

National Empowerment Center http://www.Power2u.org

National Institute of Mental Health http://www.nimh.nih.gov

National Mental Health Association http://www.nmha.org/


Substance Abuse and Mental Health Services Administration: An Agency of the U.S. Department of Health and Human Services
http://www.samhsa.gov/
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- All family members influence each other and are influenced by each other (reciprocity).

- A system is a set of interacting parts.

- Systems sometimes contain sub-systems. There are four of these sub-systems in families: (1) marital or spousal; (2) parental; (3) sibling; (4) grandparental. You are a sub-system of your family of origin.

- Boundaries separate one system from another. They may be diffuse or rigid. Clear boundaries allow information to flow between systems (permeability).

- Any change in one part of the system affects the entire system.

- Systems resist change and seek stabilization (homeostasis).

- Healthy systems encourage change. People live in a larger, complex system interacting with many types of other systems.

- Both family and environment need to be included when considering change strategy.
Family members lose options for choice in the presence of abuse…

1. when one person centralizes power
2. where choices aren’t available
3. when exerting power may put a family member in danger

Changes in the behavior of one family member can result in a negative response by the abusive family member…

1. when a sexually abused child says “no”
2. when a battered woman says, “I’m leaving.”
3. when a husband tries to stop his wife from drinking

* From Lesley Devoe (November 1993)
Diane is a 28 year old mother of four who is temporarily residing at Crossroads for Women – a residential substance abuse treatment center for women. She was admitted last Wednesday. Her two youngest children, Jason, age 3 ½ and Robby, four months are with her at Crossroads. Her two older children, Susan, 7 and Karen, 6 are living at home with their father, Diane’s husband, Philip. He works full-time for a roofing company.

Diane entered treatment after her oldest daughter, Susan, called 911. Police arrived to find Diane ‘under the influence’. Child Protective Services (CPS) was contacted by the police, because Diane was drunk and Philip could not be found. When questioned about the incident, Susan says only, “Mommy was having a struggle with me.” CPS offered Crossroads as a treatment option to Diane. Philip made the initial call to the treatment center. He really wanted Diane to enter Crossroads to get help for her problem. Philip thought it best that Susan and Karen stay at home with him so that they wouldn’t miss school. Five days later, when space became available for her and her two youngest children, Diane reluctantly agreed to go.

This is Diane’s second Crossroads admission. She spent a month there approximately 14 months ago after being picked up in Lewiston for OUI. Her children were with her when she was stopped. At that time Crossroads did not have space for children to live there with their mothers, so Philip took the children home with him.

During that stay Diane was withdrawn; she rarely interacted with other residents. Philip, a soft-spoken, shy man brought the children for visiting on children’s day each Saturday while Diane was at Crossroads. He did not leave them there as most family members do, but chose to stay as well.

Diane was able to maintain sobriety for ten months – until recently. She was unable to get to as many AA meetings as was suggested because the family has only one car, and Philip insisted on attending the meetings with Diane to support her sobriety. He was often too tired to take her or child care could not be found.

Maine Child Protective Services recently investigated this family after a referral from the Department of Social Services (DSS) in Massachusetts. Approximately four months ago the family went to Massachusetts to visit Philip’s brother. While there, Robby was born prematurely. He tested positive for marijuana while at the hospital, and the Massachusetts DSS was notified. The case was transferred to Maine when Diane returned home with Jason. Approximately five days after returning to Maine a child protective caseworker visited the home.

Diane and Philip live about 10 miles from Lewiston down a mile long dirt driveway off a secondary road. They moved there several years ago to “get out to the country” to raise their children away from the city where they both grew up. The caseworker found the small home well organized and the two youngest children seemed to be in good spirits and well cared for. Susan and Karen were at school during the visit, and Philip was at work. A referral was made for regular visits by the community health nurse.
Since last Wednesday when Diane was admitted to Crossroads, she has expressed great shame over her loss of sobriety. She blames herself. She has no recollection of the incident that led Susan to call 911. Several staff have noted that Diane is very attentive to Jason and Robby. She enjoys playing with them, and is gentle and patient. She told the staff that she is grateful to have them with her this time around.

On Saturday, Family Day at Crossroads, Philip brought Susan and Karen to spend the afternoon. He chose to remain as well. Crossroads staff noted that Susan and Karen tended to stay very close to one another; there was little interaction with their parents when both were in the same room. When staff or Diane tried to engage them they looked to their father for guidance and generally seemed reluctant to speak much. However, while Philip tended to the boys, Susan and Karen played a game of Candyland with Diane, the three of them giggling and chatting. Karen sobbed when it became time to leave. Diane is very worried about the girls, making it hard for her to concentrate on her work at Crossroads.

· What possible signals do you see indicating the presence of child abuse and neglect?
· Identify Diane’s behaviors that may indicate the presence of child abuse and neglect.
· Identify Philip’s behaviors that may indicate the presence of child abuse and neglect.
· Identify the children’s behaviors that may indicate the presence of child abuse and neglect.
· How would you respond to the behaviors of each of the family members?
· Would you refer this family? To whom would you refer? Why? How?
**HANDOUT**

Caring for the Abuse Affected Child and Family

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**CASE STUDY: DOMESTIC VIOLENCE**

Diane is a 28 year old mother of four who is temporarily residing at Crossroads for Women – a residential substance abuse treatment center for women. She was admitted last Wednesday. Her two youngest children, Jason, age 3 ½ and Robby, four months are with her at Crossroads. Her two older children, Susan, 7 and Karen, 6 are living at home with their father, Diane’s husband, Philip. He works full-time for a roofing company.

Diane entered treatment after her oldest daughter, Susan, called 911. Police arrived to find Diane ‘under the influence’. Child Protective Services (CPS) was contacted by the police, because Diane was drunk and Philip could not be found. When questioned about the incident, Susan says only, “Mommy was having a struggle with me.” CPS offered Crossroads as a treatment option to Diane. Philip made the initial call to the treatment center. He really wanted Diane to enter Crossroads to get help for her problem. Philip thought it best that Susan and Karen stay at home with him so that they wouldn’t miss school. Five days later, when space became available for her and her two youngest children, Diane reluctantly agreed to go.

This is Diane’s second Crossroads admission. She spent a month there approximately 14 months ago after being picked up in Lewiston for OUI. Her children were with her when she was stopped. At that time Crossroads did not have space for children to live there with their mothers, so Philip took the children home with him.

During that stay Diane was withdrawn; she rarely interacted with other residents. Philip, a soft-spoken, shy man brought the children for visiting on children’s day each Saturday while Diane was at Crossroads. He did not leave them there as most family members do, but chose to stay as well.

Diane was able to maintain sobriety for ten months – until recently. She was unable to get to as many AA meetings as was suggested because the family has only one car, and Philip insisted on attending the meetings with Diane to support her sobriety. He was often too tired to take her or child care could not be found.

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· What possible signals do you see indicating the presence of domestic violence?
· Identify Diane’s behaviors that may indicate the presence of domestic violence.
· Identify Philip’s behaviors that may indicate the presence of domestic violence.
· Identify the children’s behaviors that may indicate the presence of domestic violence.
· How would you respond to the behaviors of each of the family members?
· Would you refer this family? To whom would you refer? Why? How?
HANDOUT
Caring for the Abuse Affected Child and Family

CASE STUDY: SUBSTANCE ABUSE

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- What possible signals do you see indicating the presence of substance abuse?
- Identify Diane’s behaviors that may indicate the presence of substance abuse.
- Identify Philip’s behaviors that may indicate the presence of substance abuse.
- Identify the children’s behaviors that may indicate the presence of substance abuse.
- How would you respond to the behaviors of each of the family members?
- Would you refer this family? To whom would you refer? Why? How?
## ADVOCACY

By Carol Sousa

<table>
<thead>
<tr>
<th>Advocacy Is...</th>
<th>Advocacy Isn’t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing a woman a safe space within which she can be in crisis</td>
<td>Forgetting that the woman is in crisis</td>
</tr>
<tr>
<td>Listening</td>
<td>Telling a woman what she should be feeling</td>
</tr>
<tr>
<td>Asking a woman what she wants to work on</td>
<td>Telling a woman what she must work on</td>
</tr>
<tr>
<td>Respecting her limits</td>
<td>Rescuing a woman and encouraging her to feel dependent on you</td>
</tr>
<tr>
<td>Providing resources and referral information</td>
<td>Thinking you can protect a woman</td>
</tr>
<tr>
<td>Asking if she needs help</td>
<td>Encouraging her to think of herself only as a victim</td>
</tr>
<tr>
<td>Encouraging her to help herself and her children</td>
<td>Thinking you’ll be the influence that changes her life</td>
</tr>
<tr>
<td>Recognizing her inner strength and pointing it out to her, helping her to draw on that strength</td>
<td>Pressing a woman to deal with issues she is not ready to confront</td>
</tr>
<tr>
<td>Complementing her for her hard work</td>
<td>Getting frustrated because things are not moving as fast as you would like</td>
</tr>
<tr>
<td>Calling agencies on a woman’s behalf when she asks for your help</td>
<td>Calling agencies for a woman when she has not asked for help</td>
</tr>
<tr>
<td>Being honest</td>
<td>Not sharing with her what you feel about her situation</td>
</tr>
<tr>
<td>Empathizing with her</td>
<td>Telling her how much worse you had it</td>
</tr>
<tr>
<td>Recognizing that each woman reacts differently to crisis</td>
<td>Thinking that her reactions are inappropriate</td>
</tr>
<tr>
<td>Focusing, clarifying, being honest, real and present</td>
<td>Not paying attention</td>
</tr>
<tr>
<td>Having a support system for yourself</td>
<td>Believing you are a super hero</td>
</tr>
</tbody>
</table>
Session Five:
Mental Health, Family Systems, and Similarities/Differences
Overview

Unit 1: Mental Health

Unit 2: Family Systems

Unit 3: Case Study
Purpose

Unit 1, Mental Health/Mental Illness:

Consider the ways in which beliefs and attitudes affect perception of mental illness. Increase awareness of the issues of mental health and mental illness as they relate to children and families. Increase understanding of how families experiencing substance abuse, domestic violence, or child abuse and neglect may be affected also by issues related to mental health and mental illness.
Purpose

Unit 2, Family Systems:

Increase awareness of the roles and function of the family system.
Purpose
Unit 3, Case Study:

Experience the similarities, differences and interactions of domestic violence, substance abuse, and child abuse and neglect as they affect the behaviors of both the child and family.
Objectives

Mental Health/Mental Illness:

1. Identify and explore knowledge and feelings about mental health and mental illness, and beliefs about people who live with mental health problems.

2. Explore the impact of receiving and living with a mental health diagnosis.

3. Look at some of the connections between issues of abuse and issues related to mental health and mental illness.
Objectives
Family Systems:

1. Describe and demonstrate the elements and dynamics of a family system as a whole.

2. Illustrate how the behavior of individual family members affects the family as a whole.
Objectives
Case Study:

Analyze and discuss abuse from the perspective of a family case study.
Definition of Stigma

Stigma is the use of negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma, and the resulting discrimination, discourages individuals and their families from getting the help they need.

(U.S. Surgeon General’s Report, 1999)
Resist Stereotyping

The label is not the person.

