

CHILD WELFARE ISSUES IN CASES WITH PARENTAL SUBSTANCE ABUSE, DOMESTIC VIOLENCE, AND MENTAL HEALTH PROBLEMS

Kathleen Coulborn Faller, Ph.D., A.C.S.W.

Professor of Social Work

Principal Investigator, Interdisciplinary Child Welfare Training Program

Introduction

This article will summarize knowledge about the coexistence of the parental problems, substance abuse, domestic violence, and mental health problems in cases involving child maltreatment and child welfare issues. The knowledge derives from both clinical experience and research related to such cases. Both sources of information have limitations.

Clinical experience and case studies provide fairly valid (or accurate) findings about the group of cases being examined. Findings also usually are based on extensive contact with the instant cases. However, these cases may not be representative of all cases of the sort that were examined.

On the other hand, research, especially survey research, is usually based upon samples that are representative. Its vulnerability is that the researcher must assume the participants are being honest. The research may rely on a single interview with the participants. Studies of this sort are more vulnerable to respondents denying inappropriate activities. This is particularly a problem when studying unacceptable and inappropriate behavior, like the behaviors of interest here: child maltreatment, substance abuse, domestic violence, and mental health problems. In addition, this research is usually too superficial to explore the complexity of behaviors and causal relationships. Thus, research conducted to date may demonstrate correlations and associations among client characteristics for example substance abuse and child welfare problems, but usually cannot enlighten us on how precisely these problems are related.

Despite the limitations of the knowledge base, it can inform professionals about relationships among these problems that can be helpful in assessing risks and making case management decisions. Accordingly, this article will cover the following areas. First, it will address the underlying issue of poverty. Second, it will examine information about the relationship between each of the three parental problems and child welfare and maltreatment. Third will be a discussion of the relationship among the parental problems. Fourth, the article will describe the few findings related to the intersection of two or more parental problems and child welfare issues.

The neglected underlying issue: Poverty.

An important point needs to be made before addressing the issue of the co-occurrence of the three parental problems, domestic violence, substance abuse, and mental health problems in situations where there are also child welfare issues. As the discussion will demonstrate, there are both correlation among these problems and commonalties in cases

that have them. However, there is another factor, not covered in this training endeavor, which underlies many cases with the above problems. That factor is poverty. Illustrative of the importance of poverty in the equation are the poverty rates among children. They are astonishingly high and increasing. According to the Census Bureau (U.S. Bureau of Census, 1992), 25% of all children and 50% of African American children are raised in poverty.

Poverty does not, by itself, cause domestic violence, substance abuse, mental health problems, or child maltreatment. Nevertheless, it increases the risk for and the severity of all of these problems (Hawley, Halle, Drasin, & Thomas, 1995; Kolar, Brown, Haertzen, & Michaelson, 1994). Child abuse and partner abuse are found in all social classes, but at higher rates in poor families (Gelles & Straus, 1992). Moreover, victims of domestic violence have fewer options for recourse when they are poor because they lack financial resources (Strube, 1988).

Similarly, substance abusers are found in all social groups, but in greater proportions among the poor (Resnik, Gardner, & Rogers, 1998). In addition, in poor families, substance abuse has not only detrimental psychological effects, but also financial effects because resources that would be used for necessities are likely to be diverted to drugs or alcohol (Holtzworth-Munroe & Stuart, 1994).

Studies document greater rates of mental health problems in poor populations. This is probably especially true of personality disorders, which are thought to derive from early deprivation. Although personality disorders are not merely caused by physical deprivation, lack of resources can increase the risk for the kind of traumatic early life experiences that are considered at the root of personality disorders.

Finally, the correlation of poverty and being identified as a maltreating parent is well documented (Gelles, 1992; Gelles & Straus, 1988; Gil, 1970; Straus, Gelles, & Steinmetz, 1980). Poverty is associated with more violence toward children and more severe violence toward them, especially violence by mothers (Gelles, 1992). When Protective Services Agencies are asked about the most troubling problem among families referred to them for child maltreatment, 51% cite poverty and economic strains (Wang & Daro, 1998). There is an especially high correlation between poverty and child neglect, which often is a direct consequence of lack of adequate resources (Giovonnoni, 1970), and when a number of predictors of neglect are examined, low income remains a key factor (Chaffin, Kelleher, & Hollenberg, 1996). Cases of child neglect have been and continue to be the majority of cases reported to Child Protective Services (Wang & Daro, 1998).