The diagnosis is not the illness.
Family Systems and Abuse

Family members lose options for choice in the presence of abuse…

1. When one person centralizes power

2. Where choices aren’t available

3. When exerting power may put a family member in danger

From Leslie Devoe, November 1993
Family Systems and Abuse

Changes in the behavior of one family member can result in a negative response by the abusive family member…

1. When a sexually abused child says “no”

2. When a battered woman says “I’m leaving”

3. When a husband tries to stop his wife from drinking

From Leslie Devoe, November 1993
Family Systems and Abuse

Family systems theory can be used to...

1. Explain some of the inter-generational sources of abuse and trauma

2. Show the effects of abuse, trauma, or any event on family members

3. Demonstrate how abusive behaviors and abuse affected behaviors are interdependent and interactive

From Leslie Devoe, November 1998
Session Six
Abuse Affected Behaviors, Feelings, Perceptions

Table of Contents

• Trainer Preparation 2
• Session Six Purpose, Objectives, and Outline 4
• Introduction to Session 5
• Unit 1: Abuse Affected Behaviors, Feelings, Perceptions – Vignettes 6
• Unit 2: Case Study: Tina, Theresa, and Terrence 16
• Unit 3: Participant Action Planning, Workshop Evaluation, and Closure 17
• Participant Handouts
• Overheads
Trainer Preparation

For Introduction to Session:
There are overheads available for the session Overview, Purpose, and Objectives. If you do not have an overhead projector available prepare 3 sheets of flip chart paper with the following information:

- **Overview**
  Unit 1: Abuse Affected Behaviors, Feelings, Perceptions - Vignettes
  Unit 2: Case Study: Tina, Theresa, and Terrence
  Unit 3: Participant Action Planning, Workshop Evaluation, and Closure

- **Purpose**
  1. Experiential application of new knowledge, skills, and attitudes in responding to children and families affected by abuse.
  2. Planning for how participants will integrate specific action items into their work.
  3. Make closure with the group.

- **Objectives**
  1. Identify abuse affected behaviors a child or family might display in the child care setting and actions that could be taken to respond to the child and family.
  2. Apply the concepts, tools, and skills presented throughout the training sessions by examining and discussing case studies.
  3. Write individual action plans, complete evaluations, and make closure with the group.

For Unit 1:
- There is an overhead available, Vignettes Discussion Guidelines. If you do not have an overhead projector available, prepare on flip chart:
  
  - **Vignettes Discussion Guidelines**
    Discuss the behavior described in the vignette. ‘What are we seeing here?’
    What might be going on in the child’s or adult’s life that could result in this behavior?
    How might you respond? Why?
    Spend about ten minutes on each vignette.

For Unit 2:
- There is no advanced preparation needed for Unit 2.
For Unit 3:
• Read Guidelines for Writing Action Items (See Session Six, Handout 8) in preparation for guiding participants through the process of writing their own action plans.

• The team may wish to discuss and plan for some sort of closure activity, such as group appreciations.

• Read Evaluation Tools section in trainer curriculum in preparation for describing the purpose and process of the Cross Disciplinary Training Project’s ongoing evaluation process.

• Bring carbon copy version of Action Plans and envelopes to distribute to participants. (RDC team member)

• Bring Session 6 Evaluations for completion by participants. (RDC team member)

• Bring Post-Training Questionnaires for completion by participants. (RDC team member)
Session 6: Abuse Affected Behaviors, Feelings, Perceptions

Purpose:
Provide experiential application of new knowledge, skills, and attitudes in responding to children and families affected by abuse, and encourage participants to plan for how they will integrate specific action items into their work. Create closure for participants and trainers.

Objectives:
1. Identify abuse affected behaviors a child or family might display in the child care setting and actions that could be taken to respond to that child and family.
2. Apply the concepts, tools, and skills presented throughout the training sessions by examining and discussing case studies.
3. Write individual action plans, complete evaluations, and create closure for the group.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Estimated Time</th>
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<tbody>
<tr>
<td>Introduction to Session</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Unit 1: Abuse Affected Behaviors, Feelings, Perceptions - Vignettes</td>
<td>70 minutes</td>
</tr>
<tr>
<td>Break</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Unit 1: Abuse Affected Behaviors, Feelings, Perceptions - Vignettes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Unit 2: Case Study: Tina, Theresa, and Terrence</td>
<td>40 minutes</td>
</tr>
<tr>
<td>Unit 3: Participant Action Planning, Workshop Evaluation, and Closure</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Total Session Time</td>
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January 2004

Maine Child Welfare Training Institute
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**Introduction to Session** (5 minutes)

**Overheads for Introduction:**
- Session 6, Overhead 1: Overview
- Session 6, Overhead 2: Purpose
- Session 6, Overhead 3: Objectives

**Suggested Order of Activities:**

1. Welcome the group to the final session of training.

2. Briefly go over the Session Six Overview, Purpose and Objectives in your own words. There are overheads for each of these, if you would like to use them.

3. Inform participants that this session is designed to provide them an opportunity to connect what they have learned in this training directly to their work in the child care setting. Exercises have been structured to allow for large and small group discussions of vignettes and case studies typical to child care providers. Finally, each individual and the entire group must say farewell and plan for how the new learning will be integrated into practice.

4. Remind the group that the Post-Training Questionnaire will be completed, along with the session six evaluation during the final minutes of the training.
Unit 1: Abuse Affected Behaviors, Feelings, Perceptions – Vignettes (70 minutes)

**Purpose:**
Identify abuse affected behaviors a child or family might display in the child care setting and actions that could be taken to respond to that child or family.

**Handouts for Unit 1:**
- Session 6, Handout 1: Abuse Affected Behaviors, Feelings, Perceptions – Vignettes
- Session 6, Handout 2: Dimensions of Abuse
- Session 6, Handout 3: Provider Response: What Can I Do to Help?

**Overheads for Unit 1:**
- Session 6, Overhead 4: Vignettes Discussion Guidelines

**Suggested Order of Activities:**

This is an excellent activity for moderation by the Education Specialist or RDC team member. All trainers should act as consultants to the class. Fit your knowledge and experience to the participants’ situation and explanation.

1. Explain that the next hour or so will be spent looking at behaviors, feelings, and perceptions sometimes seen in children and adults who have experienced abuse. Brief vignettes will form the basis for small and large group discussions about specific behaviors that represent common responses to trauma resulting from abuse.

   In connecting participants back to the first session and discussion about trauma, the following points may be briefly addressed: Trauma may interrupt trust and create stress responses in children and adults. When children are exposed to trauma, they may back up developmentally. They may suffer PTSD (recall of the emotional moment of the traumatic event). Some children exposed to trauma and abuse may show no obvious outward signs. Sometimes behaviors are not the result of trauma or abuse.

   The Dimensions of Abuse are the building blocks for all forms of abuse: sexual, domestic, physical, and substance. Abuse often comes in these aforementioned forms simultaneously. The causes and effects are similar regardless of the type of abuse. (Lesley Devoe, LCSW, 1994)

2. Inform the group that the whole group will go through the first vignette together, as an example for how the small groups will conduct their discussions.

3. Display the overhead or flip chart, Unit 1 - Vignette Discussion Guidelines. Instruct the whole group to silently read the first vignette. Ask each of the questions presented in the guidelines of the whole group, allowing for several individual responses.
Unit 1 (Continued)

4. Explain that this is the process small groups should go through for each vignette they are assigned. Following small group work, the class will come back together to share as a large group.

5. Remind the group that this is the time for participants to share their unique knowledge and experiences with each other.

6. Divide participants into small groups, so that each group will have 3 – 5 vignettes to analyze.

7. Give small groups thirty to fifty minutes to analyze all of their assigned vignettes. Trainers will want to circulate to make sure the discussions are flowing in each group and to facilitate if necessary.

8. Break (15 minutes): following the small group work and before the large group discussion.

9. With the large group together, begin debriefing and sharing of discussions from the small groups. Refer to Session 6, Handout 2 Dimensions of Abuse during this discussion. Have each group present one of their vignettes for discussion, followed by the next group, and so on. Allow about ten minutes per vignette for discussion, and go through as many as time allows. For each vignette, ask the following questions:
   - What has been your experience with this type of behavior?
   - Why did the child act that way?
   - What did you do about it? Could you do anything about it?
   - What would you do differently now?
   - What would have been helpful for you to know, or what skill would have been good for you to have at the time?
   - Would you or should you express your concern about a child's behavior to the family? How would you do it?

Each of the vignettes with the corresponding dimension of abuse and trainer talking points is listed on the following several pages. Be sure to thoroughly cover Talking Points for each vignette. Participant Session Six, Handout 2 contains all of the information in the Talking Points.

1. Lack of Empathy: Petie (4 ½) is playing with a set of blocks. Marina (3 ½) wants to play with Petie and the blocks too. Petie isn’t interested and wants to be left alone. Marina persists. Petie hits Marina over the head with a block. Marina cries loudly. Petie appears to show little, if any remorse or concern. You intervene and reprimand Petie, though he continues to play with an absent-minded look on his face.

Talking Points:
   - Clear limit-setting is needed, so that there is little opportunity for guilt.
   - A safe environment must be created and maintained for all children in the setting.
   - Work to help Petie identify feelings in others; for instance he could be asked to look at and identify Marina’s facial expressions.
   - This is an opportunity to provide social skills training, by giving Petie appropriate strategies to speak up when others are in his personal space.
   - This is an opportunity to implement a curriculum on feelings and empathy.
   - Deal with Marina too. Firmly state that it is not okay to invade another’s space. This will give Petie a sense of safety as well.
2. **Reality Manipulation (Thinking Distortion):** At the child care center, you have a seven year old child, Donna Lee, who you know to have been sexually abused. Donna Lee likes to play with the doll house and its miniature figures. One of the things you notice is that when she is creating a bedtime scene, she places the little girl doll and the daddy doll together in the little girl’s bed. When you walk over to her, she looks up at you and says, “They are showing each other how much they love each other.”

**Talking Points:**
- Think about what kinds of questions you might ask to help you better understand what the child is doing – concrete, open-ended questions only. Remember that it is not your job to determine abuse; it is your responsibility to report what you see and hear.
- Read or tell stories about how families show love and interact with one another. Model alternative realities rather than tell the child to use them.
- This is an opportunity to offer activities to help develop healthy attachment. Talk about how much you like helping your friends. Model appropriate ways of expressing affection and regard.
- Consider intensity, frequency, or duration of the behavior you are seeing.
- Understand that the behavior is the child’s cry for help.
- Document, share, and appropriately report the behavior you see and what the child says.

3. **Denial (Defensiveness):** You work at the school-age childcare program and notice the bruises and scratches on eight year old Maurice’s face. You’ve asked him about very similar marks in the recent past, and he had said something about playing with his dog and getting scratched. Over the past five weeks, Maurice has been coming in with new bruises and he’s been wearing a long-sleeved shirt even though it’s been awfully hot. You ask about the bruises and he puts you off by telling you different stories about what happened.

**Talking Points:**
- Pay attention to any unusual behaviors or statements made by the parents.
- Be aware that the child may not be denying to himself, but might be trying to cover up for others or responding to threats made by an adult.
- Validate the child’s feelings and honor his boundaries.
- Read books or create scenarios for the children where people are hurt (physically or emotionally) by others. Discuss how the victim might be feeling and what he or she could do about it.
- Invite a community theater group in to perform related vignettes, or put on a puppet show addressing the issue.
- Document, share, and report.

4. **Powerlessness:** Whenever Archie plays with the other kids, he wants to be in charge. He barks out orders to the other children like a drill sergeant. When another child doesn’t do as he tells him, Archie punches the boy, yells at him, and calls him stupid.

**Talking Points:**
- Give the child opportunities to have ‘personal power’ rather than ‘power over’. Help the child to know he has control over some parts of his life. Activities such as freeze tag, yoga, and tai chi would be good choices.
- Use different mediums for creative self expression – clay, paint, movement.
- Be consistent and predictable in the child care setting.
- Allow choices whenever possible.
- Teach and demonstrate limit-setting without anger.
Unit 1 (Continued)

- Conduct a group meeting with the children on how people can get what they want
  (sometimes) in appropriate ways.
- Read stories that illustrate personal power and choice.

5. **Shame/Guilt:** You work with and have gotten close to Anais, a five year old girl with large, dark brooding eyes. She has told you that her father hits her mother. While at your program, she always wants to help when other children are struggling or fighting. She tries to make them stop. She is always eager to help with routine activities and tasks. She says she helps at home too. When she says this, you notice that her eyes lower, shoulders hunch, and lips quiver.

**Talking Points:**
- Teach and model appropriate problem-solving strategies.
- It is okay if Anais wants to help out.
- Talk about and model how it is not our job to fix other people’s problems and that we are not responsible for another’s behavior. For example, when a child has a problem, ask them what they think they could do about the situation rather than solving it for them. Teach Anais to use this method if she really wants to help.
- Give opportunities for creative expression.
- A puppet show could demonstrate a conflict and the follow-up discussion would center on self-responsibility.
- Model that conflict is okay; violence is not.

6. **Fear/Terror:** Philip (10) and Sonia (6) are brother and sister. Sonia was watching Philip play basketball with some of the other kids on the playground. During one vigorous series of missed shots and rebounding efforts, Philip got into a minor shoving match with one of the other kids. Lots of angry words and pushes were exchanged, but no actual blows. On observing this, Sonia began to scream and hyperventilate. She ran to one of the child care providers and breathlessly urged her to tell them to stop fighting.

**Talking Points:**
- Help the child find a way to calm down and feel supported.
- Say to the child, “It’s okay; you and your brother are safe now.”
- Join with the child in a discussion of what they see or saw happening, almost taking a third party, more objective, perspective.
- Reinforce safety in all activities.
- Do not tell the child that there is nothing to be afraid of.
- Talk to the parent about the child’s reaction in this situation.
- Document.

7. **Pre-occupation with Safety:** You have four year old Ricardo in your care, and you have noticed that he is very dependent on you. He wants to know where you are, even if you are going to the rest room. No matter what he’s doing, he always tries to make sure he keeps one of the staff (preferably you) in his line of vision. He has a very hard time settling during rest times and won’t allow himself to fall asleep.

**Talking Points:**
- Create safety in the child care environment. Send a clear and consistent message to children that you will not allow people to hurt each other here. Eliminate all name-calling and put downs.
- You must remain calm and composed even in chaotic or stressful moments.
- Depending on the age of the child, you could work on relaxation techniques.
Unit 1 (Continued)

• Demonstrate that adults are looking out for the children’s safety.
• Provide opportunities for creative expression – no right or wrong, keep it child directed, and emphasize process over product.
• Create calm nap/rest time environments – dim lights, soft music, and stay in the room with the children.

8. Physical Signs (Physiological Involvement): Maxine is four years old and she rarely eats during snacks or meal times. She tells you she’s not hungry and doesn’t want anything. Her mother reports that she comes home hungry. Recently someone accidentally dropped a tray on the floor, and it made a loud clattering sound. Maxine screamed as though terrified, covered her ears, and dropped to her knees.

Talking Points:
• Honor the child’s boundaries.
• Try to keep meal times calm and safe with light and fun conversations flowing.
• Show no emotional response to the child’s refusal to eat. Be reassuring, and do not force the child to eat.
• Consider the possibility of an open snack table (limited number of chairs, very open and inviting) and/or staggered snacks.
• Offer some fun cooking activities.
• Serve meals family style.
• Do not attach rules or rewards to consumption of food.

9. Rage: Simon and Lance are playing with toy cars. Simon wants one of Lance’s cars to complete his collection. Lance refuses. Simon shouts that he needs the red car to have them all! Lance continues to resist. The argument escalates until Simon loses his temper and hits Lance. When you intervene, Simon continues to try to attack; he hits and bites you, and continues to try to strike at the other child.

Talking Points:
• Create and reinforce safety in the environment. Restore calm as soon as possible.
• Firm limit-setting is necessary. Be sure to say clearly that not only won’t you allow him to hurt others, but that you also won’t let others hurt him.
• A calm and controlled demeanor is of utmost importance.
• Pay attention to intensity, frequency, and duration of the behavior; also note how the child is able or not able to calm down over time.
• Involve a mental health professional. Ask questions and develop a plan – is this the right place for this child?
• Document and refer.

10. Distrust: Helen (7) is waiting for you to arrive at the child care center. As soon as you walk through the door, she wants to know why you weren’t there last Friday for her birthday party. She cried, “You told me you’d always be there, and you weren’t.” You tried to explain that you were ill, but she turned and walked away from you.

Talking Points:
• Do not make promises you cannot keep.
• Place a visible, easy-to-read schedule in a location where the child can see it.
• Develop markers of the day’s events; think predictability and consistency.
• Ensure that there is communication from staff to children when one of the providers will not be present.
Unit 1 (Continued)

• Give children early and clear notice of coming transition times and advance warning when schedules must change.
• Maintain your attachment with the child and encourage other staff to try to make connections with her.
• Implement a curriculum around friendship.

11. Code of Silence: You’re talking with Antonio, an articulate eight year old. He seems to be comfortable with you, because you enjoy playing Crazy Eights with him. As you are chatting during play he lets it slip that the police were at his house last night. You ask why. He hesitates, looks away, and abruptly asks, “Aren’t you going to deal? It’s your turn.”

Talking Points:
• Be attentive but casual about what the child is saying.
• Go slowly – the child is checking out whether or not you’re a safe person with whom to talk.
• Ask casual, concrete questions such as, “How’d you feel about that?” or “Who else was there?”
• If the child puts up a barrier, back off. Respect the child’s boundaries.
• Consider the different possible parent-child relationships in a situation such as this, and how that would affect your decision to say anything to the parents about what the child has disclosed.
• Document and report if necessary.

12. Isolation: Fiona is a quiet ten year old. Despite your best efforts, she keeps to herself. Even on field trips, she’s usually last and you have to go to the end of the line where Fiona is straggling along. She eats by herself and spends most of her time reading. She even brings in her own books and is always asking for more. She never invites any of the other kids to her home.

Talking Points:
• Many children are naturally quiet and reserved. Pay attention to other signs that may indicate this is more than just a style or personality preference. For instance how does the child interact with other children and adults? Does it seem like avoidance?
• Notice if she is watching other children. When she does this, try to join her and observe them together.
• Demonstrate to the child that it is okay to be quiet by looking at her, catching her eye, and smiling.
• If possible, join with her; sit next to her and read quietly for a few minutes.
• Put together a reading group with other quiet children. This would need to be closely supervised, so that the quiet, individual space is respected also.
• Consider asking the parent about the child’s behavior. Is it usual, or could it possibly be something else? Draw the parent in as a resource in helping you to understand and work with the child.

13. Low Self Esteem: Oscar, age four, loves to draw and is very good at it. Whenever you compliment him, he says, “It’s yucky,” and scribbles over it quickly or tears it up. When he does something well and you compliment him, he turns away from you and will often leave the area. Oscar doesn’t show much emotion and resists when trying new things, even though when he does, he usually does well.
Unit 1 (Continued)

Talking Points:
- Praise can be tricky with a child with low self esteem. Praise should be specific to the behavior and should help the child focus on their own achievement. Keep it sincere and short.
- Compliment quickly and casually, and then leave the area before the child has a chance to put up a barrier.
- Provide opportunities for him to choose to do activities he does well, as a part of the activities available to all the children in the setting. Do not single the child out.
- Give choices as opposed to assigned activities whenever possible.
- Show an interest in what the child is doing. Simply noticing the child is an important part of building esteem.

14. Emotionally Flat (Limited Affect): Rowena acts as if she’s in a trance. She initiates nothing and takes no interest in anything around her. You notice that it requires a lot of effort on your part to get Rowena to do anything. You are her energy supplier. Rowena is lifeless, inert, and not connected to her surroundings.

Talking Points:
- Talk with the parent about the need for further evaluation. Provide support to the parent and stress the need for them to find support for the child.
- These behaviors could be caused by disability, or they may be trauma based.
- You might see this type of response in any age of child.
- Look for anything you do that seems to cause her body to perk up – physical touch, rocking, sitting together and reading, music – and do those activities as often as possible.
- Be careful about excess stimulation, such as loud, sudden noises.

15. Victim Blame: Three and a half year old Ted has bitten Sally, another child in your care, five times in the past two weeks. You know that Ted comes from a family where there has been abuse and that his parents have separated and reunited many times. Sally’s parents are irate with you for letting Ted bite their daughter. This morning you caught Ted as he was about to bite the girl again. You quickly rushed over to intervene, raising your voice to say, “I have had it with your biting! You cannot bite here!” You pick Ted up, carry him over to the sofa, and set him down hard. You point your finger at him and exclaim, “Just because they can’t control you at home doesn’t mean you can get away with that stuff here!”

Talking Points:
- Calm yourself.
- Take responsibility for your own behavior.
- Apologize to the child – “I shouldn’t have said that.”
- Find another adult to talk to about your own behavior in response to this child – your RDC, another provider, someone who understands children.
- Think more objectively about how you can help the child with his behavior.
- Emphasize the child’s ability to control himself to the extent that he is able – yoga, games that emphasize personal choice and power.
- Work on social skills and finding substitutes for the child’s biting.

16. Co-Dependence/No Dependence: Valerie and Vivian are six year old twins who each display very different behaviors in terms of their attachments. Vivian never leaves your side. She asks for your permission for everything and seeks your approval for every project and
activity. When you raise your voice to tell her to make her own decisions she cringes like a reprimanded dog. Valerie, on the other hand, doesn’t look to anyone for approval or for help.

Talking Points:
- Consider how you might respond to each child individually:
- Try to build an attachment with Valerie, perhaps through mutual games and activities with shared responsibilities.
- Do not push Vivian away. If there is another adult available, have that person try to build an attachment with her. This will show her that there is safety beyond the private and safe space she has created around her.
- Avoid raising your voice.
- It would be good to increase each of these girls’ involvement with materials and activities by joining with them.
- The goal is to weave in opportunities for independence, indirectly.
- Look for other signs that might give you more information about what is going on for them. Recognize when the behavior seems to fall outside the context of the situation or when it seems extreme, and document.
- Make sure to create a physically and emotionally safe environment for the children.
- Consider the relationship the girls share together as siblings and twins. What might you need to do for them together, as well as individually?

17. Feeling of Having No Choices or Options (Conditioned Learning): When you give four year old Craig choices, he invariably responds, “I don’t know” or “I don’t care.” If you make a choice for him or for the group, he falls apart, wanting the other option. If you go with the option he apparently wants, he then wants the first choice you made.