Furthermore, with welfare reform, the hardship suffered by families and children who are in situations of domestic violence, substance abuse, mental health problems, and child maltreatment will very likely get worse (Feig, 1998). Adults in families with these problems are often poorly suited to be members of the work force. Thus, they are at grave risk for being cut off welfare and associated benefits for non-compliance with the welfare work requirement. Even if they are able to comply in the short run with these

requirements, their problems are usually chronic, meaning they will need welfare support intermittently over their parenting time. Thus, they are likely to soon exhaust the five year lifetime limit for benefits.

Why is the issue of poverty not considered a legitimate factor to explore in the development of training materials to address cases involving parental domestic violence, substance abuse, and mental health problems where there are also child welfare issues? Professionals do not have to be cynical in order to understand this deficiency. Compared to other developed countries, the United States has a very minimal social welfare system. A reasonably accurate summary of the philosophy in the United States towards welfare is that that individuals are responsible for their own welfare, not society. Therefore, those who require assistance from the state are deficient. Moreover, dependence on the state is discouraged by making social welfare benefits extremely modest, when compared to benefits from work and other self support strategies (e.g. Jansson, 1993).

As a consequence, to take on the issue of the role of poverty in training such a this would lead to a recommendation of radical restructuring of the social welfare system, so that it provides a genuine safety net for those disadvantaged by poverty and its related problems, including domestic violence, substance abuse, mental health problems, and parenting deficits. Such a recommendation simply “would not fly” in Congress, which is responsible for the funding for this training; so poverty is judiciously ignored.

How should professionals proceed in the face of this governmental blind spot? Unless they are revolutionaries, they should develop strategies to help families and children within the existing structure. However, they should not lose sight of the underlying role of poverty. To do so would be to place undue blame on families and adults, with problems of domestic violence, substance abuse, mental illness, and parenting deficits, for their plight.

Parental problems and child welfare issues. There is a literature that examines the relationship of substance abuse and child welfare, domestic violence and child welfare, and even a few articles on mental health problems and child welfare. Major findings will be summarized and supported.

The strongest relationship is found between substance abuse and child welfare problems. This is not surprising, since it is estimated that there are four million substance abusing parents who have custody of six million children. These data do not include children who have been temporarily or permanently removed from the care of substance abusing parents (Feig, 1998; USDHHS, 1994). Furthermore, depending upon the source of information, between 45 and 88% of cases referred to child protective services have a parental substance abuse problem (Hampton, Senatore, & Gullotta, 1998; Wang & Daro, 1998). Not only is an extremely high correlation reported between substance abuse and being reported for child maltreatment, but child protection workers describe substance abuse to be among the most troubling problems on their caseloads (Wang & Daro, 1998). In families with substance abuse, the likelihood of child maltreatment is 3.6 times greater

than in families without substance abuse (Resnik, Gardner, & Rogers, 1998). Moreover, when there is substance in the family, 65% of maltreatment occurs when the parent is abusing substances (Resnik, Gardner, & Rogers, 1998). When children of substance abusing parents are placed in foster care, they are 4.5 times more likely to have been neglected than abused (Walker, Zangrillo, & Smith, 1991;1994). Finally, substance abuse can have an even more direct effect, in that the mother's use of substances, while she is pregnant or nursing, can physically harm the child.

The correlation between domestic violence and child maltreatment has also been documented. Fifty percent of batterers are estimated to also abuse their children (Saunders, 1994; Straus, 1983). Men who abuse their partners are seven times more likely to abuse their children than men who do not abuse their partners (Saunders, 1994; Straus, 1983). One fourth of women who are abused by their partners also abuse their children, and they are twice as likely to abuse their children than women who are not abused (Saunders, 1994; Straus, 1983). Furthermore, when Child Protection Agencies are queried about significant problems among their clients, 27% report domestic violence as a problem that characterizes a significant proportion of their cases (Wang & Daro, 1998). Recent findings from Longscan, a multi-site longitudinal study of abused and neglected children, indicates the correlation is much higher, with between 67 and 85% of child maltreatment cases having co-occurring domestic abuse (English, 1998).

As already noted, the research on the relationship between mental health problems and child welfare issues is less extensive. Moreover, it focuses on mental disorders, that is psychosis and major affective disorders, rather than personality disorders, which appear more common among clients referred to Child Protective Services (Melhuish, Gambles, & Kumar, 1988; Mowbray, Oyserman, Zemencuk, & Ross, 1995). Nevertheless, when Child Protective Agencies are polled, 39% cite lack of parenting skills, in part brought on by mental health problems, as a serious problem experienced by their clients (Wang & Daro, 1998). In one study, parents with anti-social personality disorder and parents with depression were both about five times more likely to abuse their children than parents without these diagnoses, and parents with these diagnoses were even more likely to neglect their children (Bland & Orn, 1986).