Talking Points:
- It is important to find out whether this behavior is related to not having learned how to make choices, or if previous choices have often had negative consequences or been perceived as mistakes by the child or those around him.
- You must provide support in encouraging choice, while acting responsibly.
- Provide simple choices, where the child can truly choose either, and then give the child ample time to make the choice.
- Encourage the child’s self-responsibility. Ask, “What are you going to do about that?”
- If you have a relationship with the parents, you might want to work with them on this issue.
- Be aware of the possible cultural or ethnic connections to choice-making behavior.

18. Problem-Solving: Faye, age five, has grown increasingly easily frustrated and quick to anger. Most recently, she was putting a wooden puzzle together, and when a piece didn’t fit where she wanted it, she became very frustrated, throwing the pieces against the wall and swearing repeatedly.

Talking Points:
- Document the behavior. Note intensity, frequency, and duration of this type of behavior.
- Try to teach self-calming strategies such as deep breathing and appropriate physical activities.
- Encourage the child to go back to the activity and see it through to completion, using the strategies for self-calming.
- Either ask the child, “How did that work for you?” or say, “Seems like that was really difficult for you, would you like some help?”
• Model your own problem-solving skills overtly, through behavior and verbalizing the process. Make a mistake and strategize through it.
• Depending upon your relationship with the family, you may want to mention the child’s increased frustration to see if they can provide more information about it.

19. Distorted Communication Process: You have just taken a phone call at work from your auto mechanic. Your car went in to the shop this morning. Much to your shock, the mechanic now tells you that you need a whole new engine. He said that there were bite marks caused by a rodent all along the destroyed radiator hose. You are angry and your face is red, your head shaking as you hang up the phone. You slap the wall and exclaim, “I can’t believe it – damned little rats!” As you turn around, you see four year old Violet, cringing behind the door staring at you with big eyes and a look of fear.

Talking Points:
• Talk to the child about what is really bothering you. Clear up the miscommunication for the child.
• Model for the child how you are going to calm down. Say, “I need to take a deep breath.”
• Talk about your own emotions.
• Stories and/or books about emotions and facial expressions could be used with the children.

20. Parent-Child Role Reversal: Selma, who is nine, ‘care takes’ her younger brother Freddie, age seven. Whenever he has difficulty with another child she steps in and tells everybody how to fix it. She yells at him when he does something wrong. She makes him play with her even when he’d rather be off with other children. She tells him when he’s inappropriately dressed for the weather. When he is hurt, she runs over to him and provides hugs and comfort.

Talking Points:
• Be aware that sometimes this type of caretaking provides a critical safety buffer for the younger child in abusive home environments.
• Be sensitive to the older child's need to take care of her sibling. This role is probably closely tied to her sense of identity and belonging in her family.
• Emphasize your role in a gentle manner. Say, “It’s nice that you do these things for your brother. I can help you out.”
• Wean the child from adult roles by first sharing responsibilities with her and then gradually replacing them with age-appropriate activities, separate from the younger sibling.

21. Inability to Give or Receive Nurturance or Touch: Glenda, Patrick’s mother, flinches and shrugs her shoulders when you put your hand out to welcome her to the child care center. When her son runs over to her and grabs her around her legs, she removes his hands and positions him slightly away. She does not resume physical contact with him. In your room, Patrick has touched you and other children in ways that were uncomfortable and which showed you that he is not clear about physical boundaries.

Talking Points:
• Be aware that the fact that the parent’s difficulties with giving or receiving nurturing touch will have an impact on how the child is able to understand and use touch to communicate with others.
• Set no hitting rules.
• Be sensitive to voice tones and volumes.
• Set clear limits and boundaries concerning touching and body space.
Unit 1 (Continued)

- Get consent from the child before touching or hugging.
- Encourage the child to ask for permission before touching.

22. **Multigenerational Influence:** Diane has told you of a pattern of physical and emotional abuse from her ex-husband. She reports that she was put down, sworn at, and hit. Her ten year old son Michael seems to be showing some of the same patterns of behavior. For example, when Diane came to pick Michael up he yelled at her, calling her a stupid bitch because she hadn’t brought his jacket. Diane has said that Michael has even begun hitting her.

**Talking Points:**
- Encourage the parent to find support in how to deal with her child.
- Tell the woman about domestic abuse agencies, if she is not already involved. They have resources for her and perhaps for her child as well.
- In class, talk about male and female stereotypes, challenging myths and assumptions whenever possible. Talk about what real strength and power are – self control and personal power, as opposed to power over another.
- Reinforce that though the child’s behavior is troubling, it is only a part of who the child is. Join with the parent in recognizing the positive aspects of the child’s personality.
- Help the child find more positive ways of expressing dissatisfaction.

23. **Grief and Loss:** You have worked part time at Happy Land Child Care Center for four years and have gotten fairly close to some of the children (you admit it, you have favorites). You especially like Gina, a serious eight year old. On your last day, you made it a point to say good-bye to Gina. When you told her you were leaving, she didn’t seem to care. She said, “Ok, g’bye,” and walked away.

**Talking Points:**
- Build in rituals around closures/good-byes for all children.
- Talk about your own feelings with the child. Separate your feelings from the needs of the child.
- The child may be in denial about your leaving and not able to face it in the moment.
- Consider keeping a photo album of staff and children who have left the center, or send out a card or letter to the person who has recently left.
- Sometimes children illustrate challenges around grief and loss by not letting anyone get too close to them.

24. **Social/Cultural/Religious Justification:** You notice that seven year old Justin has a bad bruise. You ask him about the bruise and he says, “My dad hit me because I did wrong.” You ask, “What did you do wrong, Justin?” He answers, “I broke the law of the church.”

**Talking Points:**
- Document what you see and what the child says.
- Talk with the parents. Explain your role.
- Implement a curriculum focusing on diversity issues – different people have different beliefs.
- Be true to your own values. What would you feel comfortable doing, based on your own experience and knowledge?
Unit 2: Case Study: Tina, Theresa, and Terrence (40 minutes)

Purpose:
Apply the concepts, tools, and skills presented throughout the training sessions by examining and discussing case studies. Share concerns, experiences, and methods with facilitators.

Handouts for Unit 2:
• Session 6, Handout 4: Case Study (Tina)
• Session 6, Handout 5: Case Study (Theresa)
• Session 6, Handout 6: Case Study (Terrence)

Suggested Order of Activities:

1. Inform participants that the next exercise is designed for them to study more intensive case studies, in order to consider the application of concepts and skills acquired through training. In addition, this is a time to ask specific questions of the training team members and to share concerns, ideas and experiences relevant to the issues presented. The shared knowledge and experience of all in the room can provide valuable information about how to work most beneficially with our service recipients and with one another.

2. Divide participants into three small groups. Assign one of the three case studies to each group: Tina, Theresa, and Terrence.

3. Each small group is to read and discuss their assigned case study, answering the four questions at the bottom of the case study:
   • What do you think might be going on in this family?
   • What is your assessment of the child’s behaviors, feelings, perceptions?
   • How would you help the child and family?
   • What are the limits to what you can do?

4. Give the small groups about 20 minutes to work together. Trainers should circulate around the groups to answer questions and to clarify case study conditions.

5. The large group debrief should focus on the following discussion questions:
   • What kinds of skills or knowledge do you need to handle this type of situation?
   • What kinds of approaches have you used in the past to help you deal with similar situations?
   • What did you find most challenging about these children and their families?
   • Under what conditions would you make a referral? To whom?

Trainer Notes:
Unit 3: Participant Action Planning, Workshop Evaluation, Closure (20 minutes)

Purpose:
Write individual action plans, complete evaluations, and make closure with the group.

Handouts for Unit 3:
- Session 6, Handout 7: Guidelines for Writing Action Items
- Carbon Copy Action Plan and Envelopes – RDC team member will have these. There is a copy of the Action Plan in the Trainer Manual for reference purposes.

Suggested Order of Activities:

1. Inform the group that it is now time to make closure, individually and as a group, and to evaluate the training program.

   Ask participants to refrain from conversations as they are finishing up Action Plans, Evaluations, and Post-Training Questionnaires to allow everyone ample time for a thoughtful process.

2. Explain the process for writing the Individual Action Plans, referring participants to Session Six, Handout 8. Encourage participants to challenge themselves to carry their new knowledge and skills forward in some measurable way. Let them know that a copy of their action plan will be sent out to them three months from now as a reminder to them. Distribute the materials.

   An exercise for group closure might fit well either before or after evaluations are completed. If before, participants are free to leave after they have completed their evaluation and post-training questionnaire.

   A structure for group appreciations might involve opening with an invitation for trainers and participants to share, in one or two sentences what they will take away from this training experience.

3. Optional: Invite participation in an activity for group closure (This activity may be placed after evaluations, depending upon the preference of the trainers).

4. Inform participants of the importance of the ongoing evaluation of the Cross Disciplinary Training Project, and encourage participants' candid reflection of their own experience in the training, the trainers - individually and as a team, and the curriculum design, content, and structure. The Session Six Evaluation and the Post –Training Questionnaire involve two separate evaluative processes, so completion of both is necessary. Remind participants to be looking for the 3 Month Follow-up Questionnaire, and stress the importance of their contribution to the ongoing evaluation process.

5. Distribute Session Six Evaluations. Distribute Post-Training Questionnaire. Allow ample time for completion of all evaluation instruments.
ABUSE AFFECTED BEHAVIORS, FEELINGS, & PERCEPTIONS - VIGNETTES

1. Petie (4 ½) is playing with a set of blocks. Marina (3 ½) wants to play with Petie and the blocks too. Petie isn’t interested and wants to be left alone. Marina persists. Petie hits Marina over the head with a block. Marina cries loudly. Petie appears to show little, if any remorse or concern. You intervene and reprimand Petie, though he continues to play with an absent-minded look on his face.

2. At the child care center, you have a seven year old child, Donna Lee, who you know to have been sexually abused. Donna Lee likes to play with the doll house and its miniature figures. One of the things you notice is that when she is creating a bedtime scene, she places the little girl doll and the daddy doll together in the little girl’s bed. When you walk over to her, she looks up at you and says, “They are showing each other how much they love each other.”

3. You work at the school-age childcare program and notice the bruises and scratches on eight year old Maurice’s face. You’ve asked him about very similar marks in the recent past, and he had said something about playing with his dog and getting scratched. Over the past five weeks, Maurice has been coming in with new bruises and he’s been wearing a long-sleeved shirt even though it’s been awfully hot. You ask about the bruises and he puts you off by telling you different stories about what happened.

4. Whenever Archie plays with the other kids, he wants to be in charge. He barks out orders to the other children like a drill sergeant. When another child doesn’t do as he tells him, Archie punches the boy, yells at him, and calls him stupid.

5. You work with and have gotten close to Anais, a five year old girl with large, dark brooding eyes. She has told you that her father hits her mother. While at your program, she always wants to help when other children are struggling or fighting. She tries to make them stop. She is always eager to help with routine activities and tasks. She says she helps at home too. When she says this, you notice that her eyes lower, shoulders hunch, and lips quiver.

6. Philip (10) and Sonia (6) are brother and sister. Sonia was watching Philip play basketball with some of the other kids on the playground. During one vigorous series of missed shots and rebounding efforts, Philip got into a minor shoving match with one of the other kids. Lots of angry words and pushes were exchanged, but no actual blows. On observing this, Sonia began to scream and hyperventilate. She ran to one of the child care providers and breathlessly urged her to tell them to stop fighting.

7. You have four year old Ricardo in your care, and you have noticed that he is very dependent on you. He wants to know where you are, even if you are going to the rest room. No matter what he’s doing, he always tries to make sure he keeps one of the staff (preferably you) in his line of vision. He has a very hard time settling during rest times and won’t allow himself to fall asleep.

8. Maxine is four years old and she rarely eats during snacks or meal times. She tells you she’s not hungry and doesn’t want anything. Her mother reports that she comes home hungry. Recently someone accidentally dropped a tray on the floor, and it made a loud clattering sound. Maxine screamed as though terrified, covered her ears, and dropped to her knees.
9. Simon and Lance are playing with toy cars. Simon wants one of Lance’s cars to complete his collection. Lance refuses. Simon shouts that he needs the red car to have them all! Lance continues to resist. The argument escalates until Simon loses his temper and hits Lance. When you intervene, Simon continues to try to attack; he hits and bites you, and continues to try to strike at the other child.

10. Helen (7) is waiting for you to arrive at the child care center. As soon as you walk through the door, she wants to know why you weren’t there last Friday for her birthday party. She cried, “You told me you’d always be there, and you weren’t.” You tried to explain that you were ill, but she turned and walked away from you.

11. You’re talking with Antonio, an articulate eight year old. He seems to be comfortable with you, because you enjoy playing Crazy Eights with him. As you are chatting during play he lets it slip that the police were at his house last night. You ask why. He hesitates, looks away, and abruptly asks, “Aren’t you going to deal? It’s your turn.”

12. Fiona is a quiet ten year old. Despite your best efforts, she keeps to herself. Even on field trips, she’s usually last and you have to go to the end of the line where Fiona is straggling along. She eats by herself and spends most of her time reading. She even brings in her own books and is always asking for more. She never invites any of the other kids to her home.

13. Oscar, age four, loves to draw and is very good at it. Whenever you compliment him, he says, “It’s yucky,” and scribbles over it quickly or tears it up. When he does something well and you compliment him, he turns away from you and will often leave the area. Oscar doesn’t show much emotion and resists when trying new things, even though when he does, he usually does well.

14. Rowena acts as if she’s in a trance. She initiates nothing and takes no interest in anything around her. You notice that it requires a lot of effort on your part to get Rowena to do anything. You are her energy supplier. Rowena is lifeless, inert, and not connected to her surroundings.

15. Three and a half year old Ted has bitten Sally, another child in your care, five times in the past two weeks. You know that Ted comes from a family where there has been abuse and that his parents have separated and reunited many times. Sally’s parents are irate with you for letting Ted bite their daughter. This morning you caught Ted as he was about to bite the girl again. You quickly rushed over to intervene, raising your voice to say, “I have had it with your biting! You cannot bite here!” You pick Ted up, carry him over to the sofa, and set him down hard. You point your finger at him and exclaim, “Just because they can’t control you at home doesn’t mean you can get away with that stuff here!”

16. Valerie and Vivian are six year old twins who each display very different behaviors in terms of their attachments. Vivian never leaves your side. She asks for your permission for everything and seeks your approval for every project and activity. When you raise your voice to tell her to make her own decisions she cringes like a reprimanded dog. Valerie, on the other hand, doesn’t look to anyone for approval or for help.

17. When you give four year old Craig choices, he invariably responds, “I don’t know” or “I don’t care.” If you make a choice for him or for the group, he falls apart, wanting the other option. If you go with the option he apparently wants, he then wants the first choice you made.
ABUSE AFFECTED BEHAVIORS, FEELINGS, & PERCEPTIONS - VIGNETTES (Continued)

18. Faye, age five, has grown increasingly easily frustrated and quick to anger. Most recently, she was putting a wooden puzzle together, and when a piece didn’t fit where she wanted it, she became very frustrated, throwing the pieces against the wall and swearing repeatedly.

19. You have just taken a phone call at work from your auto mechanic. Your car went in to the shop this morning. Much to your shock, the mechanic now tells you that you need a whole new engine. He said that there were bite marks caused by a rodent all along the destroyed radiator hose. You are angry and your face is red, your head shaking as you hang up the phone. You slap the wall and exclaim, “I can’t believe it – damned little rats!” As you turn around, you see four year old Violet, cringing behind the door staring at you with big eyes and a look of fear.

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21. Glenda, Patrick’s mother, flinches and shrugs her shoulders when you put your hand out to welcome her to the child care center. When her son runs over to her and grabs her around her legs, she removes his hands and positions him slightly away. She does not resume physical contact with him. In your room, Patrick has touched you and other children in ways that were uncomfortable and which showed you that he is not clear about physical boundaries.

22. Diane has told you of a pattern of physical and emotional abuse from her ex-husband. She reports that she was put down, sworn at, and hit. Her ten year old son Michael seems to be showing some of the same patterns of behavior. For example, when Diane came to pick Michael up he yelled at her, calling her a stupid bitch because she hadn’t brought his jacket. Diane has said that Michael has even begun hitting her.

23. You have worked part time at Happy Land Child Care Center for four years and have gotten fairly close to some of the children (you admit it, you have favorites). You especially like Gina, a serious eight year old. On your last day, you made it a point to say good-bye to Gina. When you told her you were leaving, she didn’t seem to care. She said, “Ok, g’bye,” and walked away.

24. You notice that seven year old Justin has a bad bruise. You ask him about the bruise and he says, “My dad hit me because I did wrong.” You ask, “What did you do wrong, Justin?” He answers, “I broke the law of the church.”
DIMENSIONS OF ABUSE

1. Lack of Empathy:
   • Clear limit-setting is needed, so that there is little opportunity for guilt.
   • A safe environment must be created and maintained for all children in the setting.
   • Work to help Petie identify feelings in others; for instance he could be asked to look at and identify Marina’s facial expressions.
   • This is an opportunity to provide social skills training, by giving Petie appropriate strategies to speak up when others are in his personal space.
   • This is an opportunity to implement a curriculum on feelings and empathy.
   • Deal with Marina too. Firmly state that it is not okay to invade another’s space. This will give Petie a sense of safety as well.

2. Reality Manipulation (Thinking Distortion):
   • Think about what kinds of questions you might ask to help you better understand what the child is doing – concrete, open-ended questions only. Remember that it is not your job to determine abuse; it is your responsibility to report what you see and hear.
   • Read or tell stories about how families show love and interact with one another. Model alternative realities rather than tell the child to use them.
   • This is an opportunity to offer activities to help develop healthy attachment. Talk about how much you like helping your friends. Model appropriate ways of expressing affection and regard.
   • Consider intensity, frequency, or duration of the behavior you are seeing.
   • Understand that the behavior is the child’s cry for help.
   • Document, share, and appropriately report the behavior you see and what the child says.

3. Denial (Defensiveness):
   • Pay attention to any unusual behaviors or statements made by the parents.
   • Be aware that the child may not be denying to himself, but might be trying to cover up for others or responding to threats made by an adult.
   • Validate the child’s feelings and honor his boundaries.
   • Read books or create scenarios for the children where people are being hurt (physically or emotionally) by others. Discuss how the victim might be feeling and what he or she could do about it.
   • Invite a community theater group in to perform related vignettes, or put on a puppet show addressing the issue.
   • Document, share, and report.

4. Powerlessness:
   • Give the child opportunities to have ‘personal power’ rather than ‘power over’. Help the child to know he has control over some parts of his life. Activities such as freeze tag, yoga, tai chi would be good choices.
   • Use different mediums for creative self expression – clay, paint, movement.
   • Be consistent and predictable in the child care setting.
   • Allow choices whenever possible.
   • Teach and demonstrate limit-setting without anger.
   • Conduct a group meeting with the children on how people can get what they want (sometimes) in appropriate ways.
   • Read stories that illustrate personal power and choice.
5. Shame/Guilt:
   • Teach and model appropriate problem-solving strategies.
   • It is okay if Anais wants to help out.
   • Talk about and model how it is not our job to fix other people’s problems and that we are not responsible for another’s behavior. For example, when a child has a problem, ask them what they think they could do about the situation rather than solving it for them. Teach Anais to use this method if she really wants help.
   • Give opportunities for creative expression.
   • A puppet show could demonstrate a conflict and the follow-up discussion would center on self-responsibility.
   • Model that conflict is okay; violence is not.

6. Fear/Terror:
   • Help the child find a way to calm down and feel supported.
   • Say to the child, “It’s okay, you and your brother are safe now.”
   • Join with the child in a discussion of what they see/saw happening, almost taking a third party, more objective, perspective.
   • Reinforce safety in all activities.
   • Do not tell the child that there is nothing to be afraid of.
   • Talk to the parent about the child’s reaction in this situation.
   • Document.

7. Pre-occupation with Safety:
   • Create safety in the child care environment. Send a clear and consistent message to children that you will not allow people to hurt each other here. Eliminate all name-calling and put downs.
   • You must remain calm and composed even in chaotic or stressful moments.
   • Depending on the age of the child, you could work on relaxation techniques.
   • Demonstrate that adults are looking out for the children’s safety.
   • Provide opportunities for creative expression – no right or wrong, keep it child directed, and emphasize process over product.
   • Create calm nap/rest time environments – dim lights, soft music, and stay in the room with the children.

8. Physical Signs (Physiological Involvement):
   • Honor the child’s boundaries.
   • Try to keep meal times calm and safe with light and fun conversations flowing.
   • Show no emotional response to the child’s refusal to eat. Be reassuring, and do not force the child to eat.
   • Consider the possibility of an open snack table (limited number of chairs, very open and inviting) and/or staggered snacks.
   • Offer some fun cooking activities.
   • Serve meals family style.
   • Do not attach rules or rewards to consumption of food.
9. Rage:
   • Create and reinforce safety in the environment. Restore calm as soon as possible.
   • Firm limit-setting is necessary. Be sure to say clearly that not only won’t you allow him to hurt
     others, but that you also won’t let others hurt him.
   • A calm and controlled demeanor is of utmost importance.
   • Pay attention to intensity, frequency, and duration of the behavior; also note how the child is able or
     not able to calm down over time.
   • Involve a mental health professional. Ask questions and develop a plan – is this the right place for
     this child?
   • Document and refer.

10. Distrust:
    • Do not make promises you cannot keep.
    • Place a visible, easy-to-read schedule in a location where the child can see it.
    • Develop markers of the day’s events; think predictability and consistency.
    • Ensure that there is communication from staff to children when one of the providers will not be present.
    • Give children early and clear notice of coming transition times and advance warning when
      schedules must change.
    • Maintain your attachment with the child and encourage other staff to try to make connections with her.
    • Implement a curriculum around friendship.

11. Code of Silence:
    • Be attentive but casual about what the child is saying.
    • Go slowly – the child is checking out whether or not you’re a safe person with whom to talk.
    • Ask casual, concrete questions such as, “How’d you feel about that?” or “Who else was there?”
    • If the child puts up a barrier, back off. Respect the child’s boundaries.
    • Consider the different possible parent-child relationships in a situation such as this, and how would
      that affect your decision to say anything to the parents about what the child has disclosed.
    • Document and report if necessary.