Associations between domestic violence, substance abuse, and mental health problems.

There is also clinical and research literature about the relationship between substance abuse and mental health problems, substance abuse and domestic violence, and mental health problems and domestic violence. The literature reports on both the correlations and causal links.

Mentally ill individuals may inappropriately self medicate with legal (alcohol and over the counter drugs) or illegal substances (street drugs). Approximately half of severely mentally ill persons also have a problem with alcohol or other drugs (Ries, 1994). There is a high correlation between alcohol use and depression, which is probably bi-directional (Goldberg, 1998; Ries, 1994). That is alcohol depresses the central nervous system and thereby the person using it, and depressed people may use alcohol in an attempt to numb

their feelings of depression. Women who abuse alcohol are more likely to be depressed than men (Ries, 1994). Polydrug use is more likely to be found with personality disorders. Individuals with personality disorders may use drugs or alcohol to diminish symptoms, to dampen feelings of low self esteem, to decrease guilt feelings, and to combat feelings of diminished sense of self (Ries, 1994).

Substance use can increase the probability of domestic violence (Kantor & Straus, 1987). In half of domestic violence cases, there is co-existing use of alcohol (Resnik et al., 1998). Men with a substance abuse problems are 5.5 times more likely to engage in domestic violence than men without one (Bland & Orn, 1986). Studies that compare violent men to happily married and unhappily married, non-violent men find that violent men drink more (e.g. Dutton, 1988). Similarly in a study by Coleman, Weinman, and Hsi (1980), drinking was the best predictor of whether or not men in conflictual marriages would be violent. However, this does not mean substance use causes men to be violent toward their partners, and, if they cease drinking, they will stop being violent as well. Men who have never abused substances and men who are abstinent also abuse women (Bennett, 1997). Substances may distort perception and alter judgment (Bennett, 1997). In addition, abuse of substances and domestic violence may derive from a common personality characteristic or dynamic, *machismo* or hyper-masculinity.(Bennett, 1997; Gondolf, 1995).

Although alcohol has commonly been described as a disinhibitor in situations of domestic violence, it is not clear whether it is a genuine disinhibitor or an excuse (Bennett, 1995; Giles-Sims, 1985). In any case, clinical reports indicate substances may initially play an instrumental role, but as the pattern of abuse becomes established, the batterer is less likely to need alcohol to abuse. Alcohol is not the only substance that increases the propensity for violence. So does crack-cocaine (Resnik, et al., 1998).

On the other hand, abused women may resort to alcohol or drugs to self medicate in an abusive situation. Substance abuse may also be regarded as a manifestation if the avoidance component of Post Traumatic Stress Disorder when women are being battered (Campbell & Lewandowski, 1997). Women with a pre-existing substance abuse problem may be less capable of exiting an abusive relationship, and their substance use may enrage their partners increasing the risk for assault.

Finally there are established relationships between domestic violence and mental health problems. With regard to batterers, only a small proportion have major psychiatric illness, that is Axis I diagnoses of psychoses and major depressive disorders (Saunders, 1993), but dynamics of the behavior of many batterers can also be understood in terms of personality disorders (Saunders, 1993). Psychological typologies vary somewhat, but include batterers with anti-social personality disorder, narcissistic personality disorder, borderline features, and obsessive-compulsive disorder (Healey, Smith, & O'Sullivan, 1998; Holtzworth-Munroe & Stuart, 1994). One study found that violence, including child abuse, spouse abuse, and violence in the community, was strongly associated with a

psychiatric diagnosis. Fifty-four percent of respondents with a psychiatric diagnosis were violent compared to 15.5% without a diagnosis (Bland & Orn, 1986).

There are, however, different types of batterers. Typically a differentiation has been made between those who are only violent within the family, described as dependent, with overcontrolled hostility, and those who are violent both within the family and in the community, described as dominant, with undercontrolled hostility (Hofeller, 1980; Saunders, 1993). The former are noted to commonly feel remorse about their abusive behavior and the latter not. Saunders (1992; 1993), in a multi-modal study of 165 batterers, discerned three patterns, generally aggressive, family only, and emotionally volatile. The generally aggressive type was the most likely to report a history of severe childhood abuse, to use alcohol when abusive, and to severely assault his partner. The family only abuser evidenced less severe psychological problems, being less likely to have been abused during childhood, reporting lower levels of anger and higher levels of marital satisfaction, and having less rigid sex role beliefs. Finally, emotionally volatile batterers were the most likely to evidence severe emotional distress, including extreme jealousy, anger, and depression and suicidal ideation. Alcohol was not usually associated with their abuse, and they were more likely to engage in repeated psychological abuse than in severe physical abuse. (Saunders, 1992; 1993).