12. Isolation:
    • Many children are naturally quiet and reserved. Pay attention to other signs that may indicate this is
      more than just a style or personality preference. For instance how does the child interact
      with other children and adults? Does it seem like avoidance?
    • Notice if she is watching other children. When she does this, try to join her and observe them together.
    • Demonstrate to the child that it is okay to be quiet by looking at her, catching her eye, and smiling.
    • If possible, join with her; sit next to her and read quietly for a few minutes.
    • Put together a reading group with other quiet children. This would need to be closely supervised, so
      that the quiet, individual space is respected also.
    • Consider asking the parent about the child’s behavior. Is it usual, or could it possibly be something
      else? Draw the parent in as a resource in helping you to understand and work with the child.


13. Low Self Esteem:

- Praise can be tricky with a child with low self esteem. Praise should be specific to the behavior and should help the child focus on their own achievement. Keep it sincere and short.
- Compliment quickly and casually, and then leave the area before the child has a chance to put up a barrier.
- Provide opportunities for him to choose to do activities he does well, as a part of the activities available to all the children in the setting. Do not single the child out.
- Give choices as opposed to assigned activities whenever possible.
- Show an interest in what the child is doing. Simply noticing the child is an important part of building esteem.

14. Emotionally Flat (Limited Affect):

- Talk with the parent about the need for further evaluation. Provide support to the parent and stress the need for them to find support for the child.
- These behaviors could be caused by disability, or they may be trauma based.
- You might see this type of response in any age of child.
- Look for anything you do that seems to cause her body to perk up – physical touch, rocking, sitting together and reading, music – and do those activities as often as possible.
- Be careful about excess stimulation, such as loud, sudden noises.

15. Victim Blame:

- Calm yourself.
- Take responsibility for your own behavior.
- Apologize to the child – “I shouldn’t have said that.”
- Find another adult to talk to about your own behavior in response to this child – your RDC, another provider, someone who understands children.
- Think more objectively about how you can help the child with his behavior.
- Emphasize the child’s ability to control himself to the extent that he is able – yoga, games that emphasize personal choice and power.
- Work on social skills and finding substitutes for the child’s biting.

16. Co-Dependence/No Dependence:

- Consider how you might respond to each child individually:
- Try to build an attachment with Valerie, perhaps through mutual games and activities with shared responsibilities.
- Do not push Vivian away. If there is another adult available, have that person try to build an attachment with her. This will show her that there is safety beyond the private and safe space she has created around her.
- Avoid raising your voice.
- It would be good to increase each of these girls’ involvement with materials and activities by joining with them.
- The goal is to weave in opportunities for independence, indirectly.
- Look for other signs that might give you more information about what is going on for them. Recognize when the behavior seems to fall outside the context of the situation or when it seems extreme, and document.
• Make sure to create a physically and emotionally safe environment for the children.
• Consider the relationship the girls share together as siblings and twins. What might you need to do for them together, as well as individually?

17. Feeling of Having No Choices or Options (Conditioned Learning):
• It is important to find out whether this behavior is related to not having learned how to make choices, or if previous choices have often had negative consequences or been perceived as mistakes by the child or those around him.
• You must provide support in encouraging choice, while acting responsibly.
• Provide simple choices, where the child can truly choose either, and then give the child ample time to make the choice.
• Encourage the child’s self-responsibility. Ask, “What are you going to do about that?”
• If you have a relationship with the parents, ask them to work with them on this issue.
• Be aware of the possible cultural or ethnic connections to choice-making behavior.

18. Problem-Solving:
• Document the behavior. Note intensity, frequency, and duration of this type of behavior.
• Try to teach self-calming strategies such as deep breathing and appropriate physical activities.
• Encourage the child to go back to the activity and see it through to completion, using the strategies for self-calming.
• Either ask the child, “How did that work for you?” or say, “Seems like that was really difficult for you, would you like some help?”
• Model your own problem-solving skills overtly, through behavior and verbalizing the process.
  Make a mistake and strategize through it.
• Depending upon your relationship with the family, you may want to mention the child’s increased frustration to see if they can provide more information about it.

19. Distorted Communication Process:
• Talk to the child about what is really bothering you. Clear up the miscommunication for the child.
• Model for the child how you are going to calm down. Say, “I need to take a deep breath.”
• Talk about your own emotions.
• Stories and/or books about emotions and facial expressions could be used with the children.

20. Parent-Child Role Reversal:
• Be aware that sometimes this type of caretaking provides a critical safety buffer for the younger child in abusive home environments.
• Be sensitive to the older child’s need to take care of her sibling. This role is probably closely tied to her sense of identity and belonging in her family.
• Emphasize your role in a gentle manner. Say, “It’s nice that you do these things for your brother. I can help you out.”
• Wean the child from adult roles by first sharing responsibilities with her and then gradually replacing them with age-appropriate activities, separate from the younger sibling.
21. **Inability to Give or Receive Nurturance or Touch:**

- Be aware that the fact that the parent’s difficulties with giving or receiving nurturing touch will have an impact on how the child is able to understand and use touch to communicate with others.
- Set no hitting rules.
- Be sensitive to voice tones and volumes.
- Set clear limits and boundaries concerning touching and body space.
- Get consent from the child before touching or hugging.
- Encourage the child to ask for permission before touching.

22. **Multigenerational Influence:**

- Encourage the parent to find support in how to deal with her child.
- Tell the woman about domestic abuse agencies, if she is not already involved. They have resources for her and perhaps for her child as well.
- In class, talk about male and female stereotypes, challenging myths and assumptions whenever possible. Talk about what real strength and power are – self control and personal power, as opposed to power over another.
- Reinforce that though the child’s behavior is troubling, it is only a part of who the child is. Join with the parent in recognizing the positive aspects of the child’s personality.
- Help the child find more positive ways of expressing dissatisfaction.

23. **Grief and Loss:**

- Build in rituals around closures/good-byes for all children.
- Talk about your own feelings with the child. Separate your feelings from the needs of the child.
- The child may be in denial about your leaving and not able to face it in the moment.
- Consider keeping a photo album of staff and children who have left the center, or send out a card or letter to the person who has recently left.
- Sometimes children illustrate challenges around grief and loss by not letting anyone get too close to them.

24. **Social/Cultural/Religious Justification:**

- Document what you see and what the child says.
- Talk with the parents. Explain your role.
- Implement a curriculum focusing on diversity issues – different people have different beliefs.
- Be true to your own values. What would you feel comfortable doing, based on your own experience and knowledge?
The kind of environment you provide can have a significant impact on the children with whom you have contact. You are in a position to model reasonable and caring adult behaviors. What follows is a list of behaviors that if consistently modeled, will bring lasting benefits to the children in your care—especially for the children living in an abused affected home.

1. Have consistent and clear expectations of the child. Be sure that the child understands them.

2. Give children the words they need to express their thoughts and feelings.

3. Let children know that it’s ok to feel angry, sad, confused, etc.

4. Teach and model appropriate ways of expressing feelings (shouting and hurting are not ok—help children identify and talk about their feelings).

5. Be honest; if you’re angry, sad, or perplexed, say so; don’t make promises you can’t keep.


7. Have a few easily understood rules.

8. Never shame or blame a child for inappropriate behavior.

9. Recognize that a child’s behavior is rarely, if ever random; it usually has some meaning; try to determine the feelings behind a child’s actions and direct your response toward both the behavior and the feelings behind it.

10. Try to empathize with the child—this is especially important when you perceive the child’s behavior as “offensive.”

11. Be aware that a child may have a different belief system or reality different than your own; if distortions in thinking occur, offer alternatives—for example, a little boy says, “girls can’t do anything!” You can suggest an alternative statement by offering examples of things both boys and girls do equally well like paint, write, climb mountains, teach, etc.

12. Validate a child’s behavior; that is, if it’s abuse, call it abuse.

13. Confront abuse gradually rather than abruptly; denial can be a coping mechanism which is protecting a delicate psyche. Remember not to reinforce the denial by buying into the distortion. Silence reinforces denial.


15. Facilitate problem-solving behavior.
PROVIDER RESPONSE: WHAT CAN I DO TO HELP?

16. Draw attention to times when the child is doing well.

17. Have high expectations.

18. Build in successes to develop pride and self-esteem.

19. Provide a safe environment where it’s ok to make mistakes, which is how we all learn.

20. Help children to understand that it’s not their fault... “kids cannot solve adult problems.”


22. When in doubt, document fears, anxieties, behaviors, conversations...anything that will help you uncover a significant pattern about the child’s life.

23. Be aware that holidays and weekends can trigger real anxiety in abuse affected children.

24. Anticipate when a child may need some assistance and help him ask for it.

25. Teach self-help skills.

26. Keep choices simple with a clear cause and effect the child can understand.

27. Model clear boundaries.

28. Get permission from the child before touching.

29. Listen to the child; let her know that it’s ok to talk without your probing for additional information; repeat back what you heard in a non-judgmental way; ask open-ended questions (ones that can’t be answered with just a yes or no). If you are “shocked,” take a deep breath and reflect back what the child said; (if in doubt, call DHS and assess what you heard with one of the intake workers).

PROVIDER RESPONSE: WHAT CAN I DO TO HELP?

CAUTIONS

1. Be careful not to get caught up in a feeling of powerlessness about the situation or that you don’t lose faith in your ability...you actually can make a difference!

2. Be sure that what you do helps the child and family find their power. Don’t be a rescuer.

3. Not all problem behavior is the result of abuse. Neurological problems can create similar behaviors.

4. Remember that the child is a member of a family. Helping the child means also helping the family.
5. Feeling sorry for or pitying the abused child does not help his or her already damaged sense of self-worth. Empathy is more empowering and builds self-esteem.

6. Remember to take good care of yourself!

7. Keep that sense of humor handy at all times.

8. Know your limits.

9. Be aware of your own feelings and triggers regarding a certain child or a selected set of behaviors. Ask for help when you need it.

10. Be careful that you don’t allow yourself or the parent to justify abuse based on the child’s behavior.
**CASE STUDY (Tina)**

Tina the oldest sister of three siblings in your center is 6 years old. Tina is well-liked by the child care staff. She helps change the infants’ diapers and also helps put them down for naps. Tina helps clean up after snack time too. She’s very close to her siblings, always asking about them, defending them, and hovering over them when she happens to be near them during play or snack time. Tina has become very close to Blaine, one of the child care staff. Whenever she’s not doing something to help, Tina shadows Blaine everywhere, paying close attention to everything she does and says. Blaine was flattered at first, but she’s finding Tina’s constant accompaniment annoying and has asked her to play with the other kids instead. Tina rarely plays with the other children. When she gets involved with a chore, she berates herself if she makes a mistake. She mopes on Blaine’s days off and is constantly pestering the staff to tell her when Blaine will be back. When her parents or grandmother pick her up at the end of the day, they usually yell at her to “Hurry up! I haven’t got all goddam day!” Child care staff have noticed that Tina becomes even more quiet and withdrawn towards the end of the day. She has told Blaine that she wished she could live at the child care center. When Blaine asked why, Tina shrugged and said, “I just do.”

1. What do you think might be going on in this family?
2. What is your assessment of the child’s behaviors, feelings, perceptions?
3. How would you help the child and family?
4. What are the limits to what you can do?
Theresa is 4 years old. Her older sister and younger brother also attend your center. She rarely, if ever plays with the other children. When she arrives at child care, she goes directly to the play room to play with the blocks, to look at the picture books, or to just sit. She’d watch television all the time if the staff would let her. Other children, some fairly quiet themselves, have tried to engage Theresa in games but she either ignores them or just walks away when they approach. It seems that Theresa has some artistic talent so she spends a lot of time painting and coloring. When one of the staff praises her work, Theresa replies diffidently, “It doesn’t look like the way I want.” Theresa seems disconnected to everything around her. She doesn’t react to anything that you would think a 4 year old would like. For example, she almost never finishes the special snacks like ice cream and candy. She just sits at the table playing with the spoon ignoring everything and everybody around her. She trails after all the kids when they go on field trips to the zoo or to the museum where she never seems interested in any of the exhibits. She cringes from people who try to put their arm around her to steer her in a particular direction or who are just trying to show affection. When a staff person raises her voice to get the kids to behave, like her brother Terrence for instance, Theresa puts her hands over her ears and runs to the nap room to get away. Repeated requests to the parents for meetings or more detailed information about Theresa have been ignored. When it’s time for Theresa and her siblings to leave, they wait by the door and run to the car. The parents never get out of the car. They honk their horn repeatedly if the children are still inside when they arrive, which is usually later than the rest of the parents. Usually the children are greeted by their caregivers (parents and grandmother) with, “Hurry up, we haven’t got all goddam day!”

1. What do you think might be going on in this family?
2. What is your assessment of the child’s behaviors, feelings, perceptions?
3. How would you help the child and family?
4. What are the limits to what you can do?
Terrence is 3 years old and aggressive when playing with the other children. He always seems to want things his way. He has a short and intense temper especially when he’s frustrated. For example, when he can’t figure out how to complete a puzzle, his face turns beet-red, he screams in frustration, and flings the puzzle pieces against the wall. He also refuses to do what he’s told. For example, he refuses to take naps at child care and does not follow the rules of any game. During snack times, he consistently grabs food from the other kids. He doesn’t share toys and even when he’s not playing with any one toy, he still demands it from any child who happens to be playing with it. When the child refuses, Terrence grabs the toy and they have a “tug of war” which eventually leads to Terrence physically assaulting the other child in his desire to have the toy. Because of these behaviors, Terrence is perceived as an unfeeling bully and the other children have made every effort to avoid him. As a result, Terrence has become increasingly isolated. Child care staff have tried to engage him in play and conversation but Terrence either doesn’t respond or he mumbles a refusal. It’s clear that he’s uncomfortable with their attempts to be friendly. He has revealed nothing about his home life and physically backs away when ever the topic of his siblings (who also attend the same child care program) or his parents come up. On the other hand, Terrence’s unacceptable behavior has gotten him plenty of the wrong kind of attention from the child care staff who find themselves trying to figure out new ways of disciplining him or separating him from the other children. Repeated requests to the parents for meetings or for more detailed information about Terrence have been ignored. When it’s time for Terrence and his siblings to leave, they wait by the door and run to the car. The parents never get out of the car. They honk the horn repeatedly if the children are still inside when they arrive, which is usually later than the other parents. Usually the kids are greeted by their caregivers (parents and grandmother) with, “Hurry up, I haven’t got all goddam day!”

1. What do you think might be going on in this family?
2. What is your assessment of the child’s behaviors, feelings, perceptions?
3. How would you help the child and family?
4. What are the limits to what you can do?
1. The most important thing about an Action Item is that you write it so you or someone else will know that it occurs. You do this by using specific action verbs like the following (these are examples that you can use if you choose and if they are relevant to your Action Item):

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<tr>
<th>Thinking Skill</th>
<th>Physical Skill</th>
<th>Behavioral or Attitudinal Skill</th>
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<td>State</td>
<td>Design</td>
<td>Help</td>
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<td>Name</td>
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<td>Relate</td>
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2. When you write an Action Item, ask yourself the question, “Is the behavior I’m describing, observable?” Can I see it? Will it be obvious to me or others when it happens?”

3. Here are a few examples of Action Items:
   • Consult with supervisor whenever I have a suspicion that a child might be from an abuse affected family.
   • Document the behaviors of a child over time (5 days) to see if the behavior represents a trend.
   • Accept the child’s behavior because I know why the child acts the way he/she does.
   • Identify patterns of behavior that could signify abuse, document them, and discuss with my supervisor; seek out other resources to discuss behaviors.
   • Report to CPS whenever I suspect abuse.

4. Indicate a start date for trying out the Action Item.

5. It may not work out for you to try out the Action Item in the way you originally intended. That’s OK - the key is writing down your intention recognizing that you may have to modify your Action Item once you get back to your work site.

6. Include a follow-up meeting with the regional child care consultant or supervisor (6 - 8 weeks following the completion of the workshop) so you can discuss successes, obstacles to achieving your Action Item, and other resources. You may want to revise the Action Item after you speak with your consultant or you may want to write a different one.

## WORKSHOP: Caring for the Abuse Affected Child

### ACTION PLAN

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**ACTION ITEMS**

I plan to:

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<th>EXPECTED OUTCOMES</th>
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Maine Child Welfare Training Institute  
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Session Six:

Abuse Affected Behaviors, Feelings and Perceptions
Overview

Unit 1: Abuse Affected Behaviors, Feelings, Perceptions - Vignettes

Unit 2: Case Study - Tina, Theresa, Terrence

Unit 3: Participant Action Planning, Workshop Evaluation, and Closure
Purpose

1. Experiential application of new knowledge, skills and attitudes in responding to children and families affected by abuse.

2. Planning for how participants will integrate specific action items into their work.

3. Make closure with the group.
Objectives

1. Identify abuse affected behaviors a child or family might display in the child care setting and actions that could be taken to respond to that child and family.

2. Apply the concepts, tools and skills presented throughout the training sessions by examining and discussing case studies.

3. Write individual Action Plans, complete evaluations and make closure with the group.
Vignettes Discussion Guidelines

For each vignette:

Discuss the behavior described in the vignette -
- What are we seeing here?
- What might be going on in the child’s or adult’s life that could result in these behaviors?
- How might you respond? Why?

Spend about 10 minutes on each vignette.
Appendix 1: Substance Abuse Jeopardy

For Use with Session 2, Unit 1

Copy the following pages double sided on Avery #5388 Index cards or other cardstock and cut into three cards per page.
“Maine”ly Substances

100

In recent years, Maine has become the state with one of the highest addiction rates to this drug, a powerful pain killer more addictive than most narcotics.

(Answer: Oxycontin)

200

Name 2 Organizations in your county that provide substance abuse services.

(Answer: ________________________________ )
Name the 3 most commonly used illegal substances by Maine students in grades 6-12.

(Answer: Alcohol, Tobacco, Marijuana)

What is the maximum fine and jail time that Maine adults can face if providing alcohol to minors?

A. $50 and/or 15 days in jail  
B. $100 and/or 30 days in jail  
C. $1,000 and/or 6 months in jail  
D. $2,000 and/or 1 year in jail

(Answer: D. $2,000 and/or 1 year in jail)
100

Alcohol abuse can result in a failure to encode a memory when the drinker appears to be awake and alert. What is this called?

(Answer: Blackout)

200

Which substance, mixed with alcohol, is most likely to increase the risk of liver damage?

a. Aspirin
b. Tylenol (Acetaminophen)
c. Advil (Ibuprofen)

(Answer: b. Tylenol (Acetaminophen))

300

Long term cannabis use is particularly harmful to this body system.

(Answer: The respiratory system is most affected by the smoking of marijuana. Its high tar (resin) content coupled with the depth of inhalation begins affecting the lungs immediately.)
Chronic, heavy drinking commonly causes what liver disease?

(Answer: Cirrhosis of the liver)

Questions of Substance

Which of these drugs can cause long-term depressive symptoms because of the way it “burns out” the brain’s pleasure center?

a. Marijuana
b. Tobacco
c. Heroin
d. Cocaine

(Answer: d. Cocaine)
200
Which of the following is not considered to be a “date rape drug”?

a. Methamphetamine 
b. MDMA 
c. GHB 
d. Rohypnol 

(Answer: a. Methamphetamine)

300
Withdrawal symptoms from Ecstasy can last for up to:

a. 30 minutes 
b. 30 hours 
c. 3 days 
d. 3 weeks 

(Answer: c. 3 days. Withdrawal symptoms include: depression, irritability, poor concentration, forgetfulness, exhaustion and paranoia.)

400
Which household substance is commonly found in street acid when it is tested?

a. Bleach 
b. Camping Fuel 
c. Paint Thinners 
d. All of the above 

(Answer: d. All of the above)
Myth or Fact

100

Alcoholics must consume alcohol everyday to function.

(Answer: Myth)

200

Withdrawing from alcohol is potentially more life threatening than withdrawal from heroin.

(Answer: Fact)
Women can process alcohol more effectively than men, because they have more of the enzyme that helps break down the alcohol.

(Answer: Myth)

Marijuana can be detected in your body with a urine sample up to 45 days after you smoke it.

(Answer: Fact. 45 days is the maximum amount of time when urine samples have detected marijuana)

Cultural Influences
100
This large-eared children’s character flew for the first time while under the influence of alcohol.

(Answer: Dumbo)

200
What was the first state to pass prohibition in 1851?
a. Virginia
b. Maine
c. New York
d. Maryland

(Answer: b. Maine)

300
True or False: Part of the reason why the Mayflower landed in Plymouth in 1620 was because they were running out of beer.

(Answer: True)
In this classic novel, the main character launched his river adventures in order to escape his alcoholic father.

(Answer: Huck Finn)
Appendix 2: 19-Person Interactive Exercise

*For use with Session 3 Unit 3*

Print the following two pages single sided onto cardstock and cut into 16 cards per page. This template works well with Avery perforated Business Cards.
BATTERED WOMAN: In order for the exercise to be most convincing and realistic, the trainers should draw from their personal and professional understanding of abuse. The following sample responses are meant to be used as a guide rather than a script. Take care not to portray the battered woman as entirely helpless, afraid, and overwhelmed. While these are some of her feelings, it is important to reflect a wide range of emotions, such as courage, anger, affection, sense of humor, and frustration.

<table>
<thead>
<tr>
<th>Role</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minister</td>
<td>That is probably right. He has been through a lot, and his boss is always on his back. I could be more understanding, I suppose. Perhaps this is God’s way of showing me how selfish I have been.</td>
</tr>
<tr>
<td>Doctor</td>
<td>I’ve been sober for seven years. I can’t take sleeping pills. I guess there really is no hope for me. I’m so exhausted, though.</td>
</tr>
<tr>
<td>Friend</td>
<td>It is so hard to explain to people. He really is such a sweet man sometimes. I mean, it’s awful when he goes into his rages, but it’s not that often, and he is a great dad. I just wish he would get some help and remember how much I love him.</td>
</tr>
<tr>
<td>School Counselor</td>
<td>I’m really concerned about the kids, but if I leave, I’ll have to leave town and take them away from their friends and teachers. They love this school and their dad.</td>
</tr>
<tr>
<td>Nurse</td>
<td>This is so humiliating. What will she do if I tell her? She’ll think I’m so stupid for living with someone who would do this to me. Besides, he’s sitting right outside waiting for me. What if she calls the cops or something? Then I’ll be in real trouble.</td>
</tr>
<tr>
<td>Her Dad</td>
<td>I knew I shouldn’t have told my family what was going on. That’s just like my dad. He’ll go after Joe and then get himself hurt. This is so embarrassing. My whole family thinks I’m an idiot. Everyone is telling me to do something different.</td>
</tr>
<tr>
<td>Police Officer</td>
<td>I wish she hadn’t called them. They are so sick of me. I’d get out of here if I could figure out how to do it without making things worse, but he’ll kill me if I ever send him to jail.</td>
</tr>
<tr>
<td>Housing Authority</td>
<td>References!? The last place we lived belonged to his parents! Before that, the landlord kicked us out because of the damage he did to the place, punching holes in the walls. Gosh, before that...that landlord died last year. Is she saying that I have to take my kids to a shelter in order to get help finding a place to live?</td>
</tr>
<tr>
<td>Hotline Worker</td>
<td>This is horrible. You know, when I graduated from college I wasn’t thinking, “Gosh, one day I’ll be able to take my kids and move into a shelter for battered women!” I am such a failure.</td>
</tr>
<tr>
<td><strong>His Mom</strong></td>
<td>[Sarcastically] I have always appreciated her support. Since the day I met her, she has kept me up to date on what I have done wrong and the things I could do to be a better wife to her sweet Joey. When is someone going to notice that this is really hard for me, too? When am I going to deserve a little support?</td>
</tr>
<tr>
<td><strong>Kids</strong></td>
<td>This is breaking my heart. My kids are so sad. Their whole world has been turned upside down and I’m a wreck. I don’t even know if the kitten is still there. Joe was so angry when he found out we had gone, he just trashed the house.</td>
</tr>
<tr>
<td><strong>CPS Worker</strong></td>
<td>These people are going to take my kids! What am I going to do?</td>
</tr>
<tr>
<td><strong>Lawyer</strong></td>
<td>$1500!!! Right. I’ll never find money like that. He’ll break me. Just like he’s always said. I’ll never get custody of the kids.</td>
</tr>
<tr>
<td><strong>Sister</strong></td>
<td>Maybe I should talk to him. I’ve never stayed away this long before … he must know by now that I’m serious. I could never live with myself if he killed himself. What would I say to the kids? I have to call him.</td>
</tr>
<tr>
<td><strong>Defense Attorney</strong></td>
<td>How do I explain this? There we were; the kids and I had been in our horrid little apartment for a month. I did everything they told me to – I had a protective order, and we hadn’t seen him in weeks. When the doorbell rang, the kids looked out and yelled, “Daddy!! Daddy’s here!! And he’s got presents! Can we see him, Mom?” What was I going to do? Call the police? So, yeah, I invited him in. It didn’t look like he was going to hurt me.</td>
</tr>
<tr>
<td><strong>Judge</strong></td>
<td>I’m so scared. What will happen to them? He’s never been alone with them for more than an hour or so. I’ve always been there – when he was drunk, angry, frightening – I’ve always been there to protect them. But now – If he’ll do this to me, what will he do to them?</td>
</tr>
<tr>
<td><strong>Kids</strong></td>
<td>I wish it were that simple. It breaks my heart. I don’t want them to hate their father, so I can’t tell them all the things he’s done to me. I hope they forgive me for this someday.</td>
</tr>
<tr>
<td><strong>TANF Worker</strong></td>
<td>What!? These people don’t get it. I have no money, not a cent. Really. What am I going to do? He was right, I’ll never make it. I’m too tired, too poor, and too stupid.</td>
</tr>
<tr>
<td><strong>Judge</strong></td>
<td></td>
</tr>
</tbody>
</table>
BATTERER: In order for the exercise to be most convincing and realistic, the trainers should draw from their personal and professional understanding of abuse. The following sample responses are meant to be used as a guide rather than a script. The batterer must display both sweet words and threats. He may cut her off sometimes, since one of the points to illustrate is how the batterer’s presence in her mind interrupts the battered woman’s thought process and influences her feelings and choices. It is not necessary for the batterer to speak after every card. When he skips a couple of times, the audience anticipates his voice, engaged in their own little bit of hyper vigilance. The person playing the batterer should not call the person playing the battered woman by her name. It is out of character for a batterer and unsettling for the trainer playing the role. The intensity of the batterer’s presentation should not overwhelm the battered woman’s presence. The focus of the exercise is the battered woman, not the batterer.

<table>
<thead>
<tr>
<th>Minister</th>
<th>Batterer – We made a promise to God. Are you just going to walk away from that?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>I’ll go to counseling if you come back. Why don’t you just take these pills the doctor said would help you?</td>
</tr>
<tr>
<td>Friend</td>
<td>What have you been telling people? Do you have no pride? You shame me in front of our friends. Get out and take your brats with you</td>
</tr>
<tr>
<td>School Counselor</td>
<td>You can leave, but you’re not taking MY kids!</td>
</tr>
<tr>
<td>Nurse</td>
<td>You fell down the stairs, right? Don’t you go getting me in trouble – I’ll lose my job.</td>
</tr>
<tr>
<td>Her Dad</td>
<td></td>
</tr>
<tr>
<td>Police Officer</td>
<td>We are moving out of this neighborhood. Everybody is in our business. I know you didn’t call the police, did you? Because you slapped me first, remember.</td>
</tr>
<tr>
<td>Housing Authority</td>
<td></td>
</tr>
<tr>
<td>Hotline Worker</td>
<td>Where are you? If you leave, I’ll kill myself. I can’t live without you. You and the kids are everything to me.</td>
</tr>
<tr>
<td>His Mom</td>
<td></td>
</tr>
<tr>
<td>Kids</td>
<td>If you leave, I’ll report you for being an unfit mother, and you’ll lose the kids. I’ll tell them you’re using again. Had a drink lately?</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>CPS Worker</strong></td>
<td></td>
</tr>
<tr>
<td>Lawyer</td>
<td></td>
</tr>
<tr>
<td><strong>Sister</strong></td>
<td>You’ll never get away from me. I’ll find you wherever you go.</td>
</tr>
<tr>
<td><strong>Defense Attorney</strong></td>
<td>You just have to push my buttons. I just wanted to see my kids, but you had to get in my face, didn’t you?</td>
</tr>
<tr>
<td><strong>Judge</strong></td>
<td>Well, it’s about time somebody saw my side of things. You heard what the judge said, and believe me, every other weekend is not enough. You’ll be hearing from my attorney.</td>
</tr>
<tr>
<td><strong>Kids</strong></td>
<td>I really miss you, baby. I hear from the kids that you are working really hard. You know you have a home with me. I love you. I miss my family. I need you with me.</td>
</tr>
<tr>
<td><strong>TANF Worker</strong></td>
<td>No children of mine are going to be on welfare. I haven’t worked all these years to have my kids on the state. We have a good home, and I won’t have you humiliating my kids by making them live in a project.</td>
</tr>
<tr>
<td><strong>Judge</strong></td>
<td></td>
</tr>
</tbody>
</table>
Minister: Why did he hit you? Is he having a hard time at work?

Her dad: I told you he was no good. If he ever lays a hand on you again, I’ll kill him.

Doctor: You said you are having trouble sleeping because of your family problems. I’ll give you a prescription for sleeping pills. Here is a card for our local domestic violence project. You should call them. Also, the receptionist can give you a list of marriage counselors.

Police officer: When your neighbor called, she was really concerned about your. We are, too. We’ve been here three times. Are you going to follow through this time?

School counselor: You should leave. Do you know what this is doing to your kids?

Hotline worker: You can stay in the shelter for up to 30 days.

Nurse: Who did this to you?

His mom: How can you drag this through the courts? He'll lose his job. You know he loves you. He needs your support.
11

**Kids:** Mom, I want to go home. I miss my kitten and my bedroom. I don’t want to go to a new school.

12

**Child protective worker:** You should go to your local domestic violence project’s support group and learn ways to avoid getting into abusive relationships.

13

**Lawyer:** These custody cases can be messy and complicated. I’ll need a $1500 retainer.

14

**Sister:** He called me crying and real upset. He said he couldn’t live without you. You’ve got to go see him.

15

**Defense Attorney:** Isn’t it true that you invited him in that night?

16

**Judge:** The children will visit their father every other weekend.

17

**Kids:** Dad said you don’t love him anymore; that’s why he can’t come home.

18

**TANF worker:** It will take 3 to 6 weeks to process your case.

19

**Judge:** Guilty of assault. 48 hours suspended, $100 fine, two years probation.
Appendix 3: Continuum Exercise

For use with Session 4 Unit 2
Instructions for Continuum Exercise materials:

Copy the cards on the following pages front and back onto cardstock and cut out three cards per page. If you would like to use perforated cardstock, Avery Index Cards #5388 work well with this template.

Create posters or overheads showing the definitions of Child Abuse as well as the four primary types of abuse according to your state or local statutes. The text we use in the state of Maine is provided below.

**Child Abuse and Neglect**

“Abuse and neglect means a threat to a child’s health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these, by a person responsible for the child”

Title 22 MRSA, Section 4002

**Emotional Abuse**

Using words or behaviors that threaten, harshly criticize, ridicule, or harass the child; withholding affection; holding unrealistic expectations; associated with all forms of child abuse.

**Neglect**

Non-accidental failure or failure of a caretaker to provide a child physical, medical, or emotional necessities for normal life, growth and development. Helping in Child protective Services (1992)

**Sexual Abuse**

Child abuse which results in any act of a sexual nature upon or with a child; any sexual involvement of a parent or caretaker with a child as a sexual act. Sexual exploitation is involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to, and that violate social taboos of family roles. Helping in Child Protective Services (1992)

**Physical Abuse**

Physical injuries inflicted by a parent/caretaker; also called non-accidental trauma. These could be rated as mild, moderate, or severe. Helping in Child Protective Services (1992)
Adult forces or encourages sexual contact between children and watches

Adult exposes genitals to child

Use of child in pornography
Discipline of child involving genital harm - striking, inserting implement, binding

Adult has sexual contact with child

Adult forces child to expose self
Adults engage in sexual activity with child present

Prostitution of child

Sexual conversation with child which gratifies the adult or which is seductive towards the child
Emotional Abuse

Emotional Abuse

Emotional Abuse
Corrupting - Teaching Criminal or Immoral Behavior

Denying Emotional Responsiveness

Exploiting – using child as a servant or prostitute
Rejecting

Terrorizing

Telling the child
she/he is hated
Dramatically scapegoating the child

Degrading (“you’re evil, stupid, worthless”)

Isolating (locking in a room or closet)
Threats to send child away
Child lives in a car in January - parent has rejected housing

Child not receiving vitally important medication for allergies and asthma - results in hospitalization

Child has severe dental decay and has never been to a dentist in spite of Medicaid enrollment
Leaving child with others for a month or more with no contact from parent(s).

Frequently leaving the child with multiple caregivers, barely known to parent

Rarely touching or looking at child
Child frequently shows signs of excessive hunger and is not sure when last meal was

Grossly inattentive to hygiene

Child attends school in January (in Maine) without socks, boots, and wearing only a hooded sweatshirt
Parent(s) usually in bed while child is fending for self
Physical Abuse

Physical Abuse

Physical Abuse
Stabbing or Cutting

Punching

Beating or “Spanking” with paddle, stick, board, or other object
Burning with elements or liquid

Pushing

Burning with cigarettes
Slapping

Discipline by forcing child to stand with arms outstretched for long periods of time

Throwing
Suffocating
Sexual Abuse

Sexual Abuse

Sexual Abuse