Women who are the victims of domestic violence may both have pre-existing mental health problems that make them more vulnerable to battering and may suffer mental health problems as a consequence of battering. Clinicians note some women with pre-existing mental health problems may make poor choices about partners and may have difficulty leaving battering situations. The most common sequela of battering is depression (Campbell & Lewandowski, 1997). Frequency and severity of spousal abuse are much stronger predictors of depression than pre-morbid factors (e.g. mental illness) (Campbell & Lewandowski, 1997). Another common sequela of domestic abuse is post traumatic stress disorder or complex PTSD (Campbell & Lewandowski, 1997; Dutton, 1993).¹

Situations in which parents have two or more problems and there are child maltreatment or welfare issues

Few clinicians and researchers have attempted to address cases with several parental problems and child welfare issues. However, there is some literature that suggests that a combination of a history of substance abuse and a psychiatric diagnoses markedly increases the risk for violence. In one study, a mental health diagnosis was not predictive of violence except when there is a co-morbidity of substance abuse (Chaffin, et al., 1996).

¹ The DSM IV defining criteria for PTSD are 1. A traumatizing event involving bodily injury or threat to life, 2. Intrusive re-experiencing of symptoms (e.g. nightmares, flashbacks, intrusive thoughts about the event), 3. Generalized numbing of responsiveness (e.g. emotional constriction, flat affect), and 4. Physiological reactivity (e.g. anxiety, hyperarousal). Complex PTSD results from prolonged and repeated traumatization and often is associated with “traumatic bonding” or a pathological dependency upon the offender. Complex PTSD is most often associated with hostage situations, but has also been defined as a potential consequence of battering and child abuse (Brown, Schefflin, & Hammond; 1998; Herman, 1992)

The research does not differentiate between violence generally, domestic violence, and child abuse. Similarly, 80% of individuals who had a substance abuse problem and a psychiatric diagnosis of anti-social personality disorder and 93% of individuals with co-existing substance abuse and depression had histories of violence (Bland & Orn, 1986).

Conclusion

Clinical and research based knowledge suggests that parental functioning has serious implications for parenting and child welfare. Moreover, when a parent has one problem in functioning, he/she may be predisposed to have other problems. The co-existence of more than one dysfunctional behavior pattern in parents severely jeopardizes their ability to provide adequate care for their children.

References

- Bland, R., & Orn, H. (1986). Family violence and psychiatric disorder. Canadian Journal of Psychiatry. 31, 129-137.
- Brown, D., Schefflin, A., & Hammond, C. (1998). Memory, trauma, treatment, and the law. New York: W.W. Norton.
- Campbell, J. & Lewandowski, L. (1997). Mental and physical effects of intimate partner violence on women and children. Psychiatric Clinics of North America. 20(2), 353-374.
- Chaffin, M., Kelleher, K., & Hollenberg, J. (1996). Onset of physical abuse and neglect: Psychiatric, substance abuse, and social risk factors from prospective community data. Child Abuse and Neglect. 20(3), 191-203.
- Coleman, K., Weinman, M., & Hsi, B. (1980). Factors affecting conjugal violence. Journal of Psychology. 105, 297-202.
- Dutton, D. (1988). Domestic Assault of Women: Psychological and Criminal Justice Perspectives. Boston: Allyn & Bacon.
- Dutton, M.A. (1993). Understanding women's responses to domestic violence: A redefinition of battered wives' syndrome. Hofstra Law Review. 21, 1191-1194.
- English, D. (1998, Nov. 19). Child abuse and neglect: An ecological perspective, Panel presentation with others. 12th National Conference on Child Abuse and Neglect, Cincinnati.
- Feig, L. (1998). Understanding the problem: The gap between substance abuse programs and child welfare services, (pp. 62-95). In R. Hampton, V. Senatore, & T. Gullotta, (Eds.), Substance Abuse, Family Violence, and Child Welfare. Thousand Oaks, CA.: Sage.
- Goldberg, R. (1998). Practical Guide to the Care of the Psychiatric Patient. (2nd. Ed.) New York: Mosby.
- Gelles, R. (1992). Poverty and violence toward children. American Behavioral Scientist. 35(3), 258-274.

- Gelles, R. & Straus, M. (1988). Intimate Violence. New York: Simon & Schuster.
- Gil, D. (1970). Violence toward Children: Physical Child Abuse in the United States. Cambridge: Harvard University Press.
- Giles-Sims, J. (1983). Wife-battering: A Systems Theory Approach. New York: Guilford.
- Giovonnoni, J. (1970). Parental mistreatment: Perpetrators and victims. Journal of Marriage and the Family. 11, 649-657.
- Hawley, T., Halle, T., Drasin, R., & Thomas, N. (1995). Children of addicted mothers: Effects of the “crack epidemic” on the care giving environment. American Journal of Orthopsychiatry. 65, 364-379.
- Healey, K, Smith, C., & O’Sullivan, C. (1998). Batterer Intervention: Program Approaches and Criminal Justice Strategies. Wash., D.C.: Department of Justice, National Institute of Justice.
- Herman, J. (1992). Trauma and recovery. New York; Basic Books.
- Hofeller, K. H. (1980). Social, psychological, and situational factors in wife abuse. Dissertation Abstracts International, 41(1-B), 408.
- Holtzworth-Munroe, A. & Stuart, G. (1994). Typologies of batterers: Three subtypes and differences among them. Psychological Bulletin. 116(3), 476-497.
- Jansson, B. (1993). The Reluctant Welfare State, 2nd ed. Pacific Grove, CA.: Brooks/Cole Publishing Co.
- Kantor, G. K., & Straus, M. (1987). The “drunken bum” theory of wife beating. Social Problems. 34(3), 213-230.
- Kolar, A., Brown, B., Haertzen, C., & Michaelson, B. (1994). Children of substance abusers: The life experiences of children of opiate addicts in methadone maintenance. American Journal of Drug and Alcohol Abuse. 20, 159-171.
- Melhuish, E., Gambles, C., & Kumar, R. Chapter 8: Maternal mental illness and mother-infant relationship. Pp. 191-211. In R. Kumar & I.F. Brockington (Eds.), Motherhood and mental illness V.2: Causes and consequences. Boston: Wright Publishers.
- Mowbray, C., Oyserman, D., Zemencuk, & Ross, S. (1995). Motherhood for women with serious mental illness. American Journal of Orthopsychiatry. 21-38.
- Ries, R. (1994). Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and other Drug Abuse. Wash., D.C.: USDHHS, SAMHSA.
- Resnik, H., Gardner, S., & Rogers, C. (1998). Child welfare and substance abuse: Premises, programs, and policies. (pp. 96-123). In R. Hampton, V. Senatore, & T. Gullotta, (Eds.), Substance Abuse, Family Violence, and Child Welfare. Thousand Oaks, CA.: Sage.

Saunders, D. (1994). Child custody decisions in families experiencing woman abuse. Social Work, 39(1), 51-59.

Saunders, D. (1998). Child custody and visitation decisions in domestic violence cases: Legal trends, research findings, and recommendations. Violence Against Women Net. <http://www.vaw.umn.edu/Vawnet/custody.htm>.

Saunders, D. (1992). A typology of men who batter: Three types derived from cluster analysis. American Journal of Orthopsychiatry.

Saunders, D. (1993). Husbands who assault: Multiple profiles requiring multiple responses. In N.Z. Hilton (Ed.), Legal responses to wife assault. Newbury Park, CA.: Sage.

Straus, M. (1983). Ordinary violence, child abuse, and wife-beating: What do they have in common? In D. Finkelhor, G. Hotaling, & M. Straus, (Eds.), The Dark Side of Families: Current family violence research (pp. 213-234). Beverly Hills: Sage.

Straus, M., Gelles, R., & Steinmetz, S. (1980). Behind Closed Doors. Garden City, N.Y.: Anchor.

Strube, M.(1988). The decision to leave an abusive relationship. In G. Hotaling, (Ed.), Coping with Family Violence: Research and Policy Perspectives. Newbury Park, CA.: Sage.

U.S. Bureau of Census (1992). Poverty in the United States, 1988-1989. Current Population Reports. (Series P-60, No. 171) Wash., D.C.: Government Printing Office.

U.S. DHHS. (1994). Substance Abuse among Women and Parents. Wash., D.C.: HHS Office of the Assistant Secretary for Planning and Evaluation.

Walker, C., Zangrillo, P., & Smith, J. (1991). Parental drug abuse and African American children in Foster Care: Issues and Study Findings. Wash., D.C.: HHS Office of the Assistant Secretary for Planning and Evaluation.

Walker, C., Zangrillo, P., & Smith, J. (1994). Parental drug abuse and African American children in foster care. In J. Berrick & N. Gilbert, (Eds.), Child Welfare Research Review. (pp. 109-122). New York: Columbia.

Wang, C-T., & Daro, D. (1998). Current Trends in Child Abuse Reporting and Fatalities. Chicago: National Committee to Prevent Child Abuse